

Review of COVID-19 Mandatory Vaccination Orders in Victoria

Independent Pandemic Management Advisory Committee
September 2022

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Message from the Chair

Vaccine mandates have been introduced worldwide during the COVID-19 pandemic with varying requirements to increase vaccination coverage. The mandates imposed in Victoria have been relatively extensive and prolonged in comparison to those in other jurisdictions.

They are more intrusive than other public health interventions as they impose requirements which impact the personal freedoms of individuals. For this reason, and that it is estimated they have impacted over 1.25 million of Victoria's workers, the Independent Pandemic Management Advisory Committee (IPMAC) is of the view that it is in the public interest to review the public policy considerations that have informed the use of this public health measure.

This review assesses pandemic vaccination mandate orders made by the Minister for Health against a set of core prerequisites to inform any future public policy considerations on the use of this measure. The intent is not to evaluate their effectiveness as a public health measure.

Victoria's first COVID-19 vaccine mandates were introduced in September 2021 during Victoria's last lockdown. Initial mandates applied to high-risk settings to reduce incidence of severe disease and transmissions, applying to settings where workers interact with vulnerable populations, high-transmission workplaces, and across essential services supporting service continuity. By October 2021 the scope of occupations had progressively expanded to include all general workers, with the purpose of rapidly increasing vaccination coverage and limiting community transmission. Between December 2021 and July 2022, the period of this review, vaccine mandates were retained by the Minister for Health through pandemic orders. In January 2022, the Minister further expanded requirements for some highest-risk workers and settings to include a booster third dose. They have been effective in achieving these objectives but by their very nature they have impacted people's human rights and had negative social and economic consequences for some individuals.

The Public Health and Wellbeing Act 2008 includes provisions to ensure the regular review of the necessity to retain a pandemic declaration on reasonable grounds that it is necessary to protect public health. This establishes the importance of the ongoing active review of intrusive interventions to limit their impact on human rights and promote public confidence in and support for restrictive public health measures. The mandates were regularly reviewed by the Minister for Health and the considerations taken into account in weighing the public health benefits and human rights impacts articulated in the Statement of Reasons and Human Rights Statement publicly available on the Department of Health website. The Minister found that in weighing the public health benefits against the countervailing potential impacts on individuals and the community, they were reasonably necessary to protect public health.

Maintaining high levels of participation in vaccination remains critical as long as we continue to live in a global pandemic. Vaccine mandates have proven to be a powerful measure in preventing transmission and preventing severe disease. IPMAC's findings should inform any future consideration of mandates in Victoria.

In mandating vaccines, the Victorian Government has taken responsibility for the benefit of public good instead of placing the onus on industry and other employers who have demonstrated support for this intervention. In the absence of pandemic order vaccine mandates, other regulatory and non-regulatory mechanisms require consideration to ensure employers are appropriately supported to facilitate vaccine uptake across their workforces. Regardless, critical to encouraging and facilitating vaccine uptake is strong vaccine promotion leadership from government. Equitable access to vaccines, particularly for high-risk settings, must also be sustained.

IPMAC is of the view that the Committee has a positive and beneficial role to play in informing the Minister's exercise of powers under Part 8A of the *Public Health and Wellbeing Act 2008*.

The Public Health and Wellbeing Act 2008 requires the Minister to arrange for an independent review to be conducted of the operation of Part 8A within 18 months of commencement. The role of IPMAC should be an important consideration in this review.



Penny Armytage AM
Chair

Acronyms and Abbreviations

Acronym	Explanation
ACHO	Acting Chief Health Officer
AHPPC	Australian Health Protection Principal Committee
ATAGI	Australian Technical Advisory Group on Immunisation
CALD	Culturally and linguistically diverse
CDC	Centres for Disease Control and Prevention (USA)
the Charter	Charter of Human Rights and Responsibilities Act 2006
CHO	Chief Health Officer
DET	Department of Education (Victorian)
DFFH	Department of Families, Fairness and Housing (Victorian)
DH	Department of Health (Victorian)
DJPR	Department of Jobs, Precincts and Regions (Victorian)
DO	Detention Order
DPC	Department of Premier and Cabinet (Victorian)
IHR	International Health Regulations
IPMAC	Independent Pandemic Management Advisory Committee
LGA	Local Government Area
LPHU	Local Public Health Unit
MGO	Movement and Gathering Orders
OH&S Act	<i>Occupational Health and Safety Act 2004</i>
OPO	Open Premises Order
PDAOC	Pandemic Declaration Accountability and Oversight Committee
PHW Act	Public Health and Wellbeing Act 2008

Acronym	Explanation
PPE	Personal protective equipment
QITO	Quarantine, Isolation and Testing Orders
SoR	Statement of Reasons
TGA	Therapeutic Goods Association
VE	Vaccine Effectiveness
VHCFO	Visitors to Hospital and Care Facility Orders
VOC	Variant of Concern
WHA	World Health Assembly
WHO	World Health Organisation
WO	Workplace Orders

IPMAC Membership

Penny Armytage AM (Chair)

- Former Chair of the Royal Commission into Victoria's Mental Health system and former Secretary of the Victorian Department of Justice
- KPMG Partner and Special Advisor 2012 -2019

Paris Aristotle AO

- Chief Executive Officer of Victorian Foundation for Survivors of Torture and currently the Chair of the Refugee and Migrant Services Council

Pip Carew

- Health sector professional with 20 years of experience in clinical nursing and union representation

Assoc. Prof. Joseph Doyle

- Infectious diseases physician and public health physician

Belinda Duarte

- Cultural education and training leader and Chief Executive Officer of Culture Is Life

Dr Peter Harcourt OAM

- Sport and exercise physician and Chair of International Cricket Council Medical Advisory Committee

Michael Graham

- Chief Executive Officer of the Victorian Aboriginal Health Service and Acting Chair of Victorian Aboriginal Community Controlled Health Organisation.

Rabea Khan

- Barrister, previously a lawyer with the Office of Public Prosecutions, Independent Broad-based Anti-Corruption Commission and Victorian Aboriginal Legal Service

Vivienne Nguyen AM

- Chairperson of the Victorian Multicultural Commission

Dr Amanda Rojek

- Clinical Research Fellow, Pandemic Sciences Institute, University of Oxford

Mark Stone AM

- Former Chief Executive Officer of Victorian Chamber of Commerce and Industry

Dr Helen Szoke AO

- Former Victorian Equal Opportunity and Human Rights Commissioner, and member of Advisory Boards for the Royal College of Surgeons and the Royal College of Australia and New Zealand Obstetrics and Gynaecology

Executive Summary

The use of vaccine mandates is not a new concept having been used in Australia and worldwide in different forms to increase and sustain vaccination coverage across a range of infectious diseases.

In Australia, high vaccination coverage was established as a national priority through the *National Plan to Transition Australia's COVID-19 Response* in August 2021 to enable the gradual re-opening of the country and to end the use of highly restrictive control measures. Vaccine mandates were first introduced in September 2021 as public health directions made by the Chief Health Officer under emergency powers activated on 16 March 2020 when the Minister for Health, on the advice of the Chief Health Officer, declared a 'state of emergency' under the *Public Health and Wellbeing Act 2008* (PHW Act). On 15 December 2021 when the legislative framework for making pandemic orders set out in Part 8A of the PHW Act was introduced, the vaccine mandates were sustained by the Minister for Health as the decision maker.

The mandates oblige employers to ensure workers are vaccinated to attend their place of work. They apply to high-risk workforces dealing with vulnerable clients, such as hospitals, aged care, education, some high-transmission industry settings and essential services sectors. Over time, a sub-set of high-risk workers had an additional booster third dose requirement mandated. All other general workers in Victoria were also subject to a two-dose requirement with slightly less onerous obligations placed on employers. The orders changed over time as the pandemic evolved. As of 12 July 2022, most requirements have been revoked with a three-dose mandate for highest-risk settings required to protect the vulnerable being the only mandate remaining in place.

As mandates are more intrusive than other interventions to increase vaccination coverage there are important public policy considerations that must be taken into account. Governments must balance the public health benefits with the impost on individual human rights of individuals, while also considering the other social and economic impacts both from the public health risk at hand and the impact of the mandates themselves.

High vaccination coverage has played a key role in the safe opening of Victoria and ending lockdowns – driven by Commonwealth and state policy. Vaccine mandates have contributed to high vaccination coverage amongst workers, reducing incidence of severe disease and transmission in high-risk industries, high-risk settings where workers interact with vulnerable populations and across essential services supporting service continuity. Overall, there has been industry and worker support for mandates and the fact that state-wide mandates removed the responsibility and onus from industry to implement them.

At the same time, they have impacted people's human rights and individuals differently depending on their underlying knowledge, attitudes, belief and value systems with some experiencing economic and social exclusion.

The purpose of this review is to assess pandemic vaccination mandate orders made by the Minister for Health against a set of core prerequisites to inform any future public policy considerations on the use of this as a public health measure.

IPMAC has considered the evidence base to identify prerequisites that must be met for the introduction of vaccine mandates, including the most contemporary literature, guidance from the World Health Organisation, principles of the *Public Health and Wellbeing Act 2008* and the *Charter of Human Rights and Responsibilities Act 2006*.

The prerequisites identified by IPMAC are as follows:

Human rights and legal considerations

- The mandate should be legal
- The mandate should appropriately consider and weigh human rights considerations
- The rationale for the mandate should be transparent and communicated clearly to the community

Public health considerations

- Burden of disease should be high enough to justify a mandate
- The mandated vaccines should be safe and effective
- The vaccines should reduce transmission or minimise the severity of health impacts
- Vaccine supply should be sufficient and easily accessible and equitably available
- Less restrictive, trust-promoting measures should come first.

IPMAC is of the view that vaccine mandates introduced by the Minister for Health through pandemic orders met the prerequisites at the time of their implementation. The Minister exercised powers appropriately in making vaccine mandate pandemic orders under the new pandemic management legislation. The Committee has however, found communication of some decision-making could be enhanced to improve transparency in the future.

While the Minister demonstrated vaccine mandates were reasonable to protect public health, the additional vaccination coverage gained between December and June diminished over this period with the vast majority already achieved in December 2021. At each of the key decision-making points, the Minister found the mandates were necessary and proportionate demonstrating other considerations that had informed decision-making.

The rationale for the classes of workers/occupations subject to vaccine mandates was not clearly communicated in the Minister's Statement of Reasons. This should be a focus for greater transparency in any such decision-making moving forward. There is also an opportunity to provide more clarity on the consultation undertaken given the importance of balancing the rights of individuals and the promotion of public good.

IPMAC is cognisant that this report is being produced in the third year of the pandemic and that the environment has changed significantly over this time. At the time of writing, Victoria is experiencing declining case numbers and hospitalisation having passed the peak of the winter 2022 wave. However, the scientific and public health advice is clear – the global population will continue to experience periodic waves of COVID-19 infection with some likely to be associated with significant burden of disease. The SARS-CoV-2 virus will continue to evolve with some new variants likely to evade population immunity, whether that immunity was acquired from vaccination, prior infection or a hybrid of the two. Seasonality, changing patterns of behaviour, and waning immunity over time will also contribute to waves of infection. Vaccines and vaccination policy will also continue to evolve over time, with the Australian Technical Advisory Group on Immunisation (ATAGI) already recommending a fourth dose for Victorians aged over 50 years or whom have other risk factors. Victorians 30 to 49 years are eligible for a fourth dose. A fifth dose is recommended for the immunocompromised.¹

1 [Department of Health and Aged Care, COVID-19 Booster Vaccine Advice webpage, 9 August 2022, Australian Government](https://www.health.gov.au/initiatives-and-programs/covid-19-vaccines/getting-your-vaccination/booster-doses) <<https://www.health.gov.au/initiatives-and-programs/covid-19-vaccines/getting-your-vaccination/booster-doses>>

Maintaining high levels of participation in vaccination programs will continue to be an important priority in the public health response to COVID-19. A strong health promotion and engagement effort from government is critical to encourage and facilitate vaccine uptake. Equitable access to vaccines must also be sustained.

In the absence of pandemic order vaccine mandates, other regulatory mechanisms would be required to support employers to facilitate vaccine uptake across their workforces. The recently introduced regulatory powers under the *Occupational Health and Safety Act 2004* that ensure employers have the information they need to make decisions on necessary control measures at their workplace, which may include vaccination, are one such measure. Government has a continued role to play in engaging with and facilitating industry to enable vaccine uptake among their employees.

Summary of key findings

Legal and human rights considerations

Key Findings – legal and human rights prerequisites

Prerequisite 1: The mandates should be legal

Public health rationale for mandates

1. The vaccine mandates were reasonably necessary to protect public health.
2. The Minister for Health's Statement of Reasons include minimal information on the rationale for vaccine mandates and instead focus on the reasons for them to be maintained.
3. The decision-making process for why the classes of workers were included in pandemic orders was not clearly communicated in the Minister's Statement of Reasons.

What can a pandemic order include and to whom can it apply

4. COVID-19 vaccination mandates fall inside the scope of what a pandemic order may include.
5. COVID-19 pandemic orders can be applied differently to people based on their vaccination status.

Minister must consult before making a pandemic order

6. In accordance with the *Public Health and Wellbeing Act 2008* the Minister requested and had regard for the advice of the Chief Health Officer and others to make pandemic orders for vaccination mandates.
7. The Statement of Reason provides limited detail on consultation regarding vaccination mandates.

Publication of a pandemic order and associated documents

8. All pandemic orders relating to vaccine mandates have been made publicly available on the Pandemic Orders Register in accordance with the *Public Health and Wellbeing Act 2008*.
9. The Chief Health Officer's advice, the Human Rights Statement and the Statement of Reasons have been published within seven days of the pandemic orders being made.

Scrutiny, suspension and disallowance of pandemic orders

10. The Pandemic Declaration Accountability and Oversight Committee has not requested any advice from IPMAC in relation to the disallowance in whole or in part of any vaccine mandate pandemic orders.

Prerequisite 2: The mandate should appropriately consider and weigh human rights considerations

11. The factors identified in *Equal Opportunity and Human Rights Commission Explainer: Mandatory COVID19 vaccination and your rights* are addressed in the Minister's Statement of Reasons and Human Rights Statements.
12. The assessment of human rights exceeds the requirements of the legislation by providing detail and explanation on rights both limited and affected by the vaccine mandates.
13. The Right to Life was positively impacted by the vaccine mandates by protecting vulnerable cohorts from COVID-19.
14. Alternative means and some additional supports were considered.

Prerequisite 3: The rationale for the mandate should be transparent and communicated clearly to the community

15. There was significant communication undertaken by the Victorian Government departments targeting industry through established and new networks.
16. The rationale for the occupational groups included in the different orders and thus subject to different obligations could have been more transparent.

Public health considerations

Key findings – public health prerequisites

Prerequisite 4: Burden of disease should be high enough to justify a mandate

17. The burden of disease associated with COVID-19 has been established and is high enough to warrant consideration of vaccine mandates, particularly in high-risk populations.
18. The consideration must nevertheless take into account the various other factors contained within this report.

Prerequisite 5: The mandated vaccines should be safe

19. The COVID-19 vaccines available through the mandates were found to have an acceptable safety profile by the Therapeutic Goods of Australia.

Prerequisite 6: The vaccines should be effective in reducing transmission and or minimising the severity of health impacts

20. There is evidence to support the use of vaccines to prevent severe disease, in particular for those who have received a third dose. However, vaccine effectiveness in preventing severe disease reduced over time, and the usefulness of vaccine mandates that did not require a booster in an appropriate timeframe is questionable.

21. There is evidence to support the use of vaccines to prevent transmission, in particular for those who have received a third dose. However, vaccine effectiveness against disease transmission was weaker than vaccine effectiveness for prevention of severe disease and reduced more significantly over time. The utility of vaccine mandates that did not require a booster in an appropriate timeframe is questionable.

Prerequisite 7: Vaccine supply should be sufficient and easily accessible and equitably available

22. Vaccines have been in short supply at some points in time but for the most part it has been sufficient.
23. The Department of Health has undertaken specific actions to ensure that priority groups and workforces could access vaccines.

Prerequisite 8: Less restrictive, trust promoting measures should come first

24. The Minister for Health has considered less restrictive measures than vaccine mandates to address the public health risks.
25. Vaccine mandates were adopted following the implementation of a range of less restrictive measures and at some points in time when equally or more restrictive controls were in place.
26. Mandates may also be implemented alongside less restrictive measures where the speed of uptake is critical to mitigating serious public health risks.

1. Independent Pandemic Management Advisory Committee (IPMAC)

The primary role of IPMAC is to provide advice to the Minister for Health on the exercise of powers under Part 8A of the *Public Health and Wellbeing Act 2008* (PHW Act). As an independent advisory committee, IPMAC can review, provide advice and make non-binding recommendations to the Minister on the exercise of the powers under Part 8A of the PHW Act. The provision of this advice can be on its own initiative or on request by the Minister.

Under the PHW Act, the Pandemic Declaration Accountability and Oversight Committee (PDAOC) must request and consider the advice of IPMAC before it can recommend that a pandemic order, or an instrument that extends, varies or revokes a pandemic order, be disallowed in whole or in part. PDAOC is a joint investigatory committee of the Parliament of Victoria that reviews the pandemic orders and other instruments made by the Minister for Health to ensure they are compatible with the human rights set out in the *Charter of Human Rights and Responsibilities Act 2006*.

As required by section 165CE(4) of the PHW Act, IPMAC as a group must as far as reasonably practicable have skills, knowledge and experience to encompass all of the following matters: public health; infectious diseases; primary care; emergency care; critical care; law; human rights; the interests and needs of traditional owners and Aboriginal Victorians; and the interests and needs of vulnerable communities.

IPMAC is dissolved when the Premier's pandemic declaration is revoked or not renewed.

2. Purpose of this review

The purpose of this review is to assess pandemic vaccination mandate orders made by the Minister for Health against a set of core prerequisites and suggest improvements to inform any future consideration of such mandates in Victoria.

IPMAC is undertaking this review by own motion, not in response to a request for advice by the Minister for Health.

On 8 March 2022, IPMAC received correspondence from the Clerk of the Legislative Council advising that on 23 February 2022, the Legislative Council agreed to a resolution that it refer the motion to IPMAC and request IPMAC to consider reviewing the Pandemic COVID-19 Mandatory Vaccination (General Workers) Order 2022 (No.3) and the Pandemic (Open Premises) Order 2022 (No.5). IPMAC has also received correspondence from a number of individuals raising concerns about the negative impact of the vaccine mandates on their individual circumstances.

In undertaking its work, IPMAC is cognisant that the environment has changed significantly throughout the course of the pandemic. The Committee is of the view that its role is to provide advice that is contemporaneous or future focused to be of the most value in the Minister's decision-making, not to interrogate and challenge the public health advice. Further, that it should not provide advice that duplicates matters that are being considered by or are the responsibility of other bodies. As required by the PHW Act, it only provides advice in relation to the disallowance of a pandemic order if requested to by PDAOC.

Mandates, by their nature, impose a requirement on individuals or populations which infringes on personal freedoms. It is estimated that the specified worker and facility vaccine mandates impact 1.25 million of Victoria's workers². Prior to instituting a vaccine mandate, certain prerequisites should be considered and met.³, IPMAC is of the view that it is in the public interest to assess Victoria's vaccine mandates for COVID-19 Mandatory Vaccination (Specified Facilities) Order, COVID-19 Mandatory Vaccination (Specified Workers) Order and COVID-19 Mandatory Vaccination (General Workers) introduced through pandemic orders since 15 December 2021 against a set of prerequisites identified by the Committee.

2 [Carabetta, G. Your rights under Victoria's 'authorised worker' vaccine mandate: an expert explains webpage. October 2021. The Conversation website](https://theconversation.com/your-rights-under-victorias-authorised-worker-vaccine-mandate-an-expert-explains-169137) <<https://theconversation.com/your-rights-under-victorias-authorised-worker-vaccine-mandate-an-expert-explains-169137>>

3 Leask J, Seale H, Williams JH, Kaufman J, Wiley K, Mahimbo A, et al, *Policy considerations for mandatory COVID-19 vaccination from the Collaboration on Social Science and Immunisation*, 2021, Medical Journal of Australia, vol. 215, iss. 11, pp. 499-503.

2.1 Scope of the review

The focus of IPMAC's review is on vaccine mandates imposed on workers through pandemic orders made during the period between the 15 December 2021 and 12 July 2022. The specific worker-related vaccine mandate orders are the:

- Pandemic COVID-19 Mandatory Vaccination (Specified Facilities) Order,
- COVID-19 Mandatory Vaccination (Specified Workers) Order, and
- COVID-19 Mandatory Vaccination (General Workers).

On 22 April 2022 the worker-related vaccine mandate requirements were consolidated into the (Workplace) Order, which remains in place as of 12 July 2022.

While the focus of the review is for this period, vaccine mandates were first introduced in Victoria through CHO directions from 7 September 2021 until 15 December 2021, utilising the State of Emergency framework under the PHW Act. There was no requirement under the legislation at this time for the CHO's public health advice to be made publicly available.

The new framework requires the reasoning and advice that underpin a pandemic declaration and any pandemic orders to be published. IPMAC's consideration of the rationale for Victoria's vaccine mandates must be considered in this decision-making context.

Other vaccine mandates introduced by the Minister for Health during the period 15 December 2021 to 15 July 2022 are not in scope for this review, including:

- patron vaccination requirements and worker vaccination requirements introduced through the Open Premises Order that required Victorians to demonstrate vaccination as a condition of entry to a broad range of premises,
- obligations on workers to meet their employer vaccination requirements introduced through the Movement and Gathering Order, and
- vaccination requirements that resulted in conditional application of other measures, such as visitor access to care facilities, alternative quarantine, detention and self-isolation arrangements, and testing requirements (Detention Order, Quarantine Testing and Isolation Order, and the Victorian Borders Order).

Globally, two key approaches are taken to the imposition of COVID-19 vaccine mandates. The '*pass sanitaire*' or vaccination passport approach which requires proof of vaccination to enter public places and participate in a 'vaccinated economy'. The second approach, and the focus of this review, makes vaccination a condition of employment.^{4 5} While both types of mandates were deployed in Victoria, the orders placing requirements on workers have had the most impact having been in place for the longest period of time.

4 Drew, L, *Did Covid Vaccine Mandates Work? What the Data Say* webpage, 13 July 2022, Nature, vol 607, pp 22-25.

5 Attwell K, Rizzi M, McKenzie L, Carlson SJ, Roberts L, Tomkinson S, Blyth C, *COVID-19 vaccine Mandates: An Australian attitudinal study* webpage, 30 November 2021, Vaccine, Epub ahead of print National Library of Medicine.

2.2 IPMAC's approach to the review

The key inputs to the review include:

- a literature review to inform the review questions and identification of prerequisites for vaccine mandates,
- research into vaccine mandates applied in other jurisdictions,
- documentation of the mandatory vaccination settings and changes since they were first introduced in Victoria in September 2021,
- review of the legislative framework for the making of pandemic orders as set out in Part 8A of the PHW Act and analysis of the legality of the vaccine mandate orders,
- examination of the CHO's advice, Minister's Statement of Reasons and Human Rights Statements published when the orders were made,
- a media scan including review of the Premier and Minister for Health media releases relating to vaccine mandates, and
- review of relevant transcripts from public hearings convened by PDAOC hearings.

2.3 Limitations

Given we are still in a global pandemic, there is a limited evidence base for an assessment of vaccine mandates. In addition, prior to 15 December 2021 there was no requirement for the CHO to make publicly available the rationale for the introduction of vaccine mandates. IPMAC's review is therefore limited to publicly available information.

2.4 Background

The rapid emergence and spread of COVID-19 has had an unprecedented impact on Australia and across the world.

On 5 January 2020, the World Health Organisation (WHO) notified member states that an outbreak of pneumonia of unknown cause had been identified in China. On 30 January 2020, the WHO declared the coronavirus outbreak a Public Health Emergency and on 11 March 2020 declared COVID-19 a global pandemic.⁶ The first Australian case of COVID-19 was recorded in Victoria on 25 January 2020. In response to the threat posed by COVID-19, a State of Emergency was declared in Victoria on 16 March 2020 by the Minister for Health on the advice of the CHO under the PHW Act.⁷ This activated the powers of the CHO to issue directions and set requirements to eliminate or reduce risks to public health. The first direction from the CHO under these new powers included banning non-essential mass gatherings of over 500 people such as cultural events, sporting events or conferences.

In March 2020, Australia closed international borders except for citizens and residents for permitted travel and had significant caps in place. A Hotel Quarantine program was established in Victoria to manage quarantine of returning travellers.

6 [World Health Organization, Listings of WHO's response to COVID-19, media release, 2020 webpage](https://www.who.int/news-room/detail/29-06-2020-covidtimeline) <<https://www.who.int/news-room/detail/29-06-2020-covidtimeline>>

7 Premier of Victoria, State of Emergency Declared in Victoria Over COVID-19, media release, 2020, Victorian Government, *Victoria Government Gazette*, no. s 129, 16 March 2020.

On 30 March 2020, Stage 3 restrictions were put in place with four reasons to leave home and school closures followed on 7 April 2020. Stage 3 restrictions were eased on 1 June 2020 and then tightened on 21 June 2020 with caps on visitors to home and the extension of the State of Emergency. 28 June 2020 marked the start of the second wave in Victoria with the second lockdown commencing on 1 July 2020 and State of Emergency extended on 19 July 2020. On 2 August 2020, Victoria declared a State of Disaster and Stage 4 restrictions were introduced in metropolitan Melbourne with a new peak of daily cases at 725 on 5 August 2020.

Victoria's roadmap for reopening was released on 5 September 2020 with metropolitan Melbourne and regional Victoria moving through the steps at different times. With varied restrictions in place, a border between metropolitan and regional Victoria was in place, often referred to as the 'ring of steel', restricting movement between areas of differing levels of restrictions. Restrictions were aligned on 8 November 2020 with travel allowed anywhere across the state.

While the border to other states from Victoria was closed at various times, the first time Victoria closed its border to another state was with South Australia on 19 November 2020. A permit system was then set up on 21 November for travellers entering Victoria from South Australia with the scheme ending on 12 December 2020. On 1 January 2021, Victoria closed its border with NSW. A permit system was again put in place for travellers entering Victoria on 11 January 2021. A traffic-light system was introduced at the same time to classify outbreak risks in other states and determine permit requirements.

Lockdown number three commenced on 12 February 2021 and Australia's COVID-19 vaccine rollout began on 22 February 2021 with a phased roll out implemented across the country. Victoria experienced a further three lockdowns commencing 27 May 2021 (lockdown four), 15 July 2021 (lockdown 5) and 5 August 2021 (lockdown 6). By the 4 October 2021, Melbourne marked 245 days of lockdown since the start of the pandemic and became the city with longest cumulative time in lockdown due to the COVID-19 pandemic across the world.

At the 6 August 2021 meeting of National Cabinet all states and territories agreed to the *National Plan to Transition Australia's COVID-19 Response*. The national plan outlined a clear path of vaccination targets to achieve the phased 'opening back up in a careful and safe way.'⁸ Phase A stipulated the need for measures to accelerate vaccination targets, while strong suppression to minimise community transmission was still required. This phase was associated with closed international borders, inbound passenger caps, early and stringent lockdowns, and effective Test, Trace, Isolate and Quarantine strategies. Vaccination targets were set for Phase B at 70% and Phase C at 80% to enable the gradual easing of restrictions once these were achieved.⁹

The Victorian Government announced the second plan *Victoria's Roadmap: Delivering the National Plan* (the Roadmap), the state's strategy for implementing the transition phases of the National Plan on 19 September 2021. The Roadmap linked opportunities for increased social and economic participation for the Victorian community to vaccination coverage.¹⁰

8 Department of the Prime Minister and Cabinet, *National Plan to transition Australia's National COVID-19 Response*, 2021, Commonwealth of Australia.

9 Ibid.

10 Department of Premier and Cabinet, *Victoria's Roadmap: Delivering the National Plan*, 2021, Victorian Government.

The legislative framework for introducing pandemic orders was introduced on 15 December 2021 and set out in Part 8A of the PHW Act. This framework replaced the State of Emergency framework, which was designed to respond to serious, short-term events with an expiration date of 15 December 2021.

By the end of 2021 Australia had achieved relative global success in minimising the loss of life and burden of disease from COVID-19 infection on a global scale. This had come at significant sacrifice and cost, in particular to Victorians, requiring severe and significant lockdowns to keep the virus under control. With the rest of the world progressively opening up, and with the emergence of increasingly transmissible new variants, high vaccination coverage was considered essential to avoid significant loss of life when the state and country eventually moved to the next phase of the pandemic, ending the lockdowns and learning to live with COVID-19 sustainably, as outlined in the National Plan and Victorian Roadmap.

With high vaccination coverage attained, December-January 2021 signalled a major transition in the public health response in the peak of the Delta wave and emergence of Omicron. This saw the easing of major control measures around testing, contact tracing, isolation, quarantine and furlough requirements, scaling up of the booster vaccination program and vaccination of 5-11 year olds. During January - July 2022 Victoria experienced successive waves of COVID-19 infection associated with the increasing dominance of the Omicron variants of concern, and multiple sub-lineages. While precautionary measures were maintained by the Victorian Government to protect vulnerable Victorians and protect the health system, in a general sense restrictive measures continued to ease with many restrictions removed in April and further in June 2022.

Between 15 December 2021 and 12 July 2022, 78 pandemic orders were made. During this period, changes to pandemic orders gradually became less frequent, changing four times in December 2021, three times in January 2022, four times in February 2022, once in March 2022, twice in April 2022, once in June 2022 and once in July 2022. This easing of restrictions coincided with a surge in cases with the emergence of the Omicron variant.

In April 2022, many of the public health measures were revoked through order changes signalling a major transition of the Victorian Government's pandemic response, to one of 'empowering industry, workplaces and individuals to make decisions based on public health guidance'.

This general transition to the nature of the response was demonstrated by the new Minister for Health in July 2022 when she described in the Statement of Reasons a new objective of the public health response to be one of 'maintaining enjoyment of life and the continued operation of business, cultural, sporting and other activities'.

As at 12 July 2022, 94.6 per cent of eligible Victorians over the age of 12 had received two doses of a COVID-19 vaccination. 68.6 per cent of eligible Victorians over the age of 16 had received three doses (booster) of a COVID-19 vaccination.¹¹ The total number of deaths related to COVID-19 reported in Victoria since the pandemic begun was 4,091. IPMAC acknowledges the devastating impact on the individuals, families, and communities of those who have lost their life due to COVID-19, and for those who have suffered serious illness, and continue to do so.

11 [Department of Health, *Coronavirus update for Victoria - 12 July 2022 webpage, 2022. Victorian Government*](https://www.health.vic.gov.au/media-releases/coronavirus-update-for-victoria-12-july-2022)
<<https://www.health.vic.gov.au/media-releases/coronavirus-update-for-victoria-12-july-2022>>

The severity of COVID-19 disease has changed over the course of the pandemic. This is in part due to the evolution of the virus itself, but also in the public health response with advancements in vaccination, treatment and clinical management, and more recently the availability of new therapeutics and anti-viral medications.¹² In Victoria during the early waves caused by wild type variants, 12% of cases were hospitalised and the case fatality rate was 4%. During Delta this had reduced to 6% hospitalisation and a case-fatality rate of 0.5%. With Omicron Victoria experienced 1% hospitalisation and a 0.1% case fatality rate. Cohorts that remain the most vulnerable include those that most directly suffer the highest rates of severe disease, people with severe comorbidities, in residential aged care and specialist disability accommodation and in communities with low vaccination uptake.

IPMAC acknowledges that the public health measures adopted by the Victorian and Australian Governments prevented significant loss of life and illness that may have occurred if such efforts to minimise transmission and manage the risks of COVID-19 had not occurred.

2.5 COVID-19 vaccination governance and legislative context

2.5.1 COVID-19 national policy and strategy

Decisions by the Victorian Government on COVID-19 vaccination are undertaken in the context of national and Commonwealth policy direction, and in line with clinical guidance from ATAGI.¹³

National Cabinet was established on 13 March 2020 as a forum for the Prime Minister, Premiers and Chief Ministers and is advised by the Australian Health Protection Principal Committee (AHPPC).¹⁴ ¹⁵ The AHPPC is the peak health emergency management committee responsible for preparing for and coordinating the response to national health crises. It consists of all state and territory CHOs and is chaired by the Australian Chief Medical Officer.¹⁶ AHPPC provided a number of statements of advice to National Cabinet on mandatory vaccinations in key workforces during 2021 and 2022, with advice changing as the pandemic context evolved.

Commonwealth and state and territory governments remain individually responsible for the implementation of decisions arising from National Cabinet in their jurisdiction.¹⁷ National Cabinet has been used to coordinate the response to COVID-19 across state boundaries and enable input on nationally important decisions such as mandating the vaccination of the residential aged care workforce.

12 Department of Health, 2022, Victorian Government.

13 [Department of Health and Aged Care, ATAGI Clinical Guidance for COVID-19 Vaccine Providers webpage, 21 July 2022, Australian Government](https://www.health.gov.au/initiatives-and-programs/covid-19-vaccines/advice-for-providers/clinical-guidance) <https://www.health.gov.au/initiatives-and-programs/covid-19-vaccines/advice-for-providers/clinical-guidance>

14 [Commonwealth of Australia, National Cabinet webpage, 2021, Federation website](https://federation.gov.au/national-cabinet) <https://federation.gov.au/national-cabinet>

15 Elphick, K, *Australian COVID-19 Response Management Arrangements: A Quick Guide*, 28 April 2020, Parliament of Australia.

16 [Department of Health and Aged Care, Australian Health Protection Principal Committee \(AHPPC\) webpage, 8 July 2022, Australian Government](https://www.health.gov.au/committees-and-groups/australian-health-protection-principal-committee-ahppc) <https://www.health.gov.au/committees-and-groups/australian-health-protection-principal-committee-ahppc>

17 [Commonwealth of Australia, National Cabinet webpage, 2021, Federation website](https://federation.gov.au/national-cabinet) <https://federation.gov.au/national-cabinet>

ATAGI advises the Commonwealth Minister for Health and Aged Care on the National Immunisation Program (NIP) and other immunisation issues. The ATAGI COVID-19 Working Group provides advice to the Commonwealth Minister for Health and Aged Care on the immunisation program for COVID-19 vaccines.¹⁸

On 2 August 2021, ATAGI released a statement regarding COVID-19 vaccines and the transmission of the Delta variant of concern, which stated ‘the increased transmissibility and possible increased severity of the Delta variant of SARS-CoV-2 underscores the importance and immediate benefits of achieving the highest possible COVID-19 vaccine uptake, especially in outbreak areas’.¹⁹

At the 6 August 2021 meeting of National Cabinet all states and territories agreed to the *National Plan to Transition Australia’s COVID-19 Response*. The national plan outlined a clear path of vaccination targets to achieve the phased ‘opening back up in a careful and safe way’.²⁰ Phase A stipulated the need for measures to accelerate vaccination targets while strong suppression to minimise community transmission was still required. This phase was associated with closed international borders, inbound passenger caps, early and stringent lockdowns, and effective Test, Trace, Isolate and Quarantine strategies. Phase B at 70% vaccination and Phase C at 80% fully vaccinated proposed the gradual easing of restrictions, once these vaccination targets were achieved.²¹

2.5.2 COVID-19 Victorian policy and strategy

The Victorian Government announced *Victoria’s Roadmap: Delivering the National Plan* (the Roadmap), the state’s strategy for implementing the transition phases of the National Plan on 19 September 2021. The Roadmap linked opportunities for increased social and economic participation for the Victorian community to vaccination coverage.²² Vaccination mandates an important part of this approach.

The Roadmap was based on modelling from the Burnet Institute which showed that vaccination of workers across the state is a key factor to reducing risk and being able to reopen Victoria for social and economic participation.

18 [Department of Health and Aged Care Australian Technical Advisory Group on Immunisation \(ATAGI\) webpage, 2 September 2022, Australian Government](https://www.health.gov.au/committees-and-groups/australian-technical-advisory-group-on-immunisation-atagi) <<https://www.health.gov.au/committees-and-groups/australian-technical-advisory-group-on-immunisation-atagi>>

19 [Department of Health and Aged Care, ATAGI statement regarding COVID-19 vaccines in the setting of transmission of the Delta variant of concern webpage, 2 August 2021, Australian Government](https://www.health.gov.au/news/atagi-statement-regarding-covid-19-vaccines-in-the-setting-of-transmission-of-the-delta-variant-of-concern) <<https://www.health.gov.au/news/atagi-statement-regarding-covid-19-vaccines-in-the-setting-of-transmission-of-the-delta-variant-of-concern>>

20 Department of the Prime Minister and Cabinet, *National Plan to transition Australia’s National COVID-19 Response*, 2021, Commonwealth of Australia.

21 *ibid.*

22 Department of Premier and Cabinet, *Victoria’s Roadmap: Delivering the National Plan*, 2021, Victorian Government.

The Premier's media release announcing the Roadmap states:

'Opening up too soon – before people had the chance to get the jab – would mean our hospital system simply could not cope and catastrophic numbers of Victorians would become seriously unwell.'²³

The Premier also outlined intentions for mandatory vaccination, noting that the CHO would be assessing vaccination requirements for all authorised workers in Victoria.²⁴ At this point in time the Premier acknowledged mandates were already in place for aged care, construction and freight workers, with healthcare workers the next workforce to be considered in line with AHPPC recommendation to National Cabinet on 1 October 2021.²⁵ Future plans to assess vaccine requirements for school staff, childcare staff, police and disability workers were also highlighted.²⁶

2.5.3 Legislative framework for pandemic orders in Victoria

The legislative framework for introducing pandemic orders was introduced on 15 December 2021 and set out in Part 8A of the PHW Act. This framework replaced the State of Emergency framework, which was designed to respond to serious, short-term events with an expiration date of 15 December 2021.

Prior to the introduction of this legislation, the power to issue directions and set requirements to eliminate or reduce risks to public health sat with the CHO under emergency powers activated on 16 March 2020 when the Minister for Health on the advice of the CHO, declared a 'state of emergency' under the PHW Act. The State of Emergency in Victoria ended at 11:59pm on 15 December 2021 when the pandemic management framework under the PHW Act came into effect.

Under the PHW Act, the Premier is responsible for making pandemic declarations and can only do this if satisfied on reasonable grounds that there is a serious risk to public health resulting from a disease that is or could be a pandemic disease. If satisfied, the Premier can make a pandemic declaration after considering the advice of the CHO and the Minister.

23 [Department of Premier and Cabinet, *Press Release: Victoria's Roadmap, Delivering the National Plan webpage, 2021, Victorian Government*](https://www.premier.vic.gov.au/victorias-roadmap-delivering-national-plan) <<https://www.premier.vic.gov.au/victorias-roadmap-delivering-national-plan>> accessed 4 July 2022.

24 Ibid.

25 [Department of Health and Aged Care, *AHPPC Statement on Mandatory Vaccination of All Workers in Healthcare Settings webpage, 1 October 2021, Australian Government*](https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-mandatory-vaccination-of-all-workers-in-health-care-settings) <<https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-mandatory-vaccination-of-all-workers-in-health-care-settings>>

26 Department of Premier and Cabinet, *Victoria's Roadmap: Delivering the National Plan, 2021, Victorian Government*.

The Premier made the first pandemic declaration to come into effect 11:59pm 15 December 2021 on the basis that ‘he was satisfied on reasonable grounds that there is a serious risk to public health throughout Victoria arising from the coronavirus (COVID-19) pandemic disease’.²⁷ The declaration was extended three times on 12 January 2022,²⁸ 12 April 2022,²⁹ and 12 July 2022.³⁰

Under the PHW Act, the Minister for Health may, at any time on or after the making of a pandemic declaration, make any order that the Minister believes is reasonably necessary to protect public health. Prior to making a pandemic order the Minister must request the advice of the CHO in relation to, and have regard to this advice, on:

- the serious risk to public health posed by the disease specified in the pandemic declaration to which the proposed pandemic order relates; and,
- the public health measures that the CHO considers are necessary or appropriate to address this risk.

3. COVID-19 vaccine mandates for workers in Victoria

3.1 Vaccine mandates in Victoria

Vaccine mandates were introduced through the CHO Directions during a period of lockdown for metropolitan Melbourne (ending 22 October 2021) and regional Victoria (ending 9 September 2021 for most regional areas). Initially, these mandates were introduced for workers in specific high-risk workplaces throughout September 2021; first in residential aged care facilities, followed by construction, and then healthcare and education facilities.

On 7 October 2021, mandates were then introduced for a new subset of workers through the Mandatory Vaccination (Workers) Direction, applying to all workers on the Authorised Workers List.³¹ On the 29 October 2021, the Mandatory Vaccination (General Workers) Direction was introduced that applied to all general workers covering 34 different groups of workers at this time.³² This last direction had a less onerous requirement that if it was reasonably practicable for general workers to work at home, then they must be fully vaccinated (or exempt) to attend their place of work.³³

27 Department of Premier and Cabinet, *Implementing Victoria’s New Pandemic Framework Pandemic Declaration*, 10 December 2021, Victorian Government.

28 Department of Premier and Cabinet, *New Pandemic Declaration to Support the Omicron Response*, 9 January 2022, Victorian.

29 Department of Premier and Cabinet, *Pandemic Declaration Extended to Protect Victorians*, 6 April 2022, Victorian Government.

30 Department of Premier and Cabinet, *Statement on the Pandemic Declaration*, 5 July 2022, Victorian Government.

31 Department of Premier and Cabinet, *Vaccination Required to Protect Workers and Victoria*, 1 October 2021, Victorian Government.

32 [Department of Health, COVID-19 Mandatory Vaccination \(General Workers\) Order webpage, 15 December 2021, Victorian Government](https://www.health.vic.gov.au/covid-19/covid-19-mandatory-vaccination-general-workers-order) <<https://www.health.vic.gov.au/covid-19/covid-19-mandatory-vaccination-general-workers-order>>

33 *ibid.*

On 15 December 2021, the worker vaccine mandates contained in the three previous CHO Directions were all retained when the Minister made the COVID-19 Mandatory Vaccination (Specified Facilities) Order, the COVID-19 Mandatory Vaccination (Specified Workers) Order, and the COVID-19 Mandatory Vaccination (General Workers) Order.

On 10 January 2022, it was announced that third dose booster vaccinations would form part of the mandate to work outside the home in certain high-risk sectors. This applied to workers in healthcare, aged care, disability, emergency services, correctional facilities, quarantine accommodation and food distribution.

On 22 April 2022, the three COVID-19 Mandatory Vaccination Orders were revoked, and the existing workplace settings were consolidated and continued in the Workplace Order 2022 (No.8).

On 24 June 2022, third dose mandates in education, food distribution, meat and seafood processing, and quarantine accommodation sectors were removed. The two-dose mandates on other specified workers and the general worker mandates requiring workers to work from home unless they were double vaccinated were also removed. Three dose vaccination requirements remained in place for workers who interacted with vulnerable persons, such as residential aged care, disability services, healthcare, and custodial and emergency services. These settings were continued in the order changes on 12 July 2022 and remain in place at the time of this report.

A timeline of the key developments to vaccine mandates in Victoria is summarised below in Table 1 and can be found in full detail at **Appendix 1**.

Table 1: Summary of worker vaccine mandates and key changes in Victoria³⁴

Date	CHO Direction/ Pandemic Order	Change Made
7 Sept 2021	<i>COVID-19 Mandatory Vaccination Directions</i>	Directions issued that mandated worker vaccination within residential aged care facilities to limit the spread of COVID-19.
17 Sept 2021	<i>COVID-19 Mandatory Vaccination Directions (No. 2)</i>	Worker vaccination mandate extended to construction sites .
23 Sept 2021	<i>COVID-19 Mandatory Vaccination Directions (No. 3)</i>	Worker vaccination mandate extended to people who enter Victoria under a specified worker (multiple entry) permit , such as commercial freight workers or healthcare workers.
29 Sept 2021	<i>COVID-19 Mandatory Vaccination Directions (No. 4)</i>	Worker vaccination mandate extended to healthcare and education facilities . Worker vaccination mandate not retained for those entering Victoria under a specified worker (multiple entry) permit.
1 Oct 2021	<i>COVID-19 Mandatory Vaccination Directions (No. 5)</i>	COVID-19 second dose deadline removed for workers at construction sites .

34 [Federal Court of Australia, Victorian Legislation - Coronavirus \(COVID-19\) webpage, Australian Government](https://www.fedcourt.gov.au/covid19/legislation/vic)
<<https://www.fedcourt.gov.au/covid19/legislation/vic>>

Date	CHO Direction/ Pandemic Order	Change Made
7 Oct 2021	<i>COVID-19 Mandatory Vaccination (Specified Facilities) Directions (No. 6)</i>	COVID-19 second dose deadline restored for workers at construction sites and brought earlier for workers at education facilities
7 Oct 2021	<i>COVID-19 Mandatory Vaccination (Workers) Directions</i>	<p>Directions issued which mirror COVID-19 Mandatory Vaccination (Specified Facilities) Directions, for a new subset of workers.</p> <p>The below unvaccinated workers must not attend work, unless they have a booking to receive their first dose of a COVID-19 vaccine by first dose deadline of 22 Oct 2021:</p> <ul style="list-style-type: none"> • Accommodation workers • Agricultural and forestry workers • Airport workers • Ancillary, support and welfare workers • Authorised officers • Care workers • Community workers • Creative arts workers • Custodial workers • Emergency service workers • Entertainment and function workers • Funeral workers • Higher education workers • Justice service centre workers • Manufacturing workers • Marriage celebrants • Meat and seafood processing workers • Media and film production workers • Mining workers • Physical recreation workers • Port or freight workers • Production and distribution workers • Professional sports, high performance sports or racing persons • Professional services workers • Public sector employees • Real estate workers • Religious worker • Repair and maintenance workers • Retail workers • Science and technology workers

Date	CHO Direction/ Pandemic Order	Change Made
		<ul style="list-style-type: none"> • Social and community service workers • Transport workers • Utility and urban workers • Veterinary and pet/animal care workers
29 Oct 2021	<i>COVID-19 Mandatory Vaccination (General Workers) Directions</i>	Directions issued which expand <i>COVID-19 Mandatory Vaccination (Specified Facilities) Directions</i> and <i>COVID-19 Mandatory Vaccination (Workers) Directions</i> to all general workers
15 Dec 2021	<i>COVID-19 Mandatory Vaccination (Specified Workers) Order 2021 (No. 1)</i>	Requirements in vaccination directions retained in new pandemic orders Disability Worker added to the list of Specified Workers
15 Dec 2021	<i>COVID-19 Mandatory Vaccination (General Workers) Order 2021 (No. 1)</i>	Requirements in vaccination directions retained in new pandemic orders
15 Dec 2021	<i>COVID-19 Mandatory Vaccination (Specified Facilities) Order 2021 (No. 1)</i>	Requirements in vaccination directions retained in new pandemic orders
12 Jan 2022	<i>COVID-19 Mandatory Vaccination (Specified Workers) Order 2022 (No. 2)</i>	Booster deadline imposed on certain specified worker cohorts – custodial workers, disability workers, emergency service workers, food distribution workers, meat and seafood processing workers, and quarantine accommodation workers
12 Jan 2022	<i>COVID-19 Mandatory Vaccination (Specified Facilities) Order 2022 (No. 2)</i>	Booster deadline imposed on workers at residential aged care facilities and healthcare facilities
25 Jan 2022	<i>COVID-19 Mandatory Vaccination (Specified Facilities) Order 2022 (No. 3)</i>	Booster deadline imposed on workers at education facilities
11 Feb 2022	<i>COVID-19 Mandatory Vaccination (Specified Workers) Order 2022 (No. 4)</i>	Booster deadline amended for certain specified worker cohorts – custodial workers, disability workers, emergency service workers, food distribution workers, meat and seafood processing workers, and quarantine accommodation workers
11 Feb 2022	<i>COVID-19 Mandatory Vaccination (Specified Facilities) Order 2022 (No. 5)</i>	Booster deadline amended for residential aged care facility and healthcare facility workers

Date	CHO Direction/ Pandemic Order	Change Made
25 Feb 2022	<i>COVID-19 Mandatory Vaccination (Specified Facilities) Order 2022 (No. 6)</i>	Booster deadline amended for all education facility workers to 25 March 2022
12 April 2022	<i>COVID-19 Mandatory Vaccination (Specified Facilities) Order 2022 (No. 7)</i>	Booster deadline amended for all healthcare facility workers to 29 March 2022
22 April 2022	<i>Pandemic (Workplace) Order 2022 (No. 8)</i>	New Order introduced that consolidated worker vaccination requirements previously established through the <i>COVID-19 Mandatory Vaccination (General Workers) Order 2022 (No. 4)</i> , <i>COVID-19 Mandatory Vaccination (Specified Workers) Order 2022 (No. 6)</i> , <i>COVID-19 Mandatory Vaccination (Specified Facilities) Order 2022 (No. 7)</i> and <i>Movement and Gathering Order 2022 (No. 5)</i>
24 June 2022	<i>Pandemic (Workplace) Order 2022 (No. 9)</i>	Vaccination requirements removed for general workers and workers in a ceremonial space Vaccination requirements retained for custodial workers, disability workers, emergency service workers, healthcare facility workers and residential aged care facility workers . Introduce vaccination requirements for specialist school facility workers
12 July 2022	<i>Pandemic (Workplace) Order 2022 (No. 10)</i>	Non-substantive amendments made Above vaccination requirements retained

3.2 What the worker vaccine mandates require and who they apply to

The worker vaccine mandates place obligations on employers and operators of facilities/services to ensure that workers are vaccinated to attend their place of work. Mandates were applied to specific workforces and facilities deemed high-risk, and more broadly to all other general workers not specified in the specified facility or specified worker orders.

Over the period, 15 December 2021 to the most recent order change on 12 July 2022, expanded vaccination requirements were applied to a subset of specified worker groups compared to the general worker population due to their high-risk nature. The obligations and duration of all worker vaccine mandates are set out in Table 2.

Table 2: Summary of specific obligations through the pandemic orders

<p>Pandemic (General Workers) Order</p>
<p>Required employers to not permit general workers (for whom it is reasonably practicable to work at home[^]) to work outside their home[^] if they are not fully vaccinated or exempt, to limit the spread in that workforce.</p> <p>General Worker: a general worker is a person who works that is not covered by the COVID-19 Mandatory Vaccination (Specified Facilities), COVID-19 Mandatory Vaccination (Specified Workers), or Open Premises Order.</p> <p>Obligation of employers to:</p> <ul style="list-style-type: none"> • not permit a worker to work outside of home[^] unless they are fully vaccinated or exempt • collect, record and hold worker's vaccination status when they work outside their ordinary place of residence • disclose a worker's vaccination information to an authorised officer upon request. <p>A 2-dose vaccine requirement</p>
<p>Pandemic (Specified Workers) Order</p>
<p>Required employers to not permit a worker to work outside their home[^] if they are unvaccinated* in order to limit the spread of COVID-19 within that workforce.</p> <p>Specified workers: include accommodation worker; agricultural and forestry worker; airport worker; ancillary, support and welfare worker; authorised officer; care worker; community worker; creative arts worker; custodial worker; emergency service worker; entertainment and function worker; funeral worker; higher education worker; justice worker; manufacturing worker; marriage celebrant; meat and seafood processing worker; media and film production worker; mining worker; physical recreation worker; port or freight worker; professional sports, high-performance sports or racing person; professional services worker; public sector worker; real estate worker; religious worker; repair and maintenance worker; retail worker; science and technology worker; social and community service worker; transport worker; utility and urban worker; veterinary and pet/animal care worker.</p> <p>Obligation of employers to:</p> <ul style="list-style-type: none"> • collect, record and hold vaccination information of workers • not permit specified unvaccinated* workers from working outside their home[^] • notify current and new workers of these obligations <p>A 2-dose requirement for the majority of specified occupations</p>

Pandemic (Specified Workers) Order

A 3-dose requirement for some specified workers introduced on 12 January (described in detail below)

Pandemic COVID-19 Mandatory Vaccination (Specified Facilities) Order

Required operators of specified facilities to not permit a worker to enter the premises if they are unvaccinated* to limit the spread in that workforce.

Specified facilities: residential aged care facilities, construction sites, healthcare facilities and education facilities

Obligations on operators to:

- collect, record and hold vaccination information of workers
- prevent entry of unvaccinated* workers
- notify current and new workers of these obligation

Exceptional circumstances defined

Penalties for non-compliance

A 2-dose requirement for construction sites

A 3-dose requirement for residential aged care and health care facilities introduced on 12 January, and for education facilities on 25 January

Pandemic (Workplace) Order

Imposes specific obligations on employers to assist in reducing the frequency of outbreaks of COVID-19 in Victorian workplaces.

A regulated employer must not permit a worker to work outside their ordinary place of residence, or to work at a facility or ceremony (as applicable) if the worker is unvaccinated or partially vaccinated or for certain workers, not fully vaccinated (boosted) in order to limit the spread of COVID-19 within the population of those workers. This does not apply in relation to a general worker if it is not reasonably practicable for the general worker to work at their ordinary place of residence.

Obligations on operators to:

- collect, record and hold vaccination information of workers
- not permit workers to attend the workplace or work outside of home unless compliant with vaccination requirements
- if a booster deadline is specified in relation to a worker and the worker is aged 18 years or over, the employer must not permit the worker to work outside of home unless compliant with vaccination requirements
- notify current and new workers of these obligations

Exceptional circumstances defined

Penalties for non-compliance

Specified facilities and workers are limited to:

- Custodial workers
- Disability workers

Pandemic (Workplace) Order

- Emergency service workers
- Healthcare workers
- Residential aged care facility workers
- Workers at specialist schools.

**'unvaccinated' refers to unvaccinated, partially vaccinated or previously vaccinated*

^home refers to the worker's ordinary place of residence

The scope of occupations affected by each mandate are further described in Table 3.

Table 3: Occupational groups for the first round of Pandemic Orders

Date of change	COVID-19 Mandatory Vaccination (Specified Facilities) Order	COVID-19 Mandatory Vaccination (Specified Workers) Order	COVID-19 Mandatory Vaccination (General Workers) Order
15 December 2021	<p>Two-dose requirement for workers in:</p> <ul style="list-style-type: none"> • residential aged care facility • construction site • healthcare facility • education facility. 	<p>Two-dose requirement for the following occupational groups:</p> <ul style="list-style-type: none"> • accommodation worker • agricultural and forestry worker • airport worker • ancillary, support and welfare worker • authorised officer • care worker • community worker • creative arts worker • custodial worker • disability worker • emergency service worker • entertainment and function worker • funeral worker • higher education worker • justice worker • manufacturing worker • marriage celebrant • meat and seafood processing worker • media and film production worker • mining worker • physical recreation worker • port or freight worker • professional sports, high-performance sports or racing person • professional services worker • public sector worker • real estate worker • religious worker • repair and maintenance worker 	<p>Two-dose requirement for a general worker to work outside their home, where it is reasonably practicable for the person to work from home.</p> <p>A general worker is a person who works that is not covered by the COVID-19 Mandatory Vaccination (Specified Facilities), COVID-19 Mandatory Vaccination (Specified Workers), or Open Premises Order.</p>

Date of change	COVID-19 Mandatory Vaccination (Specified Facilities) Order	COVID-19 Mandatory Vaccination (Specified Workers) Order	COVID-19 Mandatory Vaccination (General Workers) Order
		<ul style="list-style-type: none"> • retail worker • science and technology worker • social and community service worker • transport worker • utility and urban worker • veterinary and pet/animal care worker. 	
12 and 25 January	<p>A third booster dose requirement introduced for workers in:</p> <ul style="list-style-type: none"> • residential aged care facility • healthcare facility • educational facility 	<p>A third booster dose required for the following workers:</p> <ul style="list-style-type: none"> • custodial worker • disability worker • emergency service worker • food distribution worker • meat and seafood processing worker • quarantine accommodation worker. 	

Date of change	Workplace Order
22 April 2022	<p>Two-dose vaccination requirements remain in place, applying to the following:</p> <p>Specified workers:</p> <ul style="list-style-type: none"> • accommodation worker • agricultural and forestry worker • airport worker • ancillary, support and welfare worker • authorised officer • care worker • community worker • creative arts worker • entertainment and function worker • funeral worker • higher education worker • justice worker • manufacturing worker

Date of change	Workplace Order
	<ul style="list-style-type: none"> • marriage celebrant • media and film production worker • mining worker • physical recreation worker • port or freight worker • professional sports, high-performance sports or racing person • professional services worker • public sector worker • real estate worker • religious worker • repair and maintenance worker • retail worker • science and technology worker • social and community service worker • transport worker • utility and urban worker • veterinary and pet/animal care worker <p>Workers at the following specified facilities:</p> <ul style="list-style-type: none"> • accommodation facility • adult education or higher education facility • community facility • construction site • creative arts facility • entertainment and function facility • food and drink facility • gaming machine facility • physical recreation facility • restricted retail facility • tours and tourism <p>A general worker A general worker who is working outside the home, where it is reasonably practicable for the person to work from home (<i>a general worker is a worker that is not otherwise covered as a specified worker or works at a specified facility</i>)</p> <p>A person working at a ceremonial space A person working at a ceremonial space (some exemptions apply).</p>

Date of change	Workplace Order
22 April 2022	<p>Booster third dose vaccination requirements remain in place, applying to the following:</p> <p>Specified workers:</p> <ul style="list-style-type: none"> • custodial worker • disability worker • emergency service worker • food distribution worker • meat and seafood processing worker • quarantine accommodation worker <p>workers at the following specified facilities:</p> <ul style="list-style-type: none"> • education facility • healthcare facility • residential aged care facility.
24 June 2022	<p>Vaccination requirements removed for all workers, apart from booster vaccination requirements for the following:</p> <p>Specified workers:</p> <ul style="list-style-type: none"> • custodial worker • disability worker • emergency service worker <p>workers at the following specified facilities:</p> <ul style="list-style-type: none"> • healthcare facility • residential aged care facility • specialist school facility.

4. Context

4.1 The role of vaccine mandates to achieve high levels of vaccination coverage

Communicable diseases are spread from person to person. One aim of immunisation programs is to achieve herd immunity, with the coverage required for this dependent upon the disease. For other infectious diseases, achieving high vaccination rates can protect the vaccinated population from severe disease and its consequences.

Ideally vaccination targets are achieved via education, outreach and public engagement.³⁵ Both the causation of hesitancy and combating hesitancy are potential risks to incomplete vaccination. Established interventions to reach targets can be employed and include guiding or restricting choice or associating the choice to incentives or disincentives. Disincentives range from fines to exclusion from certain activities or locations.

Mandatory vaccination policies impose individual consequences for non-compliance. These vary for the population subject to the requirement, the scale and type of consequences for non-compliance, and accepted exemptions. Consequences for non-compliance include change or loss of employment; a requirement to use masks; reduced access to money, goods or services; or inability to travel internationally.³⁶

While mandates may damage public trust, create social division, and entrench opposition to vaccination, they can increase vaccine uptake and establish new social norms.³⁷ A 'mandate' is not defined; however, it can be understood to refer to any coercive intervention. However, there is precedent for coercive interventions to achieve high vaccination coverage for a range of communicable diseases, including COVID-19 both within Australia and internationally.

4.2 Use of vaccine mandates as a public health measure

Vaccine mandates are not new instruments to ensure that vaccination coverage in key populations reaches and remains at the required target. The Australian National Immunisation Program (NIP) Schedule has been in place since 1998 and incentivised with family assistance payments or disincentivised with the loss of payments. This was introduced alongside a suite of other measures including financial incentives for general practitioners, immunisation targets, education-based and research initiatives.

35 [Omer SB, Benjamin RM, et al. Promoting COVID-19 vaccine acceptance: recommendations from the Lancet Commission on Vaccine Refusal, Acceptance, and Demand in the USA National Library of Medicine webpage, 11 December 2021, Lancet, vol 398 \(10317\):2186-2192.](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8592561/) <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8592561/>>

36 Leask J, Seale H, Williams JH, Kaufman J, Wiley K, Mahimbo A, et al., *Policy considerations for mandatory COVID-19 vaccination from the Collaboration on Social Science and Immunisation*, 2021, Medical Journal of Australia, vol. 215, iss. 11, pp. 499-503.

37 [Drew L, Did Covid Vaccine Mandates Work? What the Data Say webpage, 7 July 2022, Nature website Vol 607.](https://www.nature.com/articles/d41586-022-01827-4) <<https://www.nature.com/articles/d41586-022-01827-4>>

In April 2015, the Australian Government announced that it would close off conscientious objection and religious exemptions from the immunisation eligibility requirements for the No Job, No Play policy. This removed exemptions for objection to vaccination, and while vaccination rates increased as a result, vaccine objection rates for children under seven also increased steadily, especially under the conscientious objector category.³⁸

Concurrently the Victorian Government introduced No Job No Play legislation as vaccination rates in the target population showed only 92.5 per cent were up to date with vaccinations, lagging below the 95 per cent target as recommended by the National Immunisation Program schedule. The legislation required an independent review in 2020, at which point vaccination had increased to 94.2%, and in the 1-year-old and 5-year-old cohorts' vaccination was over 95 per cent.³⁹ The review of the legislation completed by the Centre for Evaluation and Research Evidence made ten recommendations; these focus on ensuring significant impacts to individuals are minimised, particularly around unintended consequences.⁴⁰

Vaccine mandates also restrict freedom of movement internationally under the *International Health Regulations (IHR)*. Under the IHR, Yellow Fever has previously been the only disease expressly listed for which countries can require proof of vaccination from travellers as a condition of entry into a country. To enter Australia from a country deemed a yellow fever risk a traveller must produce proof of vaccination certificate no less than ten days prior. It is important to note, WHO directs a country implementing a requirement of a proof of vaccination that significantly interferes with international traffic shall provide WHO with the public health rationale and relevant scientific information for it. These restrictions are enacted by the Australian Government under the *Biosecurity Act 2015*.

There is a clear precedent for vaccination associated with workplace risks in Victoria. Under the *Occupational Health and Safety (OH&S) Act (2008)* employers must take every reasonable action to ensure health and safety in their business activities. Certain occupations are associated with an increased risk of some vaccine-preventable diseases.⁴¹ This includes healthcare workers, childcare workers, carers, emergency services and essential workers. The NIP Schedule outlines the recommended vaccines; although employers can only require vaccination for current employees where there is further specific legislation.

Employers may require recommended vaccinations prior to commencing employment, or maintenance of recommended vaccines in an enterprise agreement. Other recommendations in the NIP include workers visiting remote Aboriginal communities be vaccinated against Hepatitis A and those visiting the outer Torres Strait Islands be vaccinated against Japanese Encephalitis. Those working with animals may be recommended to get Q fever, rabies or influenza vaccination. Influenza is now required for all healthcare workers under the *Health Services Amendment (Mandatory Vaccination of Healthcare Workers) Act 2020*. In the United States some colleges and universities require meningococcal vaccination for students.

The *Occupational Health and Safety Amendment (COVID-19 Vaccination Information) Regulations 2022* allows employers to collect, record, hold and use COVID-19 information for the purpose of performing a duty relating to health and safety at a workplace imposed by Part 3 of the OH&S Act

38 Parliament of Australia, *Joint press release: No job - no play and no pay for childcare*, 12 April 2015, Australian Government.

39 Department of Health and Human Services, *No Job No Play 2020 review*, 2020, Victorian Government.

40 Ibid.

41 Australian Technical Advisory Group on Immunisation (ATAGI), *Australian Immunisation Handbook*, 2022, Australian Government Department of Health and Aged Care.

2004 and the OH&S Regulations 2017. An employer is authorised to: 'to determine reasonably practicable measures to control the risks to health and safety associated with COVID-19 at that workplace' and 'to implement any reasonably practicable control measure to control the risks to health and safety associated with COVID-19 at that workplace'. The updated regulations follow advice from the CHO that following the removal of some vaccination requirements under pandemic orders, businesses and employers should consider their own policies based on their own assessment of risk.

These regulations do not require workers to be vaccinated, but ensure employers have the information they need to make decisions on necessary control measures at their workplace, which may include vaccination.

4.3 Use of COVID-19 vaccine mandates in other jurisdictions

4.3.1 Australia

Across Australia at the federal and state government level, as at 7 June 2022, there is uniform consensus of mandatory two-dose vaccination requirements and where eligible, booster doses of COVID-19 vaccines, in order to work onsite at a residential aged care facility.

The scope of occupations and settings to which the booster dose requirement applies in Victoria is broader than other Australian states and territories. Victoria requires a booster dose for those in residential aged care facilities, as well as custodial, disability and emergency service workers, in addition to those in healthcare facilities and specialist school facilities.

By comparison, New South Wales (NSW) applies a vaccination mandate requiring healthcare workers to be fully vaccinated and requires residential aged care facility workers to be fully vaccinated and have received a booster dose. Vaccination requirements do not apply to any other occupations or settings at any scale. Queensland's vaccination mandates extend wider than this, requiring workers in healthcare and education settings, correctional and detention facilities and workers entering airports to also be fully vaccinated against COVID-19.

The Northern Territory's vaccination mandates are perhaps more closely aligned with Victoria's than any other Australian jurisdictions, with no full general worker vaccination requirements in place and a fully vaccinated and booster dose requirement for high-risk workplaces, including hospitals, residential aged care facilities (per national standard) and custodial correctional facilities. It also includes workers who come into contact with vulnerable people, those whose workplace poses a high risk of infection, or where individuals perform work that is necessary for the operation or maintenance of essential infrastructure or logistics (including electricity infrastructure, and also including teachers).

Similarly, Western Australia requires residential aged care workers, healthcare and healthcare support workers, and critical industry workers (including electricity infrastructure and teachers) to be fully vaccinated including booster dose, with no other vaccination mandate applicable to general workers. Equally, no fully vaccinated requirement applies in South Australia, with the fully vaccinated and booster dose mandate applying to healthcare workers, in-home and community aged care and disability workers, Metropolitan Fire Service workers and Forensic Science SA workers.

In Tasmania, a fully vaccinated mandate applies to workers at quarantine facilities, healthcare settings and early childhood facilities, with a booster dose also required at residential aged care facilities (per the national standard), as well as in home and community aged care and for disability support workers.

4.3.2 International

COVID-19 vaccine mandates were imposed by many governments internationally in 2021 and 2022 as part of the pandemic response. While some countries introduced mandates as soon as vaccines were available, others introduced mandates to accelerate vaccination uptake in response to the Delta waves in mid-2021, and some adopted them later in response to plateaued uptake. Most countries adopted the '*pass sanitaire*' or vaccination passport approach, requiring proof of vaccination to enter public places and participate in a 'vaccinated economy'.⁴² ⁴³ Many governments enforced vaccination requirements on government employees and healthcare workforces, and many actors within the private sector adopted mandates in their commercial settings.⁴⁴ There are also examples of countries adopting age-specific mandates such as for children entering schools, or the elderly. Punitive measures such as those requiring unvaccinated people to pay for COVID-19 hospital care were implemented in countries such as Singapore.⁴⁵

New Zealand's mandatory vaccination approach closely mirrors requirements in Victoria. Those in the education sector were previously required to be fully vaccinated, however there is an ongoing requirement for individuals in specific roles to be fully vaccinated with a booster dose remaining in place within the health and disability sector, corrections sector, Fire and Emergency New Zealand workers, police, and defence force.

In contrast, the United Kingdom as well as Singapore currently do not require workers in any sector or industry to be vaccinated to attend work or work outside of their ordinary place of residence. Similarly, whilst employers in Denmark have the right to determine whether employees have been vaccinated, there is no requirement for individuals to be vaccinated in the first instance. Germany has retained a full vaccination requirement (with no booster) for health workers; alongside France adopting the identical approach, with the addition of care and fire service workers in their respective mandate.

In the United States of America there is significant variation across individual states in the current and historic use of mandates. Some states have requirements for booster doses, others have limited requirements for 'full vaccination', while some states have no vaccination requirements at all. Vaccination mandates have been the subject of Supreme Court challenges, and as such, the enforcement of such mandates have been impeded even in states where a requirement exists.

42 [Drew, L, *Did Covid Vaccine Mandates Work? What the Data Say* webpage, 7 July 2022, Nature website Vol 607.](https://www.nature.com/articles/d41586-022-01827-4) <https://www.nature.com/articles/d41586-022-01827-4>

43 Attwell K, Rizzi M, McKenzie L, Carlson SJ, Roberts L, Tomkinson S, Blyth C, *COVID-19 vaccine Mandates: An Australian attitudinal study 2021* National Library of Medicine.

44 Drew, L, *Did Covid Vaccine Mandates Work? What the Data Say*, 7 July 2022, Nature Vol 607.

45 *ibid.*

4.4 Other social and economic impacts of vaccine mandates

Literature suggests that immunisation coverage sufficient to achieve community immunity can reap enormous health, social, and economic benefits. Furthermore, limited vaccine mandates with public support in special high-risk or high-value settings and longer-term safety data can be part of a comprehensive package of interventions to return society to pre-pandemic life.⁴⁶

Vaccination mandates on workers have both positive and negative social and economic impacts, the magnitude of which can be influenced by how well they are implemented and the level of public support for them.

In the first Statement of Reasons on 15 December 2021, the Minister outlined the following social and economic considerations for public health measures, including mandating vaccine requirements:

- mental health and wellbeing of Victorians across all age groups and vulnerable communities,
- social cohesion and the long-term impacts of the pandemic on the mental health of individuals, families, carers and workforce,
- economic confidence,
- patterns of recovery across the state economy,
- implications for the state finances and resources,
- the role of pandemic orders on supporting economic recovery and confidence for business and employers, tourism and major events,
- the return of international students and specialist occupation groupings,
- the role of vaccination mandate measures in compliance and support for vaccinations and in turn driving economic recovery and
- the importance of as close as possible alignment with other states as to the pandemic orders to encourage free movement of people, capital and industry to promote economic recovery.⁴⁷

4.4.1 The role of vaccine mandates in the safe opening of Victoria and ending lockdowns

Vaccine mandates were pitched as a key factor to enable economic and social activity safely again in Victoria. The financial burden of lockdown was significant, not only on the government who were providing support to individuals and businesses, but to many businesses who were not able to pivot and work remotely, and those who depend on in-person engagement e.g. hospitality, entertainment, beauty and personal services, gyms. Many casual and insecure workers were unable to qualify for wage subsidies and suffered severe financial hardship as a result of lockdowns.

46 Gostin L, Salmon D, Larson H, *Mandating COVID-19 Vaccines*, 2020, JAMA Network, vol.325, no.6, pp.532-533.

47 Department of Health, *Statement of Reasons (15 December 2021)*, 2021, Victorian Government.

On 17 November 2021 the Premier answered a question regarding COVID-19 vaccinations in Parliament⁴⁸ and stated:

‘If workers are not fully vaccinated, and do not have a valid medical exemption, businesses may not be able to reopen, or may not be able to apply the eased capacity limits offered in the Roadmap. Employers can choose to support their workers to receive vaccinations by providing leave or paid time off and reliable, up to date information about the effectiveness of the vaccines.

Employers also have a responsibility to protect the health and safety of their employees while they are at work. This includes reducing or eliminating the risk of COVID-19 spread in their workplace. The COVID-19 vaccine should be considered as part of a broader range of controls to reduce the risk of exposure to COVID-19 in workplaces.’

In the 15 December 2022 Statement of Reasons, the Minister noted:

‘The mandatory vaccination requirement for Specified Workers, General Workers, Specified Facilities and Open Premises reduces the risk of transmission within the broader community. This provides greater community protection and certainty, which is an important consideration as the state economy begins to recover from the unprecedented impact of the pandemic.’

Anecdotal evidence suggests that workers and businesses were in support of vaccine mandates – with many supporting workers to get vaccinated by offering time off during work hours to do so. Industry associations who took economic hits were willing to do what was necessary to open back up. The AFL introduced their own vaccination policy in October 2021: “no jab, no play”.⁴⁹ In their press release the AFL stated:

‘The Policy reflects the AFL’s strongly held view that as the governing body of the sport, we share responsibility to address the risk of exposure to COVID-19 of our Players and Football Program Staff, and in delivering upon this responsibility, TGA approved vaccines offer the best possible protection in keeping our people safe, healthy and together. Further, it provides our sport the opportunity to recover from the COVID-19 interruptions that have beset both the AFL and AFLW competitions in these past two years.’

State-wide mandates also removed the responsibility and onus from industry to implement their own mandates – a move which was welcomed by businesses and organisations. The Victorian Chamber of Commerce surveyed over 1300 members on the *Victorian Government’s Roadmap to deliver the National Plan* in September 2021 with an overwhelming 84 per cent of respondents wanting the Victorian Government to make Public Health Orders requiring vaccination to alleviate pressure on individual businesses to determine vaccine requirements on staff and customers.⁵⁰

48 [Premier of Victoria, Answer to a Question on Notice, Parliament of Victoria, Adjournment Matters No 6043 webpage, 15 October 2021, Parliament of Victoria](https://www.parliament.vic.gov.au/questions-database/details/53/10639) <<https://www.parliament.vic.gov.au/questions-database/details/53/10639>>

49 [AFL, Statement: COVID-19 vaccination policy for AFL, AFLW players and staff webpage, 21 October 2021](https://www.afl.com.au/news/685423/covid-19-vaccination-policy-for-afl-aflw-players-and-staff) <<https://www.afl.com.au/news/685423/covid-19-vaccination-policy-for-afl-aflw-players-and-staff>>

50 [Victorian Chamber of Commerce and Industry, Victorian Roadmap survey: Victorian businesses have their say webpage, 29 September 2021](https://www.victorianchamber.com.au/news/victorian-roadmap-survey-victorian-businesses-have-their-say) <<https://www.victorianchamber.com.au/news/victorian-roadmap-survey-victorian-businesses-have-their-say>>

4.4.2 Reducing economic disruptions through reduced transmission in workplaces

Victoria's approach initially involved implementing vaccine mandates in high-risk settings to protect individuals and reduce transmission, before being implemented more broadly across workforces. In September 2021, when vaccine mandates were introduced for construction workers, the rationale provided was that "public health officials have become increasingly concerned about COVID-19 transmission and exposure in construction settings, with evidence that it was emerging as a 'vector' of the virus into regional areas. Changes will be made to limit further spread in this industry, allowing people to keep working safely."⁵¹

The CHO released the following statement in December 2021:

'Worker vaccination mandates were implemented during Victoria's last lockdown in the context of escalating case numbers to rapidly increase population vaccination coverage and limit community transmission. Mandatory vaccination in workplaces helps protect workers and any members of the public in attendance, given the risk of transmission between individuals from close or sustained contact, particularly in indoor settings, and especially between unvaccinated individuals.'⁵²

The CHO advice to inform the first pandemic orders in December advised that workforce shortages resulting from the need to isolate or furlough infected staff and their contacts are a material threat to maintaining workplace operations. High workforce vaccination coverage, supported by vaccine mandates, can diminish these disruptions by reducing outbreaks in these settings.⁵³

4.4.3 Industry and Worker support for mandates – a sense of safety for returning to work

There has been considerable support among workers for their employer to mandate vaccination and make regular testing a requirement. A study undertaken by the Melbourne Institute in November 2021 showed that around 70% of employees were either strongly or somewhat supportive of a vaccine mandate, while approximately 15% of employees expressed opposition to such a mandate.⁵⁴ Support for mandates was highest in respondents from professional, scientific, and technical services industries. While the majority of people still supported, levels of support were lowest in wholesale trade, transport, postal, and warehousing industries (64%), and ranged between 65 and 70% in retail trade, financial, insurance real estate industries, manufacturing, construction and utilities, and education and training sectors. Approximately 72% of respondent employees from healthcare and social assistance industries supported mandates.⁵⁵

51 [Department of Premier and Cabinet, *Press Release: New Freedoms When 70 Per Cent First Dose Target Reached* webpage, 16 September 2021, Victorian Government](https://www.premier.vic.gov.au/new-freedoms-when-70-cent-first-dose-target-reached) <<https://www.premier.vic.gov.au/new-freedoms-when-70-cent-first-dose-target-reached>> accessed 4 July 2022.

52 *ibid.*

53 Department of Health, *Chief Health Officer Advice to Minister for Health (10 December 2021)*, 2021, Victorian Government.

54 Melbourne Institute: Applied Economic & Social Research, *Taking the pulse of the nation (Wave 44-45)*, November 2021, University of Melbourne.

55 Wilkins, R, Zilio, F. How do employees feel about COVID-19 vaccination mandates and testing mandates? *Research Insights* No. 17/21 November 2021. *Melbourne Institute: Applied Economic and Social Research*, University of Melbourne.

In August 2021 Paul Zarta, CEO of the Australian Retailers Association (ARA), stated that there is a great deal of confusion and legal ambiguity surrounding mandatory vaccines. The ARA was calling for urgent leadership from the Australian Government to enable the necessary legal protections should businesses decide to make vaccines mandatory for their staff, he added. 'It's unfair to leave small businesses to navigate this legal minefield, and expose them to additional costs, without clarity or safeguards in place,' Mr Zarta said.⁵⁶

Anecdotal evidence among healthcare workers shows that they were overwhelmingly in support of vaccine mandates, with positive correlations to morale and reductions in mental health issues, stress, and Workcover claims. The complex challenges of staff furlough and compromised bed-to-staff ratios associated with COVID-19 meant that vaccine mandates provided a way to minimise disruptions to conditions and safety in hospitals and health services for healthcare workers.

4.4.4 Social and economic disparities - protecting the most vulnerable

High vaccination coverage has been an important public health measure to help protect the more vulnerable. When endorsing the AHPPC recommendation to mandate vaccination of the residential aged care workforce against COVID-19 on 7 September 2021, National Cabinet noted the high proportion of COVID-19 cases and deaths in the elderly population, particularly those with pre-existing conditions and comorbidities. As a key vulnerable population, it was highlighted that managing their risk of infection can be assisted by decreasing transmission from people entering residential aged care facilities, as most residents who have contracted COVID-19 have been infected by staff or visitors.

4.4.5 Protecting the health system

Higher vaccination coverage supported by vaccine mandates has been reported as an important measure to protect the health system. The AHPPC Statement on Mandatory Vaccination of all workers in Health Care Settings on 1 October 2021 states:

'Hospitals and health services have been particularly vulnerable to outbreaks resulting in transmission risk in the hospital to staff and patients. This includes the furlough of staff and reduction in health system capacity. Although identified as a priority group for vaccination, there are still workers in health care settings who are unvaccinated. Vaccination of persons entering health care settings is an important mechanism to protect the public, staff, and patients in these settings. AHPPC has consistently noted that vaccinated individuals are less likely to be significant drivers of spread, and that unvaccinated people dominate community transmission.'⁵⁷

56 [Sharples, S. Majority of Australian business owners want mandatory Covid vaccines webpage, 26 August 2021](https://www.news.com.au/finance/business/retail/majority-of-australian-retail-business-owners-want-mandatory-covid-vaccines/news-story/7e263d4f124c3092b3c0cb85f9ff305b) <<https://www.news.com.au/finance/business/retail/majority-of-australian-retail-business-owners-want-mandatory-covid-vaccines/news-story/7e263d4f124c3092b3c0cb85f9ff305b>>

57 [Department of Health and Aged Care, Australian Health Protection Principal Committee \(AHPPC\) Statement on Mandatory Vaccination of All Workers in Healthcare Settings webpage, 2021, Australian Government](https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-mandatory-vaccination-of-all-workers-in-health-care-settings) <<https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-mandatory-vaccination-of-all-workers-in-health-care-settings>> accessed 4 July 2022.

4.4.6 Protecting essential services provision

The Victorian experience has shown that high vaccination coverage supported by mandates has protected essential services and supply chains. Early in the pandemic there were outbreaks in abattoirs, residential aged care facilities, hospitals and food distribution centres. This resulted in temporary closures and interruptions to essential services. Vaccine mandates have reduced workforce shortages, resulting from the need of staff to isolate or furlough, and have helped to ensure that sectors at greater risk of workplace outbreaks, or those involved in provision of essential services, were able to continue operations.

Victorians could continue to access essential food supplies through the protection of workers in manufacturing, distribution and packaging of food and beverages, other freight and logistics, and in supermarkets. Vaccine mandates also helped to ensure the continued provision of emergency services including the State Emergency Service, fire, Victoria Police, Emergency Services, and the Telecommunications Authority.

On 23 April 2022 in an article published by *The Age* and *The Sydney Morning Herald*, a number of major Australian companies confirmed they would retain worker vaccine requirements even if government mandates ceased, including Coles and Woolworths, Virgin Australia, Telstra and the Commonwealth Bank.⁵⁸

4.5 Negative social and economic impacts of the worker vaccine mandates

While there is limited quantifiable evidence available on the specific impacts in Victoria, correspondence has been received by IPMAC raising concerns from individuals about the negative impact of the vaccine mandates including:

- Inability to obtain employment resulting in financial hardship
- Social exclusion due to the stigma of being unvaccinated for personal reasons
- Mental health impacts due to loss of employment and support systems
- The impact of individuals inability to earn an income is a breach of human rights
- Termination of employment for having a medical exemption to the COVID-19 vaccine due to the requirements being misinterpreted by an employer
- Lack of experienced teachers in schools
- Retention of vaccine mandates against public health advice erodes trust in government and health officials.

There has been regular news media reporting of individuals who have spoken out about the negative impacts of the vaccines on their lives, including loss of employment and the subsequent financial hardship and duress from loss of income including housing insecurity, lack of access to loved ones in care facilities, loss of friendships and relationships, and experience of segregation, stigma and discrimination for their anti-vaccination or anti-mandate stance.⁵⁹

58 [Eddie, R. D Estcourt, D Powell and C Yeates, Major employers to keep vaccine mandates irrespective of government policy, The Age webpage, 23 April 2022](https://www.theage.com.au/politics/victoria/major-employers-to-keep-vaccine-mandates-irrespective-of-government-policy-20220422-p5afb7.html) <<https://www.theage.com.au/politics/victoria/major-employers-to-keep-vaccine-mandates-irrespective-of-government-policy-20220422-p5afb7.html>>

59 [Chang, C. Unvaccinated Australians question why they are still unable to work due to unfair mandates, 18 May 2022, News.com.au webpage](https://www.news.com.au/lifestyle/health/health-problems/unvaccinated-australians-question-why-they-are-still-unable-to-work-due-to-unfair-mandates/news-story/8b22ad83e645f7974201fc3675fdeb8) <<https://www.news.com.au/lifestyle/health/health-problems/unvaccinated-australians-question-why-they-are-still-unable-to-work-due-to-unfair-mandates/news-story/8b22ad83e645f7974201fc3675fdeb8>>

Sumit Aneja a former security supervisor at Caulfield Hospital had his employment terminated in October 2021 due to his refusal to be vaccinated, which was based on worries of severe side-effects of the vaccine and a belief that COVID-19 was not a significant risk to him given his health and age.⁶⁰ Connor Morgan a worker in the building industry lost his job in September 2021. Mr Morgan refused vaccination as he felt the mandates were government over-reach, referring to several people he knew who didn't want to get the vaccine but were compelled to do so to stay employed commenting that 'I just think that's blackmail, I think it's unfair'.⁶¹ Violet Polonski aged 46 years who was working as a mental health clinician at The Alfred Child & Youth Mental Health Services in November 2021 was anticipating losing her employment due to her unwillingness to be vaccinated. Her reason for refusal was her concern that the vaccine would have an effect on her fertility and risk of miscarriage as she was undergoing IVF treatment at the time.⁶²

Some high-profile sports figures opposition to mandates was also covered in the media. Liam Jones retired from Carlton Football Club in November 2021 over his refusal to comply with mandated vaccination requirements, requesting privacy for his personal reasons.⁶³

IPMAC has considered some of these potential impacts in further detail below.

4.5.1 Economic exclusion for unvaccinated persons

Enforcing mandatory vaccination policies may also negatively affect staffing capacity, recruitment, and morale.⁶⁴ It was acknowledged in the Minister's 15 December 2021 Statement of Reasons that:

'The order may restrict the ability of [a] business to operate if some [of] their workforce are unable, or unwilling, to comply with the pandemic orders. The pandemic orders might in the short term reduce or affect the capacity of certain businesses to generate income from their real and personal property.'

It is not yet known the total number of Victorians who lost their employment due to the vaccine mandates, and the full economic impact on these individuals. During public hearings held by PDAOC representatives from various health services, aged care service providers, school and education bodies were asked the question 'how many employees lost their job due the mandates'. In most instances, the services noted less than ten workers who ceased employment due to mandates. Central Gippsland Health Service stated 17 or 18 staff had terminated employment.⁶⁵ Mr Peter Roberts of Independent Schools Victoria advised that the independent school sector had experienced some issues with workforce loss. Mr Roberts noted that consistent with the general population 95% vaccination uptake had occurred, but there were some independent schools where the proportion unwilling to be vaccinated was greater than 5% and in these instances staffing had

60 [Jewel Topsfield. *Why some people are prepared to lose their job over the COVID vaccine.* The Sydney Morning Herald webpage 21 November 2021](https://www.smh.com.au/national/why-some-people-are-prepared-to-lose-their-job-over-the-covid-vaccine-20211118-p59a3h.html) <https://www.smh.com.au/national/why-some-people-are-prepared-to-lose-their-job-over-the-covid-vaccine-20211118-p59a3h.html>

61 *ibid.*

62 *ibid.*

63 [ABC News. *Carlton's Liam Jones announces AFL retirement after reportedly refusing COVID-19 vaccine.* ABC News webpage. 14 November 2021](https://www.abc.net.au/news/2021-11-14/afl-carlton-covid-19-liam-jones-announces-retirement/100619656) <https://www.abc.net.au/news/2021-11-14/afl-carlton-covid-19-liam-jones-announces-retirement/100619656>

64 Lim L, Bennett N, Sullivan S, Bull A, Worth L, *Beyond the COVID-19 pandemic: increasing the uptake of influenza vaccination by health and aged care workers*, 1 August 2022, Medical Journal of Australia, vol ;217 iss 3, pp 157-158.

65 Dykgraaf M, PDAOC public hearing, Melbourne, 17 February 2021, *Transcript of evidence*, Parliament of Victoria p. 51.

been a challenge.⁶⁶ Adjunct Associated Professor Kelly Rogerson, Board Chair of Palliative Care Victoria noted that in the palliative care sector she was aware of other services, such as in counselling, social work and allied health fields, that had more substantial workforce impacts from the mandates.⁶⁷

Professor Nathon Grills, a public health physician working in emergency departments in Victoria stated in an article in July 2022 titled *It's Time to Drop Vaccine Mandates*, noted

'We medics can all name multiple nurses, allied healthcare staff and even doctors who aren't working due to mandates.

I was speaking with a GP friend who can't get enough staff to run his practice. They have lost nine nurses and receptionists due to vaccine mandates. I can personally name 15 people who have left Victoria as their vaccination status made working in health nearly impossible.

Allowing those unvaccinated staff to work has little risk but carries some benefit. This is perhaps even more true for businesses which unreasonably retain vaccine mandates.'⁶⁸

As the Australian Institute of Health and Welfare's report into mental health services in Australia comments:

'The potential for COVID-19 to impact mental health and wellbeing was recognised early in the pandemic. In addition to concerns about contracting COVID-19, measures put in place to contain the spread such as lockdowns, physical isolation and social distancing were also likely to have a negative impact on mental health. The sudden loss of employment and social interaction, and the added stressors of moving to remote work or schooling, and more recently, impacts of sudden, localised 'lockdowns' to prevent further outbreaks have impacted the mental health of many Australians.'⁶⁹

In the 12 January 2022 Statement of Reasons, the Minister acknowledged that:

'[E]xclusion from a physical workplace on the basis of vaccination status may be particularly onerous for single parents, for parents of younger children, and for parents of multiple children (who may find it impossible to work effectively at home). This may... disproportionately affect women who typically bear more of the child-minding or caring responsibilities in the home.'

'The order may result in people losing their employment, or unable to obtain employment if they are unwilling to be vaccinated and unable to perform their duties from home.'

66 Roberts P, PDAOC public hearing, Melbourne, 29 March 2021, Transcript of evidence, Parliament of Victoria, p. 81.

67 Rogerson K, PDAOC public hearing, 1 March 2022, *Transcript of Evidence*, Parliament of Victoria. p.55

68 Grills, N, *It's Time to Drop COVID-19 Vaccine Mandates*, Pursuit. 14 July 2022. University of Melbourne.

69 Australian Institute of Health and Welfare, *Mental health impact of COVID-19*, 2022, Australian Government.

The Minister also acknowledged that:

‘The Order does not prohibit the employment of any unvaccinated person. It only operates to prevent attendance at workplaces. It therefore allows unvaccinated people to remain employed if an employer could continue to employ them working from home.

The Order contains an exception for people who have certification from a medical practitioner that they are unable to receive a dose or a further dose of a relevant vaccine due to a medical contraindication or an acute medical illness.

Additionally, general workers who are not fully vaccinated or exempt may continue to work at their usual place of work if it is not reasonably practicable for the person to work at their ordinary place of residence (subject to any other vaccination requirements on workers contained in other orders).’

4.5.2 Vaccine mandate impacts and the interplay with pre-existing social and economic disparities

Literature also notes that ‘mandates can compound disadvantage such as those involving loss of money, goods or services that can disproportionately affect lower income earners. The creation of a class of citizens who are not allowed to fully participate in many areas of society/social exclusion’.⁷⁰ However, the full economic impact on individuals has not been possible to quantify.

4.5.3 Vaccine hesitancy and the impact on some individuals in a diverse society

Vaccine mandates will affect individuals within society differently depending on their underlying knowledge, attitudes, belief and value systems. Willingness of an individual to participate in an immunisation program may be influenced by a myriad of factors including values and beliefs about health and wellbeing, trust and attitudes towards health care, trust and attitudes towards government, health literacy, religion etc.

Vaccine hesitancy is a ‘delay in acceptance or refusal of vaccines despite availability of vaccination services.’⁷¹ Vaccine hesitancy is complex and context specific. Factors contributing to vaccine hesitancy lie over a broad spectrum, from the risk-benefit of vaccination concerning vaccine safety, adverse events as well as religious, cultural, gender, socio-economic, and vaccine-specific factors.

One example of a concern related to religious beliefs is that vaccine production utilises science based on knowledge gained from the use of aborted foetal cells. Recognising there are a spectrum of beliefs within many religions, facets of many which exhibit a faith in divine protection and healing, or taboos that contribute to vaccine hesitancy. Opposition to mandatory vaccination may be based on vaccine hesitancy or concern that the mandate is counter to human rights.

It is important that any mandated vaccination program provides relevant exemptions, including for medical reasons.

70 Leask J, Seale H, Williams JH, Kaufman J, Wiley K, Mahimbo A, et al. *Policy considerations for mandatory COVID-19 vaccination from the Collaboration on Social Science and Immunisation, 2021*, Medical Journal of Australia, vol. 215, iss. 11, pp. 499-503.

71 MacDonald, N.E, Vaccine hesitancy: Definition, scope and determinants, 2015, *Vaccine*, vol 33 iss 34, pp.4161-4164.

According to data collected through the 'Taking the Pulse of the Nation' Survey by the Melbourne Institute, by the time pandemic orders were introduced in December 2021, vaccine hesitancy nationally had dropped from 19% in May 2021 to 9.6% and was as low as 7.3% in Victoria. The proportion of respondents unsure about whether to get vaccinated had also dropped from a peak of 16% in May to 3% in December 2021.⁶⁶ In survey data from August 2021 prior to vaccine mandates in Victoria, the primary reasons for vaccine hesitancy were 'worry about side effects and/or safety of the vaccine', 'concern the vaccines do not work/lack of trust in them', or a view that the 'vaccines are not personally needed because the person is at low risk'.⁷²

A small subset of people will be hesitant to a vaccine and a smaller subset still will refuse vaccination regardless of related restrictions in freedoms. IPMAC acknowledges that there were protests, some violent, among people who were objecting to vaccine mandates and to public health restrictions more broadly. In September 2021 when vaccine mandates were announced for the construction industry, although welcomed by Master Builders Victoria (MBV),⁷³ there were protests associated with workers at the Construction, Forestry, Maritime, Mining and Energy Union's (CFMEU) Victorian branch.⁷⁴

Approximately 500 protesters participated in the sometimes-violent protest directed towards the CFMEU building, with riot police called to disperse the crowd. Victorian building unions, including the CFMEU, Electrical Trades Union, manufacturing workers union and plumbers' union, also released a joint statement at the time in which they blamed the Victorian Government and the CHO's "heavy-handed" vaccine mandate for driving workers toward the anti-vax movement.⁷⁵ Adding to the complexity of the situation, the CFMEU also acknowledged in a statement that at the protest, 'this crowd was heavily infiltrated by neo-Nazis and other right-wing extremist groups and it is clear that a minority of those who participated were actual union members'.⁷⁶ In response to a rise in COVID-19 transmissions in the building industry, the protests and the impending mandates, a two-week shutdown of the construction industry was called after discussions between the Victorian Government and the MBV.⁷⁷

A national survey conducted in October 2021 found that 7% of respondents were not willing to be vaccinated against COVID-19, even in the face of restrictions for the unvaccinated in some states.⁷⁸ In August 2021 health.direct.gov.au reported seven common reasons why people are not getting vaccinated for COVID-19.⁷⁹ These included the belief that Astra Zeneca could cause a blood clot,

72 Lim, G and V Nguyen, *Taking the Pulse of the Nation Wave 38 (2-7 August 2021)*. Melbourne Institute: Applied Economic and Social Research. 2021, University of Melbourne.

73 [Master Builders, Master Builders Victoria \(MBV\) welcomes introduction of mandatory vaccinations in building and construction industry webpage, 16 September 2021](https://www.mbav.com.au/news-information/media-release/master-builders-victoria-mbv-welcomes-introduction-mandatory-policy) <<https://www.mbav.com.au/news-information/media-release/master-builders-victoria-mbv-welcomes-introduction-mandatory-policy>>

74 [Marin-Guzman, D., Victoria to close down construction industry after wild protests, 20 September 2021, Australian Financial Review webpage](https://www.afr.com/work-and-careers/workplace/anti-vaxxer-tradies-clash-with-cfmeu-officials-20210920-p58t7i) <<https://www.afr.com/work-and-careers/workplace/anti-vaxxer-tradies-clash-with-cfmeu-officials-20210920-p58t7i>>

75 [Marin-Guzman, D., Victoria to close down construction industry after wild protests, 20 September 2021, Australian Financial Review webpage](https://www.afr.com/work-and-careers/workplace/anti-vaxxer-tradies-clash-with-cfmeu-officials-20210920-p58t7i) <<https://www.afr.com/work-and-careers/workplace/anti-vaxxer-tradies-clash-with-cfmeu-officials-20210920-p58t7i>>

76 *ibid.*

77 [BBC News, Covid: Melbourne construction sites shut after violent vaccine protest, 21 September 2021](https://www.bbc.com/news/world-australia-58628629) <<https://www.bbc.com/news/world-australia-58628629>>

78 Leask J, Seale H, Williams JH, Kaufman J, Wiley K, Mahimbo A, et al, *Policy considerations for mandatory COVID-19 vaccination from the Collaboration on Social Science and Immunisation*, 2021, Medical Journal of Australia, vol. 215, iss. 11, pp. 499-503.

79 [HealthDirect, 7 reasons people don't get COVID-19 vaccinations — and why you should right now webpage, 5 August 2021](https://www.healthdirect.gov.au/blog/7-reasons-people-dont-get-covid-19-vaccinations) <<https://www.healthdirect.gov.au/blog/7-reasons-people-dont-get-covid-19-vaccinations>>

changing advice on the age range of people eligible to take Astra Zeneca, wanting to wait for a preferred vaccine, that COVID-19 is mild, that individual risk is low, that the vaccines were not to be trusted due to how quickly they were developed, and that a friend, relative or peer had advised not to get the vaccine.

A German study found some similar results to the health direct report, with the addition of spiritual and religious beliefs to the list of reasons for hesitancy.⁸⁰ One individual reported: 'I don't believe in this vaccination and this vaccination will not help us, I believe in God, in Jesus Christ and only he can help us, save us and protect us from this virus'.

While important to note that any religion contains variation in beliefs, the ABC also reported in late 2021 that:

'It has become common for Christians to claim that being forced to take the COVID-19 vaccine is a violation of their religious convictions because their body is a temple, and they are commanded to keep it pure. They make this argument for a variety of reasons. For example, some believe the vaccine has dangerous side-effects; others think it contains microchips; and some have suggested that it can alter your DNA or cause infertility. Each of these, it seems, would violate the purity of their bodily temple, making it unsuitable as a vessel for the Holy Spirit. It is worth stating unambiguously that there is no evidence that any of these things are true of the available COVID vaccines, beyond some extremely rare and typically mild side-effects.'⁸¹

There has been support for the COVID-19 vaccine from religious leaders and communities to counter misinformation that can lead to vaccine hesitancy. For Muslim populations there can be concerns associated with the porcine or non-halal content of vaccines in general. However, regarding the COVID-19 vaccine the ABC reported in October 2021 that Alaa Elzokm, the imam at the Elsedeaq Heidelberg Mosque in Melbourne was advising his community the vaccine was halal, and that taking measures during the pandemic was very much in accordance with the teaching of Islam. 'One of the aims of the religion is to protect others and protect yourself,' Sheikh Alaa said. 'And protecting the lives of people should come through the measures that we do and the vaccine that we take.'⁸²

Victoria's mandatory vaccine orders provide for people with acceptable certification from a medical practitioner that the person has a recognised medical reason that makes getting a COVID-19 vaccine inadvisable to receive an exemption.

80 Fieselmann, J., Annac, K., Erdsiek, F. et al. *What are the reasons for refusing a COVID-19 vaccine? A qualitative analysis of social media in Germany, 2022*, BMC Public Health vol 22, 846.

81 [Stevenson, A., "My body is a temple": Vaccine hesitancy, religious exemptions, and the integrity of Christian witness webpage. 11 October 2021. ABC Religion & Ethics](https://www.abc.net.au/religion/vaccines-religious-exemptions-and-christian-witness/13580026) <<https://www.abc.net.au/religion/vaccines-religious-exemptions-and-christian-witness/13580026>>

82 [Renaldi, E., How Australia's Muslim community is battling COVID vaccine myths, 13 October 2021, ABC News webpage](https://www.abc.net.au/news/2021-10-13/muslim-community-debunking-covid-myths/100532408) <<https://www.abc.net.au/news/2021-10-13/muslim-community-debunking-covid-myths/100532408>>

5. Prerequisites for vaccine mandates

IPMAC identified the following prerequisites for vaccine mandates as the basis of this review.

5.1 Summary of prerequisites

Prerequisite 1: The mandates should be legal

Vaccine mandates should comply with the legislative framework.

Prerequisite 2: The mandate should appropriately consider and weigh human rights considerations

The impacts on individual human rights should be considered, and the benefits to the protection of health and wellbeing of the population should outweigh the negative impacts on the rights of individuals.

Prerequisite 3: The rationale for the mandate should be transparent and communicated clearly to the community

The public should have access to clear and timely information on the reason for the mandate and why it is important.

Prerequisite 4: Burden of disease should be high enough to justify a mandate

The heavier the burden of disease the more justifiable a mandate may be to accelerate coverage.

Prerequisite 5: The mandated vaccines should be safe and effective

Vaccines should have an acceptable safety profile and where possible the safest vaccine option should be available.

Prerequisite 6: The vaccines should reduce transmission or minimise the severity of health impacts

Vaccines should generate a benefit to the broader community by reducing transmissions, as well as a benefit to the individual through a reduced risk of severe health outcomes.

Prerequisite 7: Vaccine supply should be sufficient and easily accessible and equitably available

A secure supply of vaccines should be available before the introduction of a mandate with equity in access across the population to ensure people are able to reasonably meet the requirements of the vaccine.

Prerequisite 8: Less restrictive, trust-promoting measures should come first

Sufficient time should be provided for community trust in the vaccine, voluntary acceptance and uptake of vaccines and for non-coercive measures to be fully exhausted before introducing a mandate.

5.2 Public policy considerations for more coercive measures

As mandates are more intrusive than other interventions to increase vaccination coverage, they demand stronger ethical justification. Professor Julie Leask, an Australian expert in vaccination uptake at University of Sydney, and colleagues from the Collaboration on Social Science and Immunisation published a paper on policy considerations for mandatory COVID-19 vaccination. The paper suggests policy makers should balance the rights of individuals and the promotion of public good while carefully considering the epidemiological, programmatic and legal issues.⁸³ A risk-benefit assessment needs to be considered for individuals at an individual, group and societal level, noting that requiring vaccination for one cohort does not provide sufficient evidence that this would be appropriate for other cohorts. Non-coercive alternative measures targeting known causes of low vaccination should be exhausted in concert with efforts made to understand and address other context specific barriers. However, this consideration of alternative measures should also be weighed against the urgency of the public health threat and the need for prompt action.

Leask et al identifies the following prerequisites:

- The mandate should be legal
- Burden of disease should be high enough to justify a mandate
- The mandated vaccines should be safe
- The vaccine should reduce transmission
- Less restrictive, trust promoting measures should come first.

5.2.1 WHO guidance on COVID-19 vaccination mandates

A WHO Policy Brief issued in May 2022⁸⁴ outlines the following six considerations for governments and policy makers considering COVID-19 vaccination mandates:

- Necessity and proportionality
- Sufficient evidence of vaccine safety
- Sufficient evidence of vaccine efficacy and effectiveness
- Justice in access and availability
- Public trust
- Ethical processes of decision-making.

83 Leask J, Seale H, Williams JH, Kaufman J, Wiley K, Mahimbo A, et al., *Policy considerations for mandatory COVID-19 vaccination from the Collaboration on Social Science and Immunisation*, 2021, Medical Journal of Australia, vol. 215, iss. 11, pp. 499-503.

84 [WHO. COVID-19 and mandatory vaccination: Ethical considerations webpage, 30 May 2022](https://www.who.int/publications/i/item/WHO-2019-nCoV-Policy-brief-Mandatory-vaccination-2022.1)
<<https://www.who.int/publications/i/item/WHO-2019-nCoV-Policy-brief-Mandatory-vaccination-2022.1>>

5.2.2 Principles in the *Public Health and Wellbeing Act 2008* to guide public health interventions

Principles are described in Part 2 of the PHW Act that guide actions to be taken to meet the objectives of the legislation around protecting the health and wellbeing of Victorians.

The guiding principles that inform the prerequisites of the vaccination mandates are summarised as:

- Principle of evidence-based decision-making - Decisions should be based on evidence available in the circumstances that is relevant and reliable.
- Precautionary principle - If a public health risk poses a serious threat, lack of full scientific certainty should not be used as a reason for postponing measures to prevent or control the public health risk.
- Principle of primacy of prevention - prevention of disease and death is preferable to remedial measures, and health promotion is central to reducing health inequalities
- Principle of accountability - decisions are transparent and systematic, appropriate information is available to the public, and the public has opportunities to participate in policy development.
- Principle of proportionality - Decisions and actions should be proportionate to the public health risk and should not be made or taken in an arbitrary manner.
- Principle of collaboration - Public health and wellbeing, in Victoria and at a national and international level, can be enhanced through collaboration between all levels of government and industry, business, communities and individuals.

These considerations are central to the prerequisites that must be met for vaccination mandates identified for this review.

6. Analysis – Human rights and legal prerequisites

In assessing the prerequisites identified by IPMAC for a vaccine mandate have been met, the Committee's role is not to interrogate the science or epidemiology outlined in the CHO's advice to the Minister for Health. The CHO has a statutory role under the *Public Health and Wellbeing Act 2008* to provide advice to the Premier, the Minister or the Secretary on matters relating to public health and wellbeing.

6.1 Prerequisite 1: The mandates should be legal

A vaccine mandate should only be introduced if supported by an adequate legal framework.

6.1.1 Public health rationale for mandates

Under the PHW Act, the Minister may, at any time on or after the making of a pandemic declaration, make any order that the Minister **believes is reasonably necessary to protect public health**.

IPMAC has examined the Minister's rationale outlined in the Statements of Reasons from 15 December 2021 to 12 July 2022 for why the worker-related vaccine mandates were reasonably necessary to protect public health. This examination was performed to assess whether the Minister has met this obligation under the PHW Act.

The Committee has identified four key decision points over this period:

- December 2021 – retention of mandates previously introduced by the CHO using emergency powers to issue directions under the previous legislative framework
- January 2022 – introduction of a requirement for a booster dose for high-risk workforces
- January – June 2022 - sustaining the 2-dose and specified 3-dose mandates until June through consecutive COVID-19 waves
- June 2022 - revocation of mandates, except for the highest risk workforces.

IPMAC's assessment of whether the pandemic orders met the legislative requirements is framed around these key decisions.

6.1.1.1 December 2021 - Retaining mandates

The public health rationale for the initial introduction of mandates, as communicated by the CHO and the Victorian Government at the time of the directions provides important context for the Minister's decision to retain mandates on 15 December 2021.

The Minister made the decision to retain worker-related vaccine mandates previously introduced by the CHO between September and December 2021. At this point in time, Victoria had 92.1% fully vaccinated (2-dose) coverage of the eligible population (12 years and over) and had well exceeded the final Roadmap target of 80% 2-dose for 12 years and over.

Public health context: This decision was taken amidst the Delta outbreak. The Minister described it as a 'precautionary approach' that was necessary and proportionate given the perceived threat and global uncertainty regarding the emergence and rapid spread of the Omicron Variant of Concern. The Minister describes the period as a time of increased risk for workers arising from the return to onsite work, eased restrictions on the Victorian community, and opening borders.

Public health rationale for retaining mandates: The Minister's decision was consistent with CHO advice, accepting the public health benefits of mandates to be reducing transmission and reducing the risk of severe disease and serious health outcomes from infection.

The benefits were described for (i) vaccinated individuals, (ii) workforces as they returned to onsite work, (iii) high-risk populations, and (iv) the broader community. High-risk populations were defined as cohorts vulnerable to severe disease, vaccine ineligible groups, and workforces and attendees of high-transmission settings. Particular mention was made of individuals experiencing immunocompromise, other medical exceptions, and waning immunity.

Specific rationale for highest-risk workforces: The Minister also cited public health advice accepted from the CHO regarding the need for vaccine requirements in specific high-risk settings. The requirements are captured through the pandemic orders relating to Specified Facilities and Specified Workforces.

The CHO advice referenced in the Minister's first Statement of Reasons on 15 December 2021 identified higher-risk settings requiring greater protection for workers and vulnerable populations than what is offered by general population coverage. The criteria for high-risk that is accepted and cited by the Minister continues to be elaborated over subsequent statements as high-risk worker vaccine requirements were extended to include booster doses. The settings first identified include:

- **Hospitals:** (i) patients are at risk of contracting and transmitting infection, and some patients (elderly, comorbidities, immunocompromised) are vulnerable to serious outcomes of severe disease, further hospitalisation and death. (193.7) (ii) healthcare workers are at high exposure risk while delivering care, and many control measures were retained to reduced healthcare worker infections and protect health system capacity. (193.8)
- **Care facilities:** presence of vulnerable cohorts with risk factors for severe illness, and where transmission prevention is necessary to reduce the number of deaths in Victoria. (193.6)
- **Education settings** (school and early-childhood education and care setting) high transmission risk setting, in particular where primary school age children present a transmission risk as they are unable to access vaccines (404.7)
- **Meat processing:** other transmission related factors at play. (193.5)

While not directly referenced by the Minister in the Statement of Reasons, the CHO provides some detailed advice on occupational risk profiles and rationale for vaccination requirements for some types of specific workforces in advice to the Minister on 10 December. Examples are provided of workplaces with higher transmission dynamics (such as hair, beauty and personal care services) where workers may experience prolonged interactions with patrons in closed environments. Similarly, examples of professions with lower risk of exposure are also described such as those working in real estate. While not a comprehensive explanation for the inclusion of every specified workforce, the CHO notes that the specified workforce list will enable vaccination requirements to continue even if general requirements are lifted. Finally, the CHO makes the connection between the occupations working in settings where patrons are expected to be vaccinated as per the Open Premises Order, and the appropriateness of policy consistency in applying the requirement consistently across both workers and patrons in such premises.

The Minister also cited CHO advice on the secondary and indirect benefits from vaccination mandates more broadly as part of the rationale for why mandates are proportionate, appropriate, and necessary:

‘Reducing transmission risk for the broader community enables greater community protection and certainty, an important consideration as the state economy begins to recover from the unprecedented impact of the pandemic.’

‘Vaccine requirements assist with public confidence in the government’s public health response and assists in overall improvements in community compliance in other positive behaviours regarding mask wearing, self-isolation and social distancing.’

The Minister also cited CHO advice that mandates aid in attaining high vaccination levels that can reduce outbreaks in workplaces. Workforce shortages resulting from COVID-19 impacts were described as a ‘material threat to maintaining workplace operations.’ High levels of vaccination within these workplaces were/are promoted by mandates that can reduce outbreak incidents in these settings.

6.1.1.2 January 2022 – booster (3-dose) vaccine requirements for high-risk workforces

Two order changes were undertaken by the Minister on 12 and 25 January 2022 that introduced additional booster (3-dose) requirements for specified high-risk workforces.

Public health context: The Statement of Reasons from January describes a context of dual outbreaks of Delta and Omicron with escalating and unprecedented levels of infection, hospitalisation and mortality in Victoria. Through order changes across January the Minister acted on CHO advice on the need for additional measures to respond to Omicron. The perceived threat of Omicron by 12 January 2022 was described as the ‘real possibility of widespread infection and serious illness, an unsustainable burden on the health system and substantial disruption to economic and social activity’.

By January 2022 the CHO was also advising the Minister on emerging evidence of reducing effectiveness of the two-dose vaccination and the importance of boosters based on the following factors:

- Waning immunity from vaccination over time.
- Studies signalling reduced effectiveness of current vaccines against Omicron compared to previous variants. This included significant reduced effectiveness of two doses against infection and transmission, and a somewhat reduced protection from severe health outcomes.
- Evidence forming that a third dose increased protection against severe disease and hospitalisation against Omicron, and increased protection (but to a lesser extent) against symptomatic infection.

Public health rationale for booster requirements for high-risk workers: The Minister deemed an extension of the vaccine mandates to include a third booster dose appropriate and necessary for specified high-risk settings to protect against transmission and severe disease in workers and vulnerable groups they interact with. Selected workforces were based on:

- high occupational risk of exposure
- severe health consequences for vulnerable groups
- high amplification risk
- essential service provision.

Booster requirements were first applied to health care workers, aged care workers, disability care workers, emergency services workers, workers in correctional facilities, hotel quarantine workers, workers in abattoirs and meat and poultry processing facilities and food distribution workers through order changes on 12 January 2022. The Minister cited the following CHO advice on the risk profile of these settings, where a range of additional measures were introduced in this phase:

Setting	Description from Statement of Reasons 12 January and 25 January
Hotel quarantine	Facilities remain of significance as part of the essential management of international arrivals including those who are subsequently confirmed to have COVID-19. Although the consequential risk of hotel quarantine workers acquiring infection from this setting has lessened relative to the current high rates of community transmission in Victoria, ongoing protective measures remain important in mitigating incursion risk, particularly given the recent emergence of the Omicron Variant of Concern (441.3).
Abattoirs, meat processing and seafood processing	Cold environments with high humidity, involving exertive work which increases aerosol production, and where physical distancing is often impractical. This can result in favourable conditions for COVID-19 transmission and a high risk of amplification and uncontained outbreaks. These outbreaks also have downstream consequences for essential food supply. Large uncontained outbreaks occurred in these settings in Victoria's second wave, which spread into different parts of Victoria. These industries are essential to the food supply chain locally and nationally, which can be compromised when outbreaks occur. (441.4)
Care facilities	Care facilities are sensitive settings that require additional public health measures to mitigate the risk to vulnerable residents and to protect the workforce. Residents within care facilities have several risk factors that increase their risk of severe illness, complications and death from COVID-19.... Incursion of COVID-19 into care facilities in the second wave in Victoria, resulted in large case numbers, many uncontained outbreaks, major workforce shortages and significant loss of life. Despite high vaccination coverage, this vulnerable population need additional protection, to avoid the severe consequences of transmission and in order to reduce the number of deaths in Victoria as far as practicable (441.5)
Hospitals	Hospitals are also sensitive settings where patients are at increased risk of being exposed to and transmitting COVID-19. Furthermore, hospital patients may be particularly vulnerable to the negative impacts of COVID-19 infection including severe disease, further hospitalisation and death. Vulnerable patient cohorts include the elderly, the immunocompromised, and those affected with comorbidities which are known to be associated with adverse outcomes for COVID-19 including cancer, type 2 diabetes, respiratory disease, heart disease, chronic kidney disease, and hyper-tension (441.6)
Healthcare workers	Healthcare workers are more likely to be exposed to infectious cases while delivering care. ... It is critical to protect the workforce in order to minimise exposure of other workers to infection, mitigate the need for isolation of workers who become cases and reduce the impacts of furloughing workers who are close contacts, all of which have the potential to negatively impact worker health and wellbeing and the delivery of patient care. (441.8)

Setting	Description from Statement of Reasons 12 January and 25 January
Essential services	Workforces provide essential services to the Victorian community, and the potential impacts from staffing shortfalls due to workers becoming sick with COVID-19 or being required to isolate as a close contact would be significant (61.1.10.4)

On 25 January 2022, after consultation with the education sector and in line with CHO advice from early January, the booster requirement was also extended to education workers. In addition to the immediate public health benefits cited previously, the Minister also accepted CHO advice that ‘a mandate would also partially respond to the consequential risk of a reduction in face-to-face learning, due to high levels of education worker absenteeism due to COVID-19, and the effects on health and wellbeing of children from disrupted learning and down-stream effects on society and the economy.’

Setting	Description from Statement of Reasons 12 January and 25 January
Education settings	<p>The commencement of the 2022 academic year and return to work after the summer holiday period will result in increased opportunities for viral incursion, transmission and outbreaks amongst children, students, and staff in education facility settings.</p> <p>Interactions within education facility settings often occur in close proximity and for a prolonged duration, frequently in enclosed shared spaces, which increases the likelihood of transmission. Previous experience shows the significant number and scale of outbreaks that can arise in these settings</p>

At this point in time and for the duration of the mandates, the CHO did not advise extending booster requirements for any other workforces, given the wide-spread uptake in booster vaccines that was occurring. However, across the Statement of Reasons it was regularly stated that the scope of the third dose mandate was regularly reviewed and a process was in place for the CHO and Acting CHO (ACHO) to consider whether expanding third dose mandates to other workforces was proportionate and necessary. In the Statement of Reasons on 25 January 2022 the Minister stated support for the potential inclusion of additional workforces to protect public health if it was determined appropriate by this process.

The Minister also made specific mention of the importance of community engagement and clear communications, noting that strong messaging can aid with community engagement and uptake of booster vaccines. The Minister also noted the importance of constructive engagement with other sectors not yet included in the booster mandate.

6.1.1.3 December 2021 – June 2022: sustaining mandates

Vaccine mandates were maintained in Victoria until June 2022, with only minor adjustments being made to accommodate extensions to deadlines based on industry feedback, to align with national vaccination policy, provide additional time for individuals to meet vaccination requirements when affected by COVID-related quarantine or isolation requirements or in line with ATAGI advice to delay vaccination post infection for three months. This included maintaining two-dose mandates for most workforces, and the targeted three-dose mandate for highest-risk workforces as described above even after prescribed deadlines for meeting the requirement had passed.

Public health context: Successive waves of COVID-19, driven by emerging variants of concern and sub-lineages, waning immunity, the re-opening of society, economy and borders, and seasonality – including most recently the effects of winter on respiratory illness including COVID-19. Each wave was associated with significant levels of infection, hospitalisation, strain on the health system, and disruption to economic activity. The stated priority of the COVID Response during this time was reducing mortality, morbidity, limiting the impact on those most at risk of severe disease, controlling chains of transmission and reducing the strain on the health system. Until June 2022, a concurrent objective of ‘maintaining continued operations of essential services and sectors’ was also stated.

During this time coverage increased from 92.1% (Dec) to 94.6% (July) of Victorians aged 12 years and over receiving two-doses and 68.5% of eligible 16 years and over receiving three-doses.

Public health rationale for the mandates: Consistent with CHO advice, the Minister continued mandates as a precautionary approach through successive waves of COVID-19 from December 2021 to June 2022, sustaining the public health rationale for mandates and the benefits of vaccination requirements as established in the previous sections. Throughout this period until June 2022, the Minister repeatedly stated that based on the substantial public health risk COVID-19 posed to the Victorian population, this suite of measures was needed.

From April 2022 onwards it is clear that the Minister, on CHO and ACHO advice, is giving consideration to when mandates should cease. Many other COVID-19 response measures were revoked through order changes on 22 April 2022, signalling a major transition of the Victorian Government’s pandemic response to one of ‘empowering industry, workplaces and individuals to make decisions based on public health guidance’. The Minister cited ACHO advice of a gradual change and providing lead time between removing two-dose worker vaccination mandates and shifting to it being at the discretion of industry and individual workplaces.

On April 12 2022 the Minister started to refer to the national recommendation from AHPPC on 31 March 2022 that measures to reduce transmission remain in place until after the current Omicron BA.2 wave had passed. In response the Minister stated, ‘I am holding changes until this forecasted projection to support our health systems as we/they prepare for the upcoming flu season.’[\[13\]](#).

6.1.1.4 June 2022 – revoking most mandates, except for highest-risk workforces

On 20 June 2022 the Minister for Health revoked the two-dose general worker mandate and the booster three-dose mandate for workers in education, food processing and distribution, and quarantine. Three-dose booster mandates were retained for highest-risk workforces, which included custodial workers, disability workers, emergency services workers, healthcare workers, residential aged care workers, and specialist school workers.

Public health context: By June 2022 cases had plateaued and hospitalisation was on the decline. However, the CHO advised of remaining significant mortality attributable to COVID-19 and BA.4 and BA.5 sub-lineages had emerged in circulation. By the time the pandemic orders were made on 12 July 2022 Victoria was experiencing a winter-anticipated surge in cases with modelling anticipating a significant epidemic peak in mid-August.

Public health rationale for ceasing most worker mandates: Despite this epidemiological backdrop of another wave, the Minister on CHO advice determined that worker vaccine mandates were no longer proportionate and necessary to protect public health given waning immunity and likely minimal transmission risk of the very small numbers of remaining unvaccinated workers. The Minister makes note regarding education workers, that high levels of coverage had been attained and that prolonging mandates was unlikely to achieve any additional substantial increase in coverage.

Revoking mandates broadly was described as a step-down approach in June 2022, as industry and individuals take on a greater role in protecting themselves and their workforces. In July, the Minister on CHO advice noted that workplaces and organisations ‘should consider what requirements they adopt based on their own assessment of risk and using alternative mechanisms.’ This general transition to the nature of the response is symbolically represented by the new Minister for Health in July 2022 when she describes in the Statement of Reasons a new objective of the public health response to be one of ‘maintaining enjoyment of life and the continued operation of business, cultural, sporting and other activities.’

Public health rationale for maintaining requirements for highest risk workforces: The Minister accepted CHO and ACHO advice, that mandates should be retained for workforces involved in the care of at-risk populations and at higher occupational risk of COVID-19 or are critical to providing or maintaining emergency services. The ACHO also advised that vaccine protection (3-doses) may also aid in limiting shortages in these critical workforces, and continuity of service provision. In these specific cases the harms of continued mandates were outweighed by the public health benefits to the workers, residents and patients being cared for in these settings. In the Statement of Reasons on 12 July 2022 the Minister cites specific public health rationale provided by the CHO as follows:

Setting	Public health rationale
Residential aged care, healthcare and disability	Workers provide care to population groups at increased risk of adverse health outcomes from COVID-19 infection. The nature of the work also confers an occupational exposure risk for these workforces and this requirement will provide greater protection to staff from severe adverse health outcomes. Protecting the health and wellbeing of these workers may also limit workforce shortages and ensure the ongoing delivery of safe and high-quality care to residents and patients.
Emergency services	Workers provide critical operations and essential goods and services to the community. Due to the nature of their role, there may be circumstances where it is challenging for the above workforces to maintain physical distance, increasing their transmission and acquisition risk. Further, employees providing ambulance, police and other emergency services may also interact with individuals at risk of serious consequence from COVID-19. This measure will confer direct protection to staff and help maintain workforce capacity to support the ongoing provision of essential services.
Custodial employees	Workers may work alongside individuals who are at higher risk of severe health outcomes. The physical environment of these settings also confers a risk of virus incursion, amplification and transmission to at-risk individuals.

Setting	Public health rationale
Education staff working in specialist schools	Workers work alongside children who may be at higher risk of severe COVID-19 related outcomes. There is a risk of transmission as staff work in close proximity with children who may have various ability to physically distance and often in indoor settings

The Minister through the Statement of Reasons from December 2021 to July 2022 articulated a rationale that the vaccine mandates were reasonably necessary to protect public health.

A precautionary approach to the epidemiology and impacts of COVID-19 during this period and the benefits of vaccination generally were communicated consistently. It is noted that in the statements published with each order change the overall vaccination coverage is considered by the Minister. While the public health considerations of the Minister describe the benefits from vaccination coverage of reduced transmission and severe disease in general terms, they do not specifically consider the incremental public health benefits to be gained from the two-dose mandate given such a high vaccination coverage already achieved by the 15 December 2021.

IPMAC has given consideration as to whether sufficient rationale has been provided by the Minister on the classes of workers subject to vaccination requirements. The rationale and public health advice is provided consistently across the Statement of Reasons as to why the additional booster requirement applied to specified high-risk workforces and specified facilities.

The public health rationale for why the classes of workers were included in pandemic orders was not clearly communicated in the Minister's Statement of Reasons. Vaccination requirements for those who were on the previous Authorised Worker list (created before the introduction of Pandemic Orders) appear to have been carried over without supporting rationale in the Minister's Statement of Reasons (15 December 2021) on why these specific classes of workers were included.

Workers not captured directly by the COVID-19 Mandatory Vaccination (Specified Workers) Order and COVID-19 Mandatory Vaccination (Specified Facilities) Order, were subject to the COVID-19 Mandatory Vaccination (General Workers) Order.

Decisions on classes of workers in the Specified Workers and Specified Facilities Orders are relevant, as unvaccinated workers covered by the General Workers Order were able to work outside the home if it was not reasonably practicable for these workers to work at home. The Minister's Statement of Reasons (15 December 2021) does not provide any commentary on why certain unvaccinated workers may have been able to work outside the home.

IPMAC has considered the principle described by the CHO regarding the importance of clear and consistent policy making. Given ongoing consideration of whether the third booster dose requirement should be extended to cover further workforces, the CHO describes the risk of disruption and poor community acceptance of removing requirements that may later need to be reinstated or even expanded upon.

Additional detail is available on the public health context and the public health rationale for the mandates through the CHO and Acting CHO (ACHO) advice also published with order changes.

From December 2021 to July 2022 vaccination coverage at a population level increased from 92.1% to 94.6% of eligible Victorians over 12 years. The additional coverage gained each month between December to June was diminishing, with most of the coverage already attained by December 2021. IPMAC has considered whether the reasons mandates were no longer thought proportionate in June 2022 were already relevant or apparent earlier in the period.

Prerequisite 1: The mandates should be legal

Public health rationale for mandates

Key findings:

1. The vaccine mandates were reasonably necessary to protect public health.
2. The Minister for Health's Statement of Reasons include minimal information on the rationale for vaccine mandates and instead focuses on the reasons for them to be maintained.
3. The decision-making process for why the classes of workers were included in pandemic orders was not clearly communicated in the Minister's Statement of Reasons.

6.1.2 What can a pandemic order include and to whom can it apply

The PHW Act specifies what a pandemic order can include and to whom it may apply.

The scope of the pandemic orders is established through section 165AI(2) of the PHW Act which includes but is not limited to prohibiting, requiring or regulating many aspects of life such as the carrying on of activities, businesses or undertakings or the provision of information (including information about the identity of any person or the keeping of records). Vaccination mandates are enabled by 165AI(2) by requiring businesses to keep records of employee vaccination status.

A pandemic order can apply to all persons, specified classes of person or specified persons but cannot apply to a single named individual. If such application, differentiation or variation is relevant to the serious risk to public health posed it can differentiate between or vary in its application to persons or classes of person identified by one or more of the following:

- their presence in a pandemic management area or in a particular location in a pandemic management area,
- their participation in or presence at an event,
- an activity that they have undertaken or are undertaking, and
- their characteristics, attributes or circumstances.

This provides the basis for pandemic orders applying differently to a person based on their vaccination status which were made to require differing groups of workers to be fully vaccinated within specific timeframes applying to specified classes of persons under the definitions of Specified Worker (those workers in high-risk categories), Specified Facilities (all workers accessing higher-risk facilities such as health and residential aged care), Facility Worker (a sub-set of the specified facilities groups used in the Workplace Order) and General Worker (covering most office type environments).

The below examples included as a note in the PHW Act provide further clarity of the intent regarding vaccination mandates:

A pandemic order might:

- differentiate between persons or classes of person on the basis of their vaccination status in relation to a pandemic disease or a disease of pandemic potential, by restricting persons who are unvaccinated from engaging in specified activities unless they are exempt from vaccination

- differentiate between persons or classes of person on the basis of age, if age is relevant to the risks to health posed by a pandemic disease or a disease of pandemic potential. For example, a pandemic order might limit the ability of persons or classes of person to receive visitors at, or to move within, residential care facilities.

Prerequisite 1: The mandates should be legal

What can a pandemic order include and to whom can it apply

Key findings:

4. COVID-19 vaccination mandates fall inside the scope of what a pandemic order may include.
5. COVID-19 pandemic orders can be applied differently to people based on their vaccination status.

6.1.3 Minister must consult before making a pandemic order

Prior to making a pandemic order the Minister must request the advice of the CHO in relation to, and have regard to this advice, on:

- the serious risk to public health posed by the disease specified in the pandemic declaration to which the proposed pandemic order relates; and,
- the public health measures that the CHO considers are necessary or appropriate to address this risk.

In making a pandemic order the Minister:

- may have regard to any other matter the Minister considers relevant including, but not limited to, social and economic matters.
- may consult any other person the Minister considers appropriate before making a pandemic order.

The Ministers' Statements of Reasons from 15 December 2021 until 12 July 2022 provide evidence and detail of advice from the CHO and other consultations undertaken before making pandemic orders.

Discussion of matters with a range of key stakeholders informed the making of the first set of orders on 15 December 2021: the Premier; his Coordinating Ministers Committee colleagues; Professor Brett Sutton, the CHO; Professor Euan Wallace, the Secretary of the Department of Health; Victorian Chief Psychiatrist, Dr Neil Coventry; Associate Professor Simon Stafrace of Alfred Health, Director of Psychiatry at Alfred Hospital; Professor Brendan Crabb AC, Director and Chief Executive of the Burnet Institute; Mr David Martine, Secretary of the Department of Treasury and Finance; the Hon. Tim Pallas MP, Treasurer; and Professor Allen Cheng, former deputy CHO and Co-Chair, Australian Technical Advisory Group on Immunisation (ATAGI).

Statements of Reasons regularly referred to ongoing consultation between the Deputy CHOs and the CHOs of other states and territories, including through the AHPPC. The Minister further notes, 'It has been important throughout the pandemic for states and territories to cooperate wherever possible in the alignment of public health measures to ensure national consistency where

appropriate'.⁸⁵ In particular, reference was made to the AHPPC Statement of 31 March 2022 recommending maintaining some measures to reduce transmission until after the BA.2 surge. References were made to working with other jurisdictions through National Cabinet to talk through plans for managing COVID-19.

The Department of Health, on behalf of the CHO, consulted across government to inform the scope of workers to have a COVID-19 vaccination requirement to attend onsite work. On the Minister's behalf, the Department of Health consistently engaged across the Victorian Government with key stakeholders such as Department of Education, Department of Jobs, Precincts and Regions, Department of Premier and Cabinet, Department of Families, Fairness and Housing. Engagement strategies were developed to ensure feedback from many points of view while providing consistent messaging.

Industry and sector consultation either by the Minister or by the Department of Health, informed the introduction and ongoing modifications of the three-dose booster vaccination requirement for specified workforces. Engagement took place with distribution chain companies in the food chain, including executives from Coles, Woolworths and the United Workers Union (UWU) to consider extending mandate to food distribution workers. Consultation with education sector representatives on the 21 January 2022 expressed unanimous support for booster requirements, involving the Victorian Principals Association, Catholic Education Commission of Victoria, Victorian Association of State Secondary Principals, Independent Schools Victoria, and the Early Learning and Care Council of Australia.

For some significant pandemic order changes however, such as those revoking the mandates in June and July 2022, there is no reference to consultation beyond the advice of the CHO and ACHO.

Prerequisite 1: The mandates should be legal

Minister must consult before making a pandemic order

Key findings:

6. In accordance with the PHW Act the Minister requested and had regard for the advice of the Chief Health Officer and others to make pandemic orders for vaccination mandates.
7. The Statement of Reason provides limited detail on consultation regarding vaccination mandates.

85 Department of Health, *Statement of Reasons (15 December 2021)*, 2021, Victorian Government.

6.1.4 Publication of a pandemic order and associated documents

Under the PHW Act, the Minister must:

- ensure that before a pandemic order or a variation, extension or revocation of a pandemic order comes into force, a copy of the order as made, varied or extended, or of the instrument of revocation, as the case requires, is published on the Pandemic Order Register.
- within seven days after a pandemic order or a variation, extension or revocation of a pandemic order comes into force, ensure the following documents are published on an Internet site maintained by the Department:
 - advice given by the CHO
 - Minister’s Statement of Reasons for the making, varying, extension or revocation of the order
- a statement as to whether, in the opinion of the Minister, the order does or does not limit any human right set out in the Charter of Human Rights and Responsibilities; and
- if, in the opinion of the Minister, the order as made, varied or extended does limit a human right set out in the Charter of Human Rights and Responsibilities, an explanation of
 - the nature of the human right limited;
 - the importance of the purpose of the limitation;
 - the nature and extent of the limitation
 - the relationship between the limitation and its purpose; and
 - any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve.

From 15 December 2021, all pandemic orders have been published on the [Pandemic Order Register](#) prior to coming into force. All associated documents (CHO Advice, Human Rights Statement and Statement of Reasons) have been published within seven days of the respective variation, extension or revocation. Section 165AP(2)(d) of the PHW Act will be further explored in the Human Rights section below.

Prerequisite 1: The mandates should be legal

Publication of a pandemic order and associated documents

Key findings:

8. All pandemic orders relating to vaccine mandates have been made publicly available on the Pandemic Order Register in accordance with the PHW Act.
9. The Chief Health Officer advice, the Human Rights Statement and the Statement of Reasons have been published within seven days of the pandemic orders being made

6.1.5 Scrutiny, suspension and disallowance of pandemic orders

PDAOC can recommend to Parliament that a pandemic order (or parts of an order) be disallowed or suspended.

PDAOC cannot recommend that a pandemic order, or an instrument that extends, varies or revokes a pandemic order, should be disallowed in whole or in part unless PDAOC has first requested and considered the advice of IPMAC in relation to the pandemic order concerned.

Prerequisite 1: The mandates should be legal

Scrutiny, suspension and disallowance of pandemic orders

Key findings:

10. Pandemic Declaration Accountability and Oversight Committee has not requested any advice from IPMAC in relation to the disallowance in whole or in part of any vaccine mandate pandemic orders.

6.2 Prerequisite 2: The mandate should appropriately consider and weigh human rights considerations

Human rights can be defined in many different ways however usually refer to the basic standards by which we can identify and measure inequality and fairness.⁸⁶ The introduction of vaccine mandates for COVID-19 is an action that limits some human rights in order to protect others. This has provided a complex situation for individuals and groups who feel that their rights have been unfairly limited and have lost social and economic opportunities as a result of their choice not to be vaccinated.

The Victorian Ombudsman stated in August 2021 that:

‘Victoria has had human rights legislation since 2006, protecting 20 fundamental rights and freedoms, giving us a legacy we should be proud of. But all too often human rights are poorly understood both by the public agencies who are obliged to consider them and by the public they are intended to protect...Human rights are not absolute.’⁸⁷

Under the *Charter of Human Rights and Responsibilities Act 2006* (the Charter), public authorities, such as Victorian state and local government departments and agencies, and people delivering services on behalf of government, are required to act consistently with the human rights in the Charter.

In 2021, the Victorian Equal Opportunity and Human Rights Commission developed an explainer (the Explainer) – *Explainer: Mandatory COVID-19 vaccination and your rights*⁸⁸ which provides answers to some frequently asked questions about vaccine requirements and *Victoria’s Equal Opportunity Act 2010* and Charter of Human Rights Responsibilities.

As outlined in the Explainer, determining whether these sorts of limitations on people’s rights are necessary and proportionate depends on a range of factors:

- **Necessary:** Is there a justification for making vaccinations mandatory? For example, is requiring employees or customers to be vaccinated necessary to stop the spread of COVID-19 or protect the health of employees or others?
- **Proportionate:** Is the mandatory vaccine requirement proportionate to the purpose it is seeking to achieve? For example, does the risk posed by COVID-19 spreading in the workplace or service outweigh the impact on individuals whose rights are limited? Are there people in the

86 Australian Human Rights Commission. *Human Rights Explained: Fact Sheet1: Defining Human Rights*, 2009, Australian Government.

87 Victorian Ombudsman, *The Ombudsman for human rights: a casebook*, August 2021.

88 Victorian Human Rights and Equal Opportunity Commission, *Explainer: Mandatory COVID-19 vaccination and your rights*, December 2021, Victorian Government.

workplace or service who are likely to be at increased risk of severe symptoms if they contract COVID-19? Does the requirement to vaccinate take into account the differing needs of people with disabilities, health conditions or who might otherwise have valid reasons for not wanting to be vaccinated?

- **Availability of other less restrictive means:** Is there another less restrictive option reasonably available? For example, are there measures other than vaccination that would effectively stop the spread of COVID-19 in the workplace or service?

As noted, under the *Equal Opportunity Act 2010*, vaccination status is, in itself, not a protected attribute. This means that if an individual's reason for not getting vaccinated is not connected to one of the grounds contained in the PHW Act, for example you do not want to be vaccinated due to personal views, then this would not be discrimination under the PHW Act.⁸⁹

A lawsuit was considered in the Supreme Court of Victoria against the CHO and ACHOs in Victoria relating to mandatory vaccination directions, with a ruling provided in November 2021. In this proceeding, 129 plaintiffs from across a number of industries including health, education, construction and corrections were seeking judicial review remedies in relation to a number of directions given by the defendants in the exercise of their emergency powers under s 200(1)(d) of the *Public Health and Wellbeing Act 2008 (Vic)*.⁹⁰ As part of the suit, the plaintiffs sought declarations that the Vaccination Directions are unlawful and invalid, including because they are incompatible with various human rights protected by the *Charter of Human Rights and Responsibilities Act 2006 (Vic)*. In the affidavits of the plaintiffs most referenced concerns with loss of employment and income as a result of personal decisions not to be vaccinated. In its decision, the court said that 'many of these directions have intruded on freedoms that most Victorians have previously been able to take for granted.' However, it said that 'no statutory power is available to support the orders sought.'⁹¹

Similar lawsuits have been heard in NSW, where the public interest can be noted by the 58,000 people who tuned in to a live stream of the hearing on the Supreme Court's website.⁹² The judge found that it was a matter for the Minister to determine whether reasonable grounds existed for the making of the order. The Court's role is to adjudicate on the legality of the administrative action and not the merits of the decision and the application was dismissed.⁹³

89 Victorian Human Rights and Equal Opportunity Commission, *Explainer: Mandatory COVID-19 vaccination and your rights*, December 2021, Victorian Government

90 [Harding v Sutton, 2021, VSC 741, Supreme Court of Victoria webpage](https://www.supremecourt.vic.gov.au/news/harding-v-sutton) <<https://www.supremecourt.vic.gov.au/news/harding-v-sutton>>

91 *ibid.*

92 [Rooney, K, NSW Supreme Court dismisses anti-Covid vaccine mandate cases, 15 October 2021, Daily Mail Australia and Australian Associated Press MSN webpage](https://www.msn.com/en-au/news/australia/nsw-supreme-court-dismisses-anti-covid-vaccine-mandate-cases/ar-AAPxXPa) <<https://www.msn.com/en-au/news/australia/nsw-supreme-court-dismisses-anti-covid-vaccine-mandate-cases/ar-AAPxXPa>>

93 *ibid.*

6.2.1 Minister's Human Rights Statement

When making or varying pandemic orders, the PHW Act requires the Minister to provide a statement on whether the pandemic orders do or do not limit any human rights set out in the Charter of Human Rights and Responsibilities. This is known as the Human Rights Statement which needs to be read together with the Statement of Reasons and addresses:

- the nature of the human right limited; and
- the importance of the purpose of the limitation; and
- the nature and extent of the limitation; and
- the relationship between the limitation and its purpose; and
- any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve.

For each of the vaccine mandate pandemic orders the Minister was required to consider if the limitations on people's rights were necessary and proportionate based on the circumstances at that time. As noted in the section 7.5 on less restrictive measures later in this review, the CHO outlined less restrictive measures that could be applied in his advice on 10 December 2021 but ultimately concluded that they would not be sufficient to counteract the public health risks associated with retirement of vaccine mandates.

6.2.2 Human rights limited and engaged by the mandates

The specific human rights limited and engaged by the vaccine mandates as identified in the Human Rights Statements are described below.

As explained in the Human Rights Statements, a human right may be affected either positively or negatively, by a particular restriction. This is sometimes referred to as the human right being "engaged". For example, a human right might be negatively engaged by a restriction. However, some rights are subject to exceptions or qualifications contained within the right itself. If the relevant impact on the right imposed by a pandemic order falls within an internal exception or qualification to that right, it will not "limit" the human right. It is important to note that the "limitation" of a human right by an order does not mean that the order is "incompatible" with a human right.

As outlined in the Human Rights Statements between 15 December 2021 to 12 July 2022 the below were noted as human rights that were limited, affected or engaged as a result of the introduction of vaccine mandates:

- **Freedom of movement** - Prevents a person from attending a particular place – namely, the workplace – if they are unvaccinated
- **Freedom of thought, conscience, religion and belief** - Individuals may be required to act inconsistently with their beliefs in order to enable them to attend the workplace
- **Freedom of expression** - Requiring evidence of being vaccinated may limit an individuals' right to hold an opinion about a vaccine without interference
- **Cultural rights** - Individuals may disagree with aspects of the way that certain vaccinations are made
- **Right to equality** - Exclusion from the workplace may be particularly onerous for some individuals, including single parents, however in connexion with the statement of reasons, such actions are reasonable
- **Privacy and reputation** - Requirement to disclose vaccination status, however given that this is not in breach of any legislation, such restrictions are not arbitrary

- **Property rights** - Inability to generate income if workforce is unwilling to become vaccinated, however the right is not limited because the restriction is not unlawful or arbitrary
- **Right to life** - The right is positively affected as the order assists in protecting priority cohorts' right to life

The Human Rights Statements highlight the importance of the relationship between limitations potentially imposed by the vaccine mandates and the purpose of adopting the mandates - noting that given the significance of workplaces as a site of transmission throughout the pandemic, the purpose of the orders to limit the spread of COVID-19 is very important.

In each of the Statement of Reasons, the Minister confirms that it 'is reasonably necessary to make the order to protect public health', having weighed up and considered these impacts on human rights (as described in the Human Rights Statements) and other countervailing potential impacts on individuals and the community. The Minister further states 'I [have] formed the opinion that the limits placed on human rights by the order are demonstrably justified for the purposes of the Charter.'⁹⁴

In all of the Statement of Reasons the Minister also highlights the specific CHO advice that continuing the ongoing vaccination requirements is unlikely to pose significant imposition on workers for the reason that 'many workers are already required to be fully vaccinated (or exempt) to attend work and thus, continuing vaccination requirements for workforces that are already subject to a mandate would not be expected to result in significant disruption to affected industries or sectors, or an imposition on workers.'

The right to life and the right not to be arbitrarily deprived of life are fundamental human rights found to be positively engaged by the making of the pandemic orders. Because the COVID19 virus is life-threatening, the orders further that right, particularly in relation to vulnerable members of society who are at particular risk from broad and unrestricted transmission of COVID-19. The Minister notes in the Human Rights Statement released on 15 December 2021, 'I consider the differential treatment of general workers based on vaccination status assists in protecting vulnerable cohorts' right to life'.

COVID-19 is a life-threatening virus, particularly for vulnerable members of society, and the mandates are intended to reduce the risk of transmission of the virus in high-risk settings and cohorts. The pandemic orders contain an exemption for people who have a certification from a medical practitioner that they are unable to receive a dose or a further dose of a relevant vaccine due to a medical contraindication, which seeks to protect the right to life for those persons for whom taking the vaccine comes at an increased medical risk.

For each set of pandemic orders, the Human Rights Statement read together with the Statement of Reasons, detail the purpose of the orders and corresponding vaccine mandates, and the human rights affected or limited by the same. In line with the requirements of the PHW Act, the pandemic orders pertaining to vaccine mandates have fulfilled their legislative obligations in explaining the human rights limited by the orders, as well as the purpose of implementing the orders, having considered the human rights affected or limited.

Both the Minister's Statement of Reasons and Human Rights Statement address the factors identified in the Explainer.

94 [Department of Health, *Statement of Reasons \(15 December 2021\) webpage, 2021, Victorian Government*](https://www.health.vic.gov.au/covid-19/covid-19-mandatory-vaccination-general-workers-order)
<<https://www.health.vic.gov.au/covid-19/covid-19-mandatory-vaccination-general-workers-order>>

Prerequisite 2: The mandate should appropriately consider and weigh human rights considerations

Key findings:

11. The factors identified in *Equal Opportunity and Human Rights Commission Explainer: Mandatory COVID19 vaccination and your rights*. are addressed in the Minister's Statement of Reasons and Human Rights Statements.
12. The assessment of human rights exceeds the requirements of the legislation by providing detail and explanation on rights both limited and affected by the vaccination mandates.
13. The Right to Life was positively impacted by the vaccine mandates by protecting vulnerable cohorts from COVID-19.
14. Alternative means and some additional supports were considered.

6.3 Prerequisite 3: The rationale for the mandate should be transparent and communicated clearly to the community

Copies of the vaccine mandates pandemic orders were published on the pandemic order register (on the Department of Health's website) before they came into force. The Minister's Statement of Reasons and Human Rights Statements, along with the CHO Advice have been published on the Department of Health (DH) website.

As previously described, the public health rationale is outlined in the Minister's Statement of Reasons. Concurrent with this review, IPMAC has undertaken a separate review of the Victorian Government's communication approach relating to pandemic orders and health related communications against best practice to identify any learnings that can inform pandemic communications going forward. This review has found that significant effort was made across the Victorian Government to ensure the timely provision of consistent and relevant information on pandemic orders that maximised reach utilising a diversity of methods and platforms. A broad range of communication and engagement activities were undertaken by the Victorian Government informed by consistent messaging that was tailored for different sectors and priority cohorts and their audiences. This was distributed through their networks using existing channels and a diversity of new mechanisms.

The Department of Jobs, Precincts and Regions (DJPR) used a variety of channels to communicate requirements under pandemic orders and cater for the various ways in which businesses and industry consume information. The DH coronavirus.vic.gov.au website had various web pages dedicated to workplace requirements and provided links for businesses to download signs, posters, templates and COVIDSafe Plans in different formats to enable them to comply with workplace requirements. There has been a significant number of downloads and visits to business support pages on the DH coronavirus.vic.gov.au website from 15 December 2021 to 6 June 2022 including 334,556 views on the 'How we work current restrictions' page, 160,728 views on the 'COVIDSafe Plan' page, and 140,624 views on the 'Signs, posters, templates' page. The 'Signs, posters, templates' page had a total of 135,174 downloads (126,863 English, 8,311 in-language). The 'COVIDSafe Plan' page also had a significant number of downloads with a total of 82,174 downloads (78,078 English, 4,096 in-language).

Industry information sessions/roundtables were held online along with consultations with key stakeholders. Industry engagement and information sessions were also a source of stakeholder feedback providing opportunities for 'Questions and Answers' which reinforced communications but also gauged their effectiveness informing responsive communication initiatives.

To complement all-sector roundtables conducted by DJPR, a number of smaller ad-hoc tailored engagements were undertaken for stakeholder groups and individual organisations where there were perceived barriers to accessing information. These included tailored forums with Traditional Owners, the Victorian Multicultural Commission, local government CEOs, Agriculture Victoria, Creative Victoria and regional business forums.

The DJPR 'Being COVIDSafe is Good for Business' campaign ran from 7 March to 1 April 2022 targeting three business segments: non-CALD metro, non-CALD regional and state-wide CALD (nine priority languages: Arabic, Greek, Hindi, Italian, Punjabi, Simplified Chinese, Traditional Chinese, Turkish and Vietnamese). The campaign focused on six key messages including vaccination requirements. It drove considerable traffic to the coronavirus.vic.gov.au website and contributed significantly to increased traffic to in-language Business and Work pages on the website.

Different vaccination deadlines and requirements (two or three doses) for different worker groups were found to be challenging to communicate with specific stakeholders. Reminders were sent to DJPR stakeholders via SMS to support business and industry to understand industry specific mandates. This was used as an opportunity to direct business and industry to both information regarding vaccination requirements for their industry and reinforcing and linking to broader COVID-Safe messaging.

Consultation with industry and operators of specified facilities occurred between February 2022 and April 2022 regarding challenges in meeting the deadlines for booster third dose. The Statement of Reasons explains that the CHO and the Minister were aware that challenges included workforce shortages and challenges for workers complying with the deadlines if they were in self-isolation or quarantine. As a result of engagement, the Minister made amendments to deadlines to provide additional time.

As discussed in section 6.1.1.4, the public health rationale for why the classes of workers were included in pandemic orders was not clearly communicated in the Minister's Statement of Reasons.

Prerequisite 3: The rationale for the mandate should be transparent and communicated clearly to the community

Key findings:

15. There was significant communication undertaken by the Victorian Government departments targeting industry through established and new networks.
16. The rationale for the occupational groups included in the different orders and thus subject to different obligations could have been more transparent.

7. Analysis - public health prerequisites

7.1 Prerequisite 4: Burden of disease should be high enough to justify a mandate

Vaccine mandates must be considered in the context of the burden of disease, with heavier disease burdens justifying impositions on personal liberty.⁹⁵ These considerations must be based in the epidemiological context of disease incidence and prevalence, with resultant potential for transmission between individuals, of serious illness causing morbidity or mortality for the individual, or increased burden on the health system.

It must be noted that by their nature, the epidemiology of pandemics changes quickly. The burden of disease will change with time, dependent on:

- Differential attack rates in population groups who are more or less susceptible to poor outcomes (for example, if the disease becomes prevalent in nursing homes or schools),
- The emergence of new variants that alter either disease severity or transmissibility
- The introduction, availability, and effectiveness of medical countermeasures (vaccines and treatments)
- The effectiveness of other public health measures and community compliance with these
- Changing level of population immunity (either naturally or vaccine acquired)
- Interaction with other diseases with epidemic potential, including seasonal influenza.

As such, the burden of disease is not certain in advance, which is precisely when vaccines must be deployed as a preventative measure. Within the *Public Health and Wellbeing Act (2008)*, this consideration is encapsulated by the 'precautionary principle', in which interventions in response to a serious to public health should not be delayed by lack of full scientific certainty. While disease modelling aids in this decision, it may not always reflect future progression of the disease. Regular review of contemporary scientific evidence and epidemiology should be undertaken by public health experts to estimate the burden of disease as it changes over time, in order to ensure the burden of disease remains high-enough to justify a mandate.

As COVID-19 is an infectious disease transmitted by the airborne route (among others), individual choices that affect transmission not only influence the individual risk of COVID-19 but also the collective risk at a workplace and the risks to any clients or patients.⁹⁶

95 Leask J, Seale H, Williams JH, Kaufman J, Wiley K, Mahimbo A, et al, *Policy considerations for mandatory COVID-19 vaccination from the Collaboration on Social Science and Immunisation*, 2021, Medical Journal of Australia, vol. 215, iss. 11, pp. 499-503.

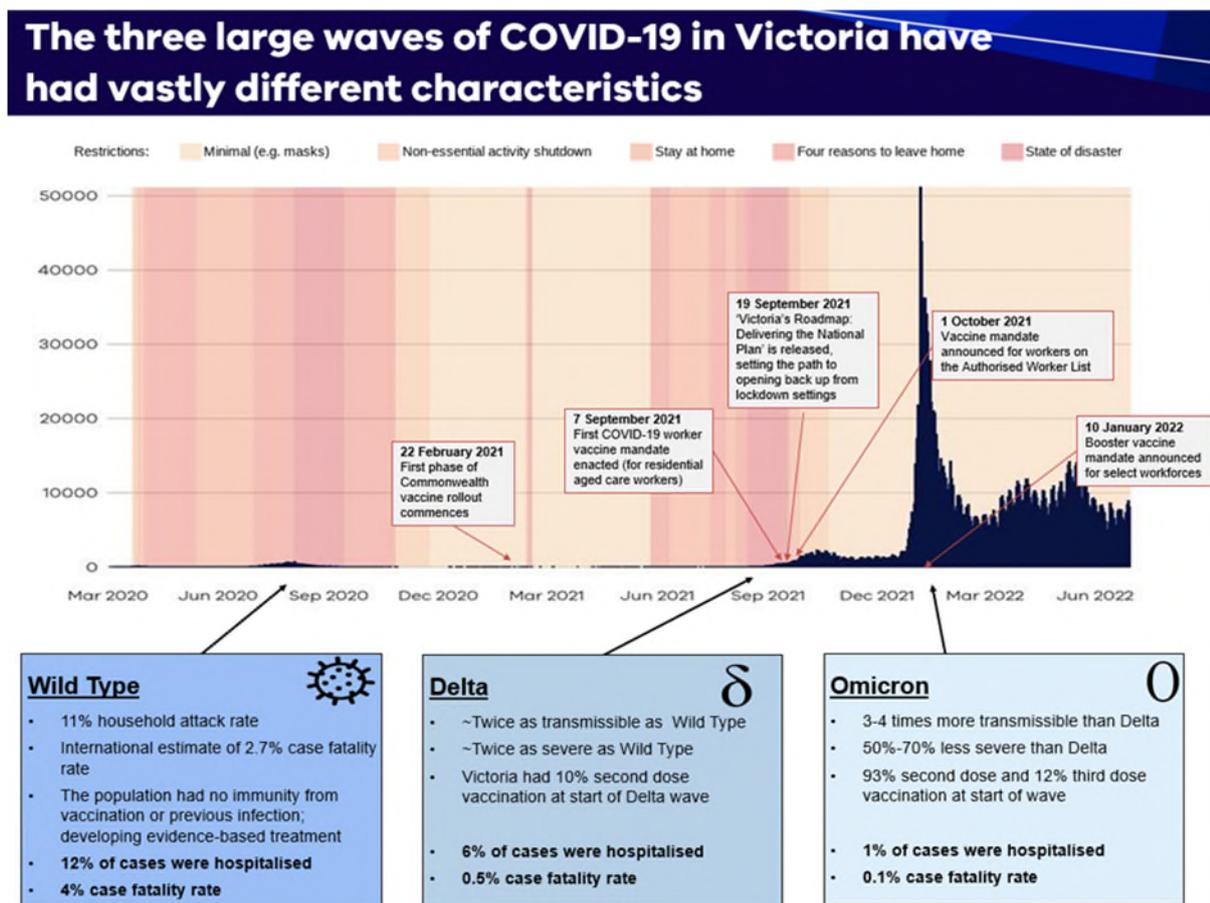
96 Pandemic Declaration Accountability and Oversight Committee, *Nancy Baxter: Worker Vaccine Mandates: Submission to the Pandemic Declaration Accountability and Oversight Committee*, 2022, Parliament of Victoria.

On 11 March 2020, the World Health Organisation Director-General, Dr. Tedros Adhanom Ghebreyesus, declared COVID-19 a global pandemic.⁹⁷ WHO expressed a deep concern for the levels of transmission and the severity of the illness, with daily calls urging the countries to take urgent and aggressive action against a disease that would cause not just a public health crisis, but effect society at large.⁹⁸

To make this consideration under the Public Health and Wellbeing Act (2008) the Minister for Health must make decisions on pandemic orders based on the risks to public health of Victorians. Therefore, the Minister should consider global, national, state and local level data to understand the burden of disease COVID-19 represents to individuals, communities, industries and the broader health system.

These considerations are outlined in the Minister’s Statements of Reasons from 15 December 2021 until 20 June 2022. The Minister must rely on current epidemiological data to have the most up-to-date picture of the burden of disease when making pandemic orders. The Minister’s Statements of Reasons provides expert advice from the CHO on the risks COVID-19 poses to public health and the appropriate measures to address these risks. This advice includes epidemiological data including those complex factors outlined above.

Some of this complexity is demonstrated in the following diagram:



97 [World Health Organization, *Speech: WHO Director-General's opening remarks at the media briefing on COVID-19, webpage, 11 March 2020*](https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020) <https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>

98 [United Nations in Western Europe, *WHO: Mandatory vaccinations are a last resort, webpage, 2021, UNRIC*](https://unric.org/en/who-mandatory-vaccinations-are-a-last-resort/) <https://unric.org/en/who-mandatory-vaccinations-are-a-last-resort/> accessed 4 July 2022.

This demonstrates various waves of infection caused by the original virus, followed by subsequent Variants of Concern (VOC) – Delta and Omicron. When considering disease ‘severity’, this refers to the inherent characteristics of the variant that would apply to a completely ‘naïve’ population (i.e. one without prior immunity conferred by prior infection or vaccination). As such, while Delta was considered twice as severe as Wild Type, it demonstrated lower hospitalisation and case fatality rates due to the actual population impact being influenced by measures such as vaccination, treatment and social measures such as mask wearing. Omicron proved to be an inherently less severe variant that caused a lower proportion of hospitalisations and deaths, aided by high levels of vaccination in the population. Nonetheless, it is far more transmissible, contributing to much higher case numbers and consequent hospitalisations and deaths than seen with previous variants.⁹⁹

This demonstrates three general points:

- The rapidity with which variants with new characteristics can emerge and cause a surge in cases, hospitalisations and deaths
- The complex interplay between viral characteristics and public health actions such as vaccinations and their influence on relative and absolute measures of hospitalisations and deaths
- The ongoing burden of disease posed by COVID-19, particularly in high-risk population groups

The burden of disease is not equal in all populations. COVID-19 has been found to disproportionately affect older Australians, particularly those aged over 70 years and those living in residential aged care facilities.^{100,101} Individuals residing in areas of greater socioeconomic disadvantage also experience higher rates of hospitalisation, ICU admissions and deaths.¹⁰²

While the initial two-dose vaccine mandates under the Minister’s pandemic orders were quite broad, subsequent iterations targeted high-risk industries, either due to the nature of the work increasing transmission risk, or significant contact with populations vulnerable to severe disease, or both. This includes healthcare, aged care and disability sector workers, areas in which vaccinations may protect the workers and their clients, but also aid in reducing staff furlough and maintaining an adequate workforce. Other industries that had shown increased burden of disease were also targeted (e.g. abattoirs, construction).

99 Department of Health, 2022, Victorian Government.

100 [Department of Health, *Additional COVID-19 case data webpage, 2022, Victorian Government*](https://www.coronavirus.vic.gov.au/additional-covid-19-case-data) <https://www.coronavirus.vic.gov.au/additional-covid-19-case-data> accessed 4 July 2022.

101 [Department of Health and Aged Care, *COVID-19 outbreaks in Australian residential aged care facilities webpage – 1 July 2022, 2022, Australian Government*](https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-residential-aged-care-worker-covid-19-vaccination) <https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-residential-aged-care-worker-covid-19-vaccination> accessed 4 July 2022.

102 Department of Health, *Acting Chief Health Officer Advice to Minister for Health (7 July 2022)*, 2022, Victorian Government.

The rationale for the two-dose general worker mandate was outlined in advice provided to the Minister for Health by the CHO, or ACHO on 10 December 2021:

‘Worker vaccination mandates were implemented during Victoria’s last lockdown in the context of escalating case numbers to rapidly increase population vaccination coverage and limit community transmission. Mandatory vaccination in workplaces helps protect workers and any members of the public in attendance, given the risk of transmission between individuals from close or sustained contact, particularly in indoor settings, and especially between unvaccinated individuals.’¹⁰³

‘Victoria has now achieved significant population vaccination coverage of greater than 90% full vaccination in those aged 12 years and above, meaning there is an established level of protection within the community and across workplaces. However, COVID-19 case rates remain elevated despite this coverage and although the rate of hospitalisation and intensive care unit admission is slowly stabilising, a new threat is emerging in the Omicron VOC.’¹⁰⁴

Initial vaccine mandates were based on ATAGI advice on a two-dose course. As ATAGI advice evolved there was a need to review mandates and whether they needed to be expanded. Third dose mandates were introduced for some workforces in line with the following considerations provided by the ACHO on 10 January 2022,:

‘The workforces set out below warrant specific consideration for mandatory third doses, not only because they were some of the earliest workers to receive the COVID-19 vaccine, but also because the workforces themselves are higher risk:

- i. there is an increased risk of exposure to COVID-19 for the individual worker (i.e., higher occupational exposure risk), such as healthcare workers
- ii. transmission is more likely to lead to severe health consequences for vulnerable individuals with whom the worker may regularly interact during the course of their work (i.e., higher risk for transmission to persons who are medically vulnerable to severe disease and death due to COVID-19 infection);
- iii. the workplace setting involves high risk for viral amplification and rapid spread between workers due to factors inherent to the working environment or the nature of the work being undertaken, such as meat processing workers, as outlined in paragraph 102; and
- iv. the workforces provide essential services to the Victorian community, and the potential impacts from staffing shortfalls due to workers becoming sick with COVID-19 or being required to isolate as a close contact would be significant.’

103 Department of Health, *Chief Health Officer Advice to Minister for Health (10 December 2021)*, 2021, Victorian Government.

104 Department of Health, *CHO Advice to Minister for Health (10 December 2021)*, 2021, Victorian Government.

In advice provided by the CHO on 7 April 2022, two-dose vaccination mandates were no longer felt to be warranted, in the context of their plateaued effect on vaccine uptake, the waning immunity of those immunised many months ago, and a transition in the response toward individual responsibility and empowerment.¹⁰⁵ Nevertheless, the second dose mandates were continued until June, with the Minister stating they be kept in place to allow lead time prior to the introduction of individualised workplace vaccination policies.¹⁰⁶ Additionally, in the CHO's April 7 2022 advice, third-dose mandates were once again recommended for specific high-risk workers:

'These groups of workers have been included in the third dose (booster) mandate to date because they are those involved in the care of at-risk populations, are at higher occupational risk of COVID-19, are critical to maintaining emergency services or food supply chains or are at higher risk of being involved in large workplace outbreaks because of the nature of their work environment.'¹⁰⁷

These statements would suggest the utility of second-dose mandates was limited beyond the date third-doses were due (though allowing time for Industry development of individualised policies is reasonable). Nevertheless, the ongoing pandemic (as declared by the WHO) combined with local factors and epidemiology were sufficient to say that the burden of disease caused by COVID-19 remained significant throughout the vaccine mandates. While this in itself is insufficient to justify vaccine mandates, it satisfies one criteria among many.

Prerequisite 4: Burden of disease should be high enough to justify a mandate

Key findings:

17. The burden of disease associated with COVID-19 has been established and is high enough to warrant consideration of vaccine mandates, particularly in high-risk populations.
18. The consideration must nevertheless take into account the various other factors contained within this report.

105 Department of Health 2022, *Acting CHO Advice to Minister for Health (7 April 2022)*, 2022, Victorian Government.

106 Department of Health, *Statement of Reasons (22 April 2022)*, 2022, Victorian Government.

107 Department of Health 2022, *Acting CHO Advice to Minister for Health (7 April 2022)*, 2022, Victorian Government.

7.2 Prerequisite 5: The mandated vaccines should be safe

Vaccines are a medical intervention that may pose rare but serious risks to an individual. As such, vaccines approved for use in the population must have an acceptable safety profile, with those considered the safest ideally being made available.¹⁰⁸ This must also be the case for vaccines approved for emergency or provisional use.¹⁰⁹ This is particularly important principle in the setting of mandates, whereby an individual's right to informed consent has been circumvented.

The COVID-19 vaccines currently use in Victoria have met specific criteria as established by the TGA. They must be safe and effective to be approved for use in Australia and contribute to a significant reduction in the chance of a person developing symptomatic infection, severe disease or requiring hospitalization. Details of TGA's COVID-19 vaccine approval process can be found [here](#). The TGA collects, analyses and publishes [reports](#) on all safety concerns related to COVID-19 vaccines.

In the CHO's Advice 15 December 2021, the following statement provides clear advice on the safety and effectiveness of COVID-19 vaccines:

'COVID-19 vaccines currently in use in Victoria have met specific criteria as established by the TGA. They must be safe and effective to be approved for use in Australia and contribute to a significant reduction in the chance of a person developing symptomatic infection, severe disease or requiring hospitalisation (Therapeutic Goods Administration, 2021).'¹¹⁰

Given the TGA is Australia's primary medicine and therapeutic goods regulator agency, their advisement on the safety of a vaccine may be considered sufficient when considering vaccine mandates. Nevertheless, when multiple vaccines are available, those with the best safety profile (in relation to effectiveness) should be selected and informed by post-licensure safety surveillance provided to TGA and ATAGI.

Prerequisite 5: The mandated vaccines should be safe

Key findings:

19. The COVID-19 vaccines available through the mandates were found to have an acceptable safety profile by the Therapeutic Goods Administration.

108 Leask J, Seale H, Williams JH, Kaufman J, Wiley K, Mahimbo A, et al, *Policy considerations for mandatory COVID-19 vaccination from the Collaboration on Social Science and Immunisation*, 2021, Medical Journal of Australia, vol. 215, iss. 11, pp. 499-503.

109 [World Health Organisation 2022. COVID-19 and mandatory vaccination: Ethical considerations. webpage. 30 May 2022](https://www.who.int/publications/i/item/WHO-2019-nCoV-Policy-brief-Mandatory-vaccination-2022.1) <<https://www.who.int/publications/i/item/WHO-2019-nCoV-Policy-brief-Mandatory-vaccination-2022.1>>

110 Department of Health, *CHO Advice to Minister for Health (10 December 2021)*, 2021, Victorian Government.

7.3 Prerequisite 6: the vaccines should be effective in reducing transmission or minimising the severity of health impacts

Vaccinations required under a mandate should be effective for the purpose of the mandate.¹¹¹ In the Statement of Reasons underpinning the mandates from December 2021 and April 2022, the Minister for Health requires various groups of workers to be vaccinated (with either primary or booster dose) in order to protect workers in high-risk settings, vulnerable populations they serve, staffing levels of key workforces, and the broader community.^{112,113} In this statement, the Minister describes vaccination's ability to limit severe disease and reduce transmission as the key means by which these goals will be met, taking into account variations caused by differing variants and number of doses received. These are the metrics by which the effectiveness of the vaccines must be reviewed.

7.3.1 Prevention of severe disease

While it is ethically difficult to justify mandating an individual to be vaccinated purely for their own protection,¹¹⁴ it may be considered in circumstances where prevention of large numbers of hospitalisations is intended to preserve capacity of the healthcare system.¹¹⁵

This was evidenced by advice provided by the CHO in December 2021:

‘The COVID-19 vaccines in use in Australia have been shown to reduce severity of illness and hospitalisation, providing protection for the individual but also helping to protect the health system from becoming overwhelmed (Tenforde et al., 2021).’¹¹⁶

The emergence of Omicron as the dominant variant in 2022 altered this balance of risks. In a summary of evidence provided by the WHO, a primary course of COVID-19 vaccination offers less protection against severe disease against Omicron as compared to previous variants.¹¹⁷ Vaccine Effectiveness (VE) estimates against severe disease demonstrated that 12 of 27 estimates for mRNA vaccines were ≥ 70 per cent and 18 were greater than 50 per cent. The immunity generated by vaccines waned over time, however, this was less so than seen with prevention of infection. A third dose improved this for all investigated schedules, with 18 of 20 VE estimates greater than 70 per cent at three to six months post mRNA booster dose.

111 [World Health Organisation 2022, COVID-19 and mandatory vaccination: Ethical considerations, webpage, 30 May 2022](https://www.who.int/publications/i/item/WHO-2019-nCoV-Policy-brief-Mandatory-vaccination-2022.1) <https://www.who.int/publications/i/item/WHO-2019-nCoV-Policy-brief-Mandatory-vaccination-2022.1>

112 Department of Health, *Statement of Reasons (15 December 2021)*, 2021, Victorian Government.

113 Department of Health, *Statement of Reasons (12 April 2022)*, 2022, Victorian Government.

114 Leask J, Seale H, Williams JH, Kaufman J, Wiley K, Mahimbo A, et al, *Policy considerations for mandatory COVID-19 vaccination from the Collaboration on Social Science and Immunisation*, 2021, Medical Journal of Australia, vol. 215, iss. 11, pp. 499-503.

115 [World Health Organisation 2022, COVID-19 and mandatory vaccination: Ethical considerations webpage, 30 May 2022](https://www.who.int/publications/i/item/WHO-2019-nCoV-Policy-brief-Mandatory-vaccination-2022.1) <https://www.who.int/publications/i/item/WHO-2019-nCoV-Policy-brief-Mandatory-vaccination-2022.1>

116 Department of Health, *CHO Advice to Minister for Health (10 December 2021)*, 2021, Victorian Government.

117 [World Health Organisation, Weekly epidemiological update on COVID-19 – 25 May 2022 webpage](https://www.who.int/publications/m/item/weekly-epidemiological-update-on-covid-19---25-may-2022) <https://www.who.int/publications/m/item/weekly-epidemiological-update-on-covid-19---25-may-2022> accessed 2 June 2022.

Evidence such as this underpinned CHO advice to the Minister for Health when recommending vaccine mandates for workers in December 2021¹¹⁸ and boosters for specified workers and high-risk settings in January and April 2022.^{119,120,121} In conclusion, then, vaccines were effective against prevention of severe disease if administered according to appropriate dosing guidelines.

7.3.2 Prevention of transmission

A vaccine mandate can be more easily justified when the intention is not to protect the individual, but those around them.¹²² This is particularly pertinent in settings with vulnerable populations, such as healthcare, aged care and disability care, or in settings that pose increased risk of transmission between workers (such as abattoirs) – particularly if that industry provides a vital function for society.

Once again, this was encapsulated in advice given by the CHO in December 2021 in reference to the original mandates:

‘Maintaining a vaccine mandate as a baseline will protect workers from the increasing incursion and transmission risk represented by the return to onsite work, easing of restrictions in the Victorian community, and easing of domestic and international border restrictions, particularly in the face of the emerging threat posed by the Omicron VOC.’¹²³

The evidence for protection from infection or symptomatic illness conferred by vaccines decreased in the Omicron variant when compared to Delta, and this waned significantly and more so than for severe disease.¹²⁴ Within the first three months post primary vaccinations Only three of the 13 VE estimates for the mRNA vaccines were greater than 70 per cent and seven were greater than 50 per cent against symptomatic disease. All three VE estimates for AstraZeneca-Vaxzevria against symptomatic infection were less than 50 per cent. For symptomatic disease and infection, none of the VE estimates were above 50 per cent post three months. A third dose booster improved VE for infection, symptomatic illness and the risk of transmission, however, once again this waned significantly after three to six months.

Further studies on VE against the different Omicron sublineages are needed, however, early evidence suggests VE is likely similar between BA.1 and BA.1.1.529, and when considering VE against BA.4/5 and B.2.12.1, emerging evidence suggests a potential for greater breakthrough infections including in the vaccinated population.¹²⁵

118 Department of Health, *CHO Advice to Minister for Health (10 December 2021)*, 2021, Victorian Government.

119 Department of Health, *Acting CHO Advice to Minister for Health (10 January 2022)*, 2022, Victorian Government.

120 Department of Health 2022, *Acting CHO Advice to Minister for Health (7 April 2022)*, 2022, Victorian Government.

121 Department of Health, *Acting CHO Advice to Minister for Health (22 April 2022)*, 2022, Victorian Government.

122 Leask J, Seale H, Williams JH, Kaufman J, Wiley K, Mahimbo A, et al., *Policy considerations for mandatory COVID-19 vaccination from the Collaboration on Social Science and Immunisation*, 2021, Medical Journal of Australia, vol. 215, iss. 11, pp. 499-503.

123 Department of Health, *CHO Advice to Minister for Health (10 December 2021)*, 2021, Victorian Government.

124 World Health Organisation, *Weekly epidemiological update on COVID-19 – 25 May 2022*, 2022.

125 Wang, Q. Guo Y, Iketani S, Li Z, Mohri H, et al, *SARS-CoV-2 Omicron BA.2.12.1, BA.4, and BA.5 subvariants evolved to extend antibody evasion*, August 2022, Nature, vol 608 iss 7923 pp 603-608 National Library of Medicine.

In summary, the evidence once again suggested a use for vaccines in reducing infection and symptomatic illness (and thereby transmission), however, this effect was less so than for severe disease and waned more over time, reducing their utility in vaccine mandates that do not require booster doses.

Prerequisite 6: The vaccines should reduce transmission or minimise the severity of health impacts

Key findings:

20. There is evidence to support the use of vaccines to prevent severe disease, in particular for those who have received a third dose. However, vaccine effectiveness in preventing severe disease reduced over time, and the usefulness of vaccine mandates that did not require a booster in an appropriate timeframe is questionable.
21. There is evidence to support the use of vaccines to prevent transmission, in particular for those who have received a third dose. However, vaccine effectiveness against disease transmission was weaker than vaccine effectiveness for prevention of severe disease and reduced more significantly over time. The utility of vaccine mandates that did not require a booster in an appropriate timeframe is questionable.

7.4 Prerequisite 7: Vaccine supply should be sufficient and easily accessible and equitably available

Before the introduction of a vaccine mandate, government needs to ensure a stable vaccine supply, effective distribution, equity of access and convenient services.

Victoria reached an initial target of 80% of the population receiving double doses of a COVID-19 vaccine by mid-October 2021, within eight months of the vaccination program commencing. A vaccine uptake rate of more than 93% was reached by the end of 2021, exceeding rates achieved by most high-income countries. Victoria achieved an equitable roll out when compared to other states, with little variation across Local Government Areas when grouped by socio-economic disadvantage. Regional Victoria achieved the initial 80% double-dose target before metropolitan Melbourne which is important given that access to vaccination can be a challenge to those living in regional areas. Victoria also achieved higher vaccination rates for Aboriginal and Torres Strait Islander people than all other states, with 86% of the population fully vaccinated by 6 January 2022.

Vaccination supply in Victoria has been distributed according to population data, as agreed by Local Public Health Units (LPHU). To mitigate the risk of undersupply, steps were taken such as the transfer of stock between LPHUs to ensure all hubs had adequate doses, redistributing doses to ensure minimal loss of vaccine through wastage and ensuring additional doses from overseas were distributed based on LPHU booking targets.

During periods when vaccine was in short supply in certain areas (such as during outbreaks in certain areas such as Shepparton and Mildura), small volumes of extra vaccines were able to be moved to these areas. Similarly, when some Local Government Areas were falling behind the state vaccination rate, vaccine was moved to try and achieve an equitable vaccination rate.

Changes have also made during vaccine rollout to increase vaccination coverage for certain groups. For example, to increase vaccination coverage among construction workers in September, major

vaccination centres temporarily opened up to walk-ups without bookings, and extra priority appointments were made available to the construction sector.

Vaccine supply in Victoria was limited until August 2021, which required a targeted approach to delivering vaccines. Supply constraints of the Pfizer vaccine were also experienced in August due to high demand, and in September due to Commonwealth delivery delays over two consecutive weeks. However, measures were put in place to ensure workers who required vaccinations to meet deadlines to continue to work on-site, had priority access to vaccination such as for construction workers. Construction workers were able to access four major vaccination centres without making an appointment, as well as being able to access 20,000 priority booking appointments for the Pfizer vaccine across the state.^{126,127}

To maximise access the Victorian Government made a significant investment through the COVID-19 Engagement and Partnership program to develop material and engage with priority people, places and workplaces where there is the highest risk of exposure of COVID-19. This included an investment of more than \$9.3 million funding for 220+ Ambassador organisations, and clinical and community Champions to support to support individuals and communities to obtain vaccination and evidence-based information.

A key objective of the program was 'Victorians can access trusted and credible information about vaccination and the vaccine program, increasing confidence to get vaccinated'.

Priority places include:	Priority places include:	Priority workplaces include:
<ul style="list-style-type: none"> • Culturally and linguistically diverse (CALD) communities, particularly newly arrived migrants • Aboriginal Victorians • People with existing health issues • Younger and older Victorians • People with disability • Residents of aged care facilities • Older populations • Unpaid carers of any above 	<ul style="list-style-type: none"> • Local Government Areas that have historically had the highest and most complex COVID-19 cases in Victoria • Border towns (for as long as there are positive cases in other parts of Australia) • High density housing 	<ul style="list-style-type: none"> • Tertiary and primary health care • LGA immunisers • Corrections facilities • Ports of entry (airports, ports) • Quarantine facilities • Workplaces that have historically experienced outbreaks including aged care, schools, meat processing, supermarket distribution, hospitality, health services and hospitals

126 [Victorian Building Authority, *Important COVID-19 update: Mandatory vaccination for construction workers webpage, 2021, Victorian Government*](https://www.vba.vic.gov.au/news/news/2021/important-covid-19-update-mandatory-vaccination-for-construction-workers) <https://www.vba.vic.gov.au/news/news/2021/important-covid-19-update-mandatory-vaccination-for-construction-workers> accessed 30 June 2022.

127 [Victorian Building Authority, *Important COVID-19 update: Priority vaccinations for construction workers and construction site compliance blitz webpage, 2021, Victorian Government*](https://www.vba.vic.gov.au/news/news/2021/important-covid-19-update-priority-vaccinations-for-construction-workers-and-construction-site-compliance-blitz) <https://www.vba.vic.gov.au/news/news/2021/important-covid-19-update-priority-vaccinations-for-construction-workers-and-construction-site-compliance-blitz> accessed 30 June 2022.

The program made high volume vaccination hubs more accessible for people with disabilities and engaged bicultural workers to assist people from CALD backgrounds. It also took vaccinations to people, via in-home vaccinations, and pop-up sites at schools, sports clubs, community centres, cafes, and faith-based locations.

Engagement with industry was a key pillar of the program as key industries were identified as essential for continuation of services to the Victorian community or occupations at high risk of disease transmission.

Industry specific forums were established to plan vaccination programs and engage with employers and workers. Some of the forums were established in 2020 as part of COVID-19 testing and control measures, others were established in 2021 specifically for the vaccination program. Industries engaged in these forums included:

- Construction
- Agriculture
- Meat industry
- Supermarket distribution centres
- Police
- Ports of Entry
- Public Transport
- Corrections
- Fire and Emergency Services
- Agriculture

On a number of occasions, the mandatory vaccination orders were amended to postpone deadlines to be fully vaccinated to ensure specific industries including health and education could access vaccination rather than causing additional disruptions to workforces. The deadline for key healthcare workers receiving their booster dose was extended by a month to 12 March 2022¹²⁸ and the deadline for education workers receiving their booster dose was extended by a month to 25 March 2022.¹²⁹

Prerequisite 7: Vaccine supply should be sufficient and easily accessible and equitably available

Key findings:

22. Vaccines have been in short supply at some points in time but for the most part it has been sufficient.
23. The Department of Health has undertaken specific actions to ensure that priority groups and workforces could access vaccines.

128 [ABC News, Victorian government gives key workers extra month to receive third coronavirus dose webpage, 10 February 2022](https://www.abc.net.au/news/2022-02-10/victoria-covid-cases-deaths-hospitalisations-third-dose-vaccine/100818442) <https://www.abc.net.au/news/2022-02-10/victoria-covid-cases-deaths-hospitalisations-third-dose-vaccine/100818442> accessed 30 June 2022.

129 [Business Victoria, Return to the office, mask rules and vaccination requirement updates webpage, 22 February 2022, Victorian Government](https://business.vic.gov.au/news-and-updates/2022/return-to-the-office-mask-rules-and-vaccination-requirement-updates) <https://business.vic.gov.au/news-and-updates/2022/return-to-the-office-mask-rules-and-vaccination-requirement-updates> accessed 30 June 2022.

7.5 Prerequisite 8: Less restrictive, trust-promoting measures should come first

The Committee considered The Nuffield Ladder of Intervention in developing the prerequisite that 'less restrictive, trust-promoting measures should come first'. This public health ethics tool presents a scale of policy options that progress from individual freedom and responsibility towards increasing degrees of state intervention. To determine the appropriate intervention to achieve a specific public health objective, consideration is given to:

- weighing the societal public health benefit against the erosion of individual freedom
- consideration of economic costs and benefits alongside the health and societal benefits and costs.¹³⁰

The ladder is presented in the diagram below:



Nuffield Intervention Ladder, Nuffield Council on Bioethics. Public health ethical issues. London: Nuffield Council on Bioethics. 2007.

The prerequisite that 'less restrictive, trust promoting measures should come first' can be interpreted in the context of the Nuffield Intervention Ladder to mean that less interventionist options be considered first, before adopting the most intrusive intervention option of regulation, such as mandates. These options, that are less restrictive and trust promoting measures include providing information, enabling and/or guiding choices, use of incentives, and the adoption of disincentives.

¹³⁰ Nuffield Council of Bioethics, *Public Health: Ethical Issues*, 2007, p.42.

7.5.1 Timing and the precautionary principle

According to some literature, prior to the introduction of a vaccine mandate, there should be enough time for the voluntary acceptance of vaccination. Alternative, non-coercive alternative measures targeting known causes of low vaccination should be first implemented and exhausted (such as on-site vaccination) together with proper efforts to understand and address other context specific barriers.¹³¹ Once reasonable steps have been taken to build vaccination rates in a relevant group voluntarily, mandatory vaccination should be used as a last resort and limited to where protection is needed most, such as for the most vulnerable.¹³²

However, timing of actions and consideration must be considered in the context of the public health objective and the imminency and magnitude of a threat. The precautionary principle as described in the PHW Act requires public health interventions in some instances before full information is available or potentially before other measures have been fully tried, if timing of intervening is critical.¹³³

7.5.2 Building trust and acceptance

The use of a vaccine mandate is one of the most powerful public health interventions that can be used. To ensure trust in ethical norms and in institutions, it should be used sparingly and carefully.¹³⁴ It is important to ensure community trust and confidence in vaccination programs and that people have the chance to ask questions and have their concerns addressed adequately. Well-designed and targeted communications is required as the use of mandates has the potential to undermine trust in voluntary vaccination programs.¹³⁵

Research by Torrens University showed that Melbourne's immunisation rates in September 2021 (before the announcement of broader worker vaccination mandates) were linked to levels of socio-economic disadvantage.¹³⁶ Vaccination requirements alone will not increase vaccine uptake among all groups, and there are other measures such as geographically targeted vaccine drives or community dialogue within low-trust groups which may be more effective.

131 Leask J, Seale H, Williams JH, Kaufman J, Wiley K, Mahimbo A, et al, *Policy considerations for mandatory COVID-19 vaccination from the Collaboration on Social Science and Immunisation*, 2021, Medical Journal of Australia, vol. 215, iss. 11, pp. 499-503.

132 Atwell K, Rizzi M, McKenzie L, Carlson S, Roberts L et al, *COVID-19 vaccine Mandates: An Australian attitudinal study*, 2021, Vaccine, Elsevier [preprint].

133 Nuffield Council of Bioethics, *Public Health: Ethical Issues*, 2007, p.42,

134 Bardosh K, de Figueiredo A, Gur-Arie R, Jamrozik E, Doidge J, Lemmens T, et al, *The Unintended Consequences of COVID-19 Vaccine Policy: Why Mandates, Passports, and Segregated Lockdowns May Cause more Harm than Good*, May 2022, BMJ Global Health, [pre-print].

135 Leask J, Seale H, Williams JH, Kaufman J, Wiley K, Mahimbo A, et al, *Policy considerations for mandatory COVID-19 vaccination from the Collaboration on Social Science and Immunisation*, 2021, Medical Journal of Australia, vol. 215, iss. 11, pp. 499-503.

136 [Tomazin, F & Mannix, L. Vaccine passports risk disadvantaging poor webpage, 28 September 2021, The Age website](https://www.theage.com.au/national/victoria/vaccine-passports-risk-disadvantaging-poor-20210927-p58v0q.html) <<https://www.theage.com.au/national/victoria/vaccine-passports-risk-disadvantaging-poor-20210927-p58v0q.html>> accessed 27 May 2022.

7.5.3 The aim of the vaccine mandate, the public health context, and the rationale for coercive measures

In assessing whether less restrictive, trust-promoting measures were sufficiently considered prior to the introduction of the vaccine mandates it is necessary to consider the aim of the mandates.

The CHO provided the following advice to the Minister confirming rationale for the introduction of vaccination mandates on 10 December 2021:

‘Worker vaccination mandates were implemented during Victoria’s last lockdown in the context of escalating case numbers to rapidly increase population vaccination coverage and limit community transmission. Mandatory vaccination in workplaces helps protect workers and any members of the public in attendance, given the risk of transmission between individuals from close or sustained contact, particularly in indoor settings, and especially between unvaccinated individuals.’¹⁷²

At the time of the introduction of vaccine mandates, other highly restrictive measures were already in place to help manage community transmission. There were lockdowns across Victoria, curfews in place in metropolitan Melbourne, along with domestic border restrictions. The introduction of vaccination mandates for different classes of workers was staggered with the vaccine mandate for residential aged care workers enacted on 7 September 2021, and for authorised workers on 7 October 2021.

The Statement of Reasons between December 2021 and April 2022 all references CHO advice regarding a range of less restrictive measures that were considered but ultimately deemed to be insufficient to manage the serious risk to public health of COVID-19. Such measures included health promotion, education, epidemiology and monitoring, none of which were considered sufficient in workplaces with high-risk of transmissions. According to the CHO advice education involves ensuring that people are aware of the risks of COVID-19 and what they can do to protect themselves, while health promotion involves tailoring measures to community values including the use of trusted voices, use of different channels to reach different audiences and working with peak bodies. Epidemiology and monitoring are used to track trends over time, identify emerging issues and inform new or assess existing public health policies. They allow contact tracing to occur (to identify likely new sources of transmission) while the use of wastewater surveillance and surveillance testings can be used as a proactive measure to increase the likelihood of early detection of and prioritise testing and outbreak management resources.¹³⁷

Measures had also been implemented to manage transmission in workplaces prior to the introduction of vaccine mandates. These include the use of COVIDSafe Plans, QR code check-in requirements, and obligations on workplaces and educational facilities to notify workers and students if they attended while an infectious case was present. Access to workplaces (or to work outside the home) was also limited to those on the Authorised Worker List (removed on 9 September 2021 for regional Victoria). Additional industry specific measures were also in place to minimise the risk of transmission in high-risk places where there is a risk of an amplification (infection of a lot of people) or there is a need to protect vulnerable groups of people and supply chains. These measures included the use of appropriate PPE, COVIDSafe training, surveillance testing and workforce bubbles, and applied as appropriate to settings such as residential aged care, hospitals, meat, seafood and poultry processing, commercial passenger vehicles.¹³⁸ Data at this

137 Department of Health, Chief Health Officer Advice to Minister for Health (10 December 2021), 2021, Victorian Government.

138 Department of Health, *CHO Advice to Minister for Health (10 December 2021)*, 2021, Victorian Government.

point showed significant transmission in the construction sector so a range of additional public health measures were introduced including workforce capacity caps, workforce bubbles, outdoor break areas along with the introduction of vaccination mandates.

In the case of residential aged care facility workers (the subject of the first COVID-19 worker vaccine mandate to be enacted in Victoria) the AHPPC noted in June 2021 that less restrictive measures had not received high levels of vaccination coverage in these workers.¹³⁹ Professor Paul Kelly, Commonwealth Chief Medical Officer and Chair of AHPPC commented at a National Cabinet Press Conference that:

‘[AHPPC] had robust discussions about the issue of mandatory vaccination and there were a number of issues that the CHOs, particularly, wanted addressed. So, they’ve now, subsequently, been addressed. One was about, do we know how many have taken up their vaccine voluntarily? We have that now. It’s a requirement of the aged care sector to provide that information. They are providing that every week. There’s 33 per cent have taken up that dose. We need more. The second one was the issue that the PM has announced tonight, about the \$11 million to support people to get vaccination and if they are, for example, a casual worker and needs a day off, that will be provided through the grants. And a whole range of other matters related to these have been or are being addressed. And, so, today, the CHOs were unanimous to say that they agree that there should be a target, middle of September, to have that mandated. But of course we all agreed, and have always agreed, that we should have that extra level of protection for our most vulnerable people, who are our people in aged care.’¹⁴⁰

The Human Rights Statement that describes which human rights will be limited by pandemic orders that the Minister is required to provide under the legislation must provide details on less restrictive measures (than vaccination mandates) considered to achieve the same public health outcome.

When read in conjunction with the Minister’s Statements of Reason (15 December 2021), the following has been provided on the consideration of less restrictive measures:

- ‘Public education and health promotion can provide community members with an understanding of COVIDSafe behaviours and actions, such as hand hygiene, staying home when unwell and testing when symptomatic. However, onsite work, particularly at specified facilities, typically involves a significant amount of workforce interaction and movement. In addition, it is possible for individuals to be asymptomatic and infectious. Education and practicing of COVIDSafe behaviours consequently not sufficient to manage the risk high levels of workforce interaction poses to public health.’
- ‘There are a number of challenges that prevent the combination of mask wearing and testing being an equally robust solution to the risks of exposure and transmission compared to vaccines. Mask wearing is appropriate in many higher risk settings, and these settings often require an N95 face mask, other PPE, training in PPE use, and a buddy system in place for donning and offing. Even though these settings reported generally high levels of compliance, compliance clearly fluctuated across time and depended on participants’ (variable) motivation to comply.’

139 [Department of Health and Aged Care, Australian Health Protection Principal Committee \(AHPPC\) statement on residential aged care worker COVID-19 vaccination webpage, 2021, Australian Government](https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-residential-aged-care-worker-covid-19-vaccination) <<https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-residential-aged-care-worker-covid-19-vaccination>> accessed 4 July 2022.

140 [Department of the Prime Minister and Cabinet, Virtual Press Conference \(28 June 2021\), 2021, Australian Government, PM Transcripts webpage](https://pmtranscripts.pmc.gov.au/release/transcript-43455) <<https://pmtranscripts.pmc.gov.au/release/transcript-43455>> accessed 4 July 2022.

- ‘The effectiveness of face mask use in communities is influenced by the general compliance and appropriate monitoring and wearing of masks, in addition to education, communication and guidance campaigns. There would be significant problems with providing sufficient resources to upscale and maintain the auditing processes across the general community to a level that is sufficient to ensure correct PPE use.’
- ‘Negative point in time test results for COVID-19, while less onerous than a mandatory vaccination requirement for Specified Workers, fails to provide the same protection for workforces.’¹⁴¹

Having described these other less restrictive measures, the Minister for Health concluded:

‘In considering whether a combination of testing, distancing and screening might be sufficiently effective, although the risk of transmission is less in some settings – especially outdoors or places that were highly ventilated – not all workplaces and settings are organised, outdoors or highly ventilated. It is necessary to protect Victorians in all the settings they visit, whether shopping, working or engaging in essential activities. No other mitigation than vaccination applies universally in all settings and circumstances. A vaccine, once administered, provides continuous protection that doesn’t require compliance (albeit in a manner that wanes over time).’

The Minister and CHO’s stated perspective on the relative value of less restrictive measures has changed over time. By April 2022 all vaccination requirement deadlines had passed. Around this time, the Minister started to cite public health advice of a general transition towards empowerment of community, industry and individuals in place of restrictive measures like mandates. In this context, worker vaccine mandates were gradually considered as less appropriate or proportionate, with the CHO and Acting CHO recommending less restrictive measures involving engagement, health promotion and health education and communication as more appropriate and effective tools to sustain normalised and long-term behaviour change.

On 22 April 2022 the Minister cited Acting CHO advice preparing for a transition towards industry and individual workplace discretion, with workplace policies proposed as the potential instrument for vaccine requirements on workers in the future.

When removing the three-dose requirement for education workers on 20 June 2022, the Minister made reference to other COVID-control measures that schools and early-childhood centres had in place to reduce transmission risk, including enhanced ventilation, rapid antigen testing, and embedded COVID-safe prosocial behaviours including physical distancing and hand and respiratory hygiene.

The clearest articulation of this model by the Minister was made in the 12 July 2022 Statement of Reasons where the Minister cited the Acting CHO’s advice to transition to a model that encourages a shared community responsibility through education, communication and engagement. This is the most evident departure from a mandate or restrictions-based response, with the Acting CHO describing a devolution of responsibility where communities come to understand and manage their own risks accordingly. The Acting CHO also remarks on the criticality of community goodwill and social acceptance to underpin compliance with restrictions, and it is noted that there is growing fatigue in the Victorian population with COVID-19 and COVID-19 response measures.¹⁴²

141 Department of Health, Statement of Reasons (15 December 2021), 2021, Victorian Government, *COVID-19 Mandatory Vaccination (General Workers) Order*.

142 Department of Health, *Statement of Reasons (12 July 2022)*, 2022, Victorian Government.

Prerequisite 8: Less restrictive, trust-promoting measures should come first**Key findings:**

24. The Minister for Health has considered less restrictive measures than vaccine mandates to address the public health risk of essential workforces and vulnerable cohorts.
25. Vaccine mandates were adopted following the implementation of a range of less restrictive measures and at some points in time when equally or more restrictive controls were in place.
26. Mandates may also be implemented alongside less restrictive measures where the speed of uptake is critical to mitigating serious public health risks.

8. Conclusion

IPMAC is of the view that the vaccine mandates introduced through pandemic orders by the Minister meet the prerequisites for the introduction of these measures. The Committee is satisfied they were a reasonable and justified intervention to protect public health within the legislative framework contained in Part 8A of the PHW Act at the time they were introduced.

They contributed to high vaccination coverage amongst workers, reducing incidence of severe disease and transmission in high-risk industries, high-risk settings where workers interact with vulnerable populations and across essential services supporting service continuity.

While the Minister demonstrated they were reasonable to protect public health, the additional vaccination coverage gained between December and June diminished over this period with the vast majority already achieved in December 2021. The mandates were regularly reviewed by the Minister for Health and the considerations taken into account in weighing the public health benefits and human rights impacts articulated in the Statement of Reasons and Human Rights Statement publicly available on the Department of Health website. At each of the key decision-making points, the Minister found they were necessary and proportionate demonstrating other considerations that had informed decision-making.

The rationale for the classes of workers/occupations subject to vaccine mandates was not clearly communicated in the Minister's Statement of Reasons and should be a focus for greater transparency in any such decision-making moving forward. There is also an opportunity to provide more clarity on the consultation undertaken given the importance of balancing the rights of individuals and the promotion of public good.

At the time of writing, Victoria is experiencing declining case numbers and hospitalisation having past the peak of the winter 2022 wave. However, the scientific and public health advice is clear – the global population will continue to experience periodic waves of COVID-19 infection with some likely to be associated with significant burden of disease. The SARS-CoV-2 virus will continue to evolve with some new variants likely to evade population immunity, whether that immunity was acquired from vaccination, prior infection or a hybrid of the two. Seasonality, changing patterns of behaviour, and waning immunity over time will also contribute to waves of infection. Vaccines and vaccination policy will also continue to evolve over time, with ATAGI already recommending a fourth dose for adults who are aged over 50 years or whom have other risk factors. Victorians 30 to 49 years are also eligible for a fourth dose. A fifth dose is recommended for severely immunocompromised.¹⁴³

In this context, maintaining high levels of participation in vaccination will continue to be an important priority in the public health response to COVID-19. A strong health promotion and engagement effort from government is critical to encourage and facilitate vaccine uptake. Equitable access to vaccines must also be sustained.

143 [Department of Health and Aged Care, COVID-19 Booster Vaccine Advice webpage, 9 August 2022, Australian Government](https://www.health.gov.au/initiatives-and-programs/covid-19-vaccines/getting-your-vaccination/booster-doses) <<https://www.health.gov.au/initiatives-and-programs/covid-19-vaccines/getting-your-vaccination/booster-doses>>

In the absence of pandemic order vaccine mandates, other regulatory mechanisms may be required to support employers to facilitate vaccine uptake across their workforces. The recently introduced regulatory powers under the OH&S Act 2004 that ensure employers have the information they need to make decisions on necessary control measures at their workplace, which may include vaccination, are one such measure. Government has a continued role to play in engaging with and facilitating industry to enable vaccine uptake among their employees.

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Appendix 1: Mandatory Vaccination Settings for Workers and Changes

7 September 2021 – 12 July 2022

Date	CHO Direction/Order	Change Made
7 Sept 2021	<i>COVID-19 Mandatory Vaccination Directions</i>	<p>Directions issued which mandate worker vaccination within residential aged care facilities, to limit the spread of COVID-19. To attend work after 17 Sept 2021, workers were required to provide evidence by 17 Sept 2021, that they were:</p> <ul style="list-style-type: none"> • Fully vaccinated; • Partially vaccinated and had a booking to become fully vaccinated by 15 Nov 2021; • Not vaccinated but had a booking to receive their first COVID-19 vaccine by 1 Oct 2021; • Excepted from vaccination.
17 Sept 2021	<i>COVID-19 Mandatory Vaccination Directions (No. 2)</i>	<p>Above worker vaccination mandate extended to construction sites. To attend work after 24 Sept 2021, construction site workers were required to provide evidence by 24 Sept 2021, that they were:</p> <ul style="list-style-type: none"> • Fully vaccinated; • Partially vaccinated; • Not vaccinated but had a booking to receive their first COVID-19 vaccine by 2 Oct 2021; • Excepted from vaccination.
23 Sept 2021	<i>COVID-19 Mandatory Vaccination Directions (No. 3)</i>	<p>Above worker vaccination mandate extended to people who enter Victoria under a specified worker (multiple entry) permit, as commercial freight workers or healthcare workers. From 24 Sept 2021, these workers were required to carry evidence that they were:</p> <ul style="list-style-type: none"> • Fully vaccinated; • Partially vaccinated; • Not vaccinated but had a booking to receive their first COVID-19 vaccine by 7 Oct 2021; • Excepted from vaccination.
29 Sept 2021	<i>COVID-19 Mandatory Vaccination Directions (No. 4)</i>	<p>Above worker vaccination mandate extended to healthcare and education facilities. Worker vaccination mandate not retained for those entering Victoria under a specified worker (multiple entry) permit. Operators now required to collect, record and hold vaccination information about if and when:</p> <ul style="list-style-type: none"> • A partially vaccinated worker has a booking to receive a final dose of a COVID-19 vaccine.

Date	CHO Direction/Order	Change Made
		<ul style="list-style-type: none"> • An unvaccinated worker has a booking to receive their first dose of a COVID-19 vaccine. <p>Unvaccinated workers must not attend work, unless they have a booking to receive their first dose of a COVID-19 vaccine by below first dose deadline:</p> <ul style="list-style-type: none"> • 1 Oct 2021 – for residential aged care facility; • 2 Oct 2021 – for construction sites; • 29 Oct 2021 – for healthcare facility; • 25 Oct 2021 - for education facility.
1 Oct 2021	<i>COVID-19 Mandatory Vaccination Directions (No. 5)</i>	COVID-19 second dose deadline is removed for workers at construction sites .
7 Oct 2021	<i>COVID-19 Mandatory Vaccination (Specified Facilities) Directions (No. 6)</i>	COVID-19 second dose deadline is restored for workers at construction sites and brought earlier for workers at education facilities .
7 Oct 2021	<i>COVID-19 Mandatory Vaccination (Workers) Directions</i>	<p>Directions issued which mirror <i>COVID-19 Mandatory Vaccination (Specified Facilities) Directions</i>, for a new subset of workers.</p> <p>Below unvaccinated workers must not attend work, unless they have a booking to receive their first dose of a COVID-19 vaccine by first dose deadline of 22 Oct 2021:</p> <ul style="list-style-type: none"> • Accommodation workers • Agricultural and forestry workers • Airport workers • Ancillary, support and welfare workers • Authorised officers • Care workers • Community workers • Creative arts workers • Custodial workers • Emergency service workers • Entertainment and function workers • Funeral workers • Higher education workers • Justice service centre workers • Manufacturing workers • Marriage celebrants

Date	CHO Direction/Order	Change Made
		<ul style="list-style-type: none"> • Meat and seafood processing workers • Media and film production workers • Mining workers • Physical recreation workers • Port or freight workers • Production and distribution workers • Professional sports, high performance sports or racing persons • Professional services workers • Public sector employees • Real estate workers • Religious worker • Repair and maintenance workers • Retail workers • Science and technology workers • Social and community service workers • Transport workers • Utility and urban workers • Veterinary and pet/animal care workers <p>Unvaccinated workers are excepted from above requirement, and are permitted to attend work after the first dose deadline, if they:</p> <ul style="list-style-type: none"> • Were unable to be vaccinated because they were in self-quarantine; and • Had a booking to receive their first dose of a COVID-19 vaccine within 7 days of the end of their period of self-quarantine. <p>Employers are required to collect, record and hold vaccination information about if and when:</p> <ul style="list-style-type: none"> • A partially vaccinated worker has a booking to receive a final dose of a COVID-19 vaccine. • An unvaccinated worker has a booking to receive their first dose of a COVID-19 vaccine.
14 Oct 2021	<i>COVID-19 Mandatory Vaccination (Specified Facilities) Directions (No. 7)</i>	<p>Additional type of exception incorporated into the Directions, permitting unvaccinated people to attend work after the first dose deadline, if they:</p> <p>Were unable to be vaccinated because they were in self-quarantine; and</p> <p>Had a booking to receive their first dose of a COVID-19 vaccine within 7 days of the end of their period of self-quarantine.</p>
14 Oct 2021	<i>COVID-19 Mandatory Vaccination (Workers)</i>	Non-substantive amendment made to Directions, excluding persons under 12 from definition of worker, and amending detail of

Date	CHO Direction/Order	Change Made
	<i>Directions (No. 2)</i>	worker specific definitions. Remove specific reference to production and distribution worker cohort.
15 Oct 2021	<i>COVID-19 Mandatory Vaccination (Specified Facilities) Directions (No. 8)</i>	Non-substantive amendment made to Directions, removing coroners from the definition of healthcare workers .
15 Oct 2021	<i>COVID-19 Mandatory Vaccination (Workers) Directions (No. 3)</i>	Non-substantive amendment made to Directions, amending detail of worker specific definitions.
19 Oct 2021	<i>COVID-19 Mandatory Vaccination (Specified Facilities) Directions (No. 9)</i>	Non-substantive amendment made to Directions, adding Coroner's Court to definition of healthcare facility , and coroners to the definition of healthcare workers .
19 Oct 2021	<i>COVID-19 Mandatory Vaccination (Workers) Directions (No. 4)</i>	Non-substantive amendment made to Directions, amending detail of worker specific definitions.
21 Oct 2021	<i>COVID-19 Mandatory Vaccination (Specified Facilities) Directions (No. 10)</i>	Impose requirement that unvaccinated and partially vaccinated workers at residential aged care facilities and construction sites must not attend work from below second dose deadline: <ul style="list-style-type: none"> • 15 Nov 2021 – for residential aged care facility; • 13 Nov 2021 – for construction sites.
21 Oct 2021	<i>COVID-19 Mandatory Vaccination (Workers) Directions (No. 5)</i>	Non-substantive amendment made to Directions, amending detail of worker specific definitions.
29 Oct 2021	<i>Stay Safe Directions</i>	Directions issued which require persons working at a ceremonial space to be fully vaccinated or excepted persons, unless they:

Date	CHO Direction/Order	Change Made
	<i>(Victoria)</i> <i>(No. 28)</i>	<ul style="list-style-type: none"> • Conduct services of public worship and acknowledgement of faith; or • Perform marriages, funerals and special memorial services; or • Visit members of the community the provide advice and religious comfort for end-of-life faith reasons.
29 Oct 2021	<i>COVID-19 Mandatory Vaccination (General Workers) Directions</i>	<p>Directions issued which expand <i>COVID-19 Mandatory Vaccination (Specified Facilities) Directions</i> and <i>COVID-19 Mandatory Vaccination (Workers) Directions</i>, to all general workers.</p> <p>If it is reasonably practicable for general workers to work at their ordinary place of residence, to attend work, they must be:</p> <ul style="list-style-type: none"> • Fully vaccinated; • Excepted from vaccination.
29 Oct 2021	<i>COVID-19 Mandatory Vaccination (Specified Facilities) Directions (No. 11)</i>	<p>Impose requirement that to attend work, workers must be:</p> <ul style="list-style-type: none"> • Fully vaccinated; • Partially vaccinated; • Excepted from vaccination. <p>If it is reasonably practicable for the worker to work at their ordinary place of residence, to attend work, they must be:</p> <ul style="list-style-type: none"> • Fully vaccinated; • Excepted from vaccination. <p>Removed exception permitting unvaccinated workers to attend work if they had a booking to receive their first dose of a COVID-19 vaccine by the first dose deadline. Exception was removed as all first dose deadlines had passed by 29 Oct 2021.</p> <p>Added palliative care workers to the definition of healthcare workers.</p>
29 Oct 2021	<i>COVID-19 Mandatory Vaccination (Workers) Directions (No. 6)</i>	<p>Impose requirement that to attend work, workers must be:</p> <ul style="list-style-type: none"> • Fully vaccinated; • Partially vaccinated; • Excepted from vaccination. <p>If it is reasonably practicable for the worker to work at their ordinary place of residence, to attend work, they must be:</p> <ul style="list-style-type: none"> • Fully vaccinated; • Excepted from vaccination. <p>Removed exception permitting unvaccinated workers to attend work if they had a booking to receive their first dose of a COVID-19 vaccine by the first dose deadline. Exception was removed as all first dose deadlines had passed by 29 Oct 2021.</p> <p>Added exception permitting unvaccinated agricultural and forestry workers employed through the Pacific Australia Labour</p>

Date	CHO Direction/Order	Change Made
		Mobility scheme, with a booking to receive their first dose of a COVID-19 vaccine within 4 weeks of arrival in Australia, to work.
5 Nov 2021	<i>COVID-19 Mandatory Vaccination (General Workers) Directions (No. 2)</i>	Non-substantive amendments, retaining above vaccination requirements.
5 Nov 2021	<i>COVID-19 Mandatory Vaccination (Specified Facilities) Directions (No. 12)</i>	Restrict exception permitting unvaccinated people to attend work after the first dose deadline, if they: <ul style="list-style-type: none"> • Were unable to be vaccinated because they were in self-quarantine; and • Had a booking to receive their first dose of a COVID-19 vaccine within 7 days of the end of their period of self-quarantine; to healthcare and education workers.
5 Nov 2021	<i>COVID-19 Mandatory Vaccination (Workers) Directions (No. 7)</i>	Non-substantive amendment made to Directions, amending detail of worker specific definitions.
18 Nov 2021	<i>Stay Safe Directions (Victoria) (No. 29)</i>	Retain directions which require persons working at a ceremonial space to be fully vaccinated or excepted persons, unless above noted exceptions apply.
18 Nov 2021	<i>COVID-19 Mandatory Vaccination (General Workers) Directions (No. 3)</i>	Non-substantive amendments, retaining above vaccination requirements.
18 Nov 2021	<i>COVID-19 Mandatory Vaccination (Specified Facilities) Directions (No. 13)</i>	Impose requirement that to attend work prior to the full dose deadline, workers must be: <ul style="list-style-type: none"> • Fully vaccinated; • Partially vaccinated; • Excepted from vaccination. To attend work on or after the full dose deadline workers must be: <ul style="list-style-type: none"> • Fully vaccinated; • Excepted from vaccination.

Date	CHO Direction/Order	Change Made
		<p>Extend exception permitting unvaccinated people to attend work after their first dose deadline, if they:</p> <ul style="list-style-type: none"> • Were unable to be vaccinated because they were in self-quarantine; and • Had a booking to receive their first dose of a COVID-19 vaccine within 7 days of the end of their period of self-quarantine; <p>to all workers.</p> <p>Noting, the full dose deadline for workers was:</p> <ul style="list-style-type: none"> • 15 Nov 2021 – residential aged care facility; • 13 Nov 2021 – construction site; • 15 Dec 2021 – healthcare facility; • 29 Nov 2021 - education facility.
18 Nov 2021	<i>COVID-19 Mandatory Vaccination (Workers) Directions (No. 8)</i>	Extend above exception for unvaccinated agricultural and forestry workers , to partially vaccinated persons.
25 Nov 2021	<i>Stay Safe Directions (Victoria) (No. 30)</i>	Retain directions which require persons working at a ceremonial space to be fully vaccinated or excepted persons, unless above noted exceptions apply.
15 Dec 2021	<i>COVID-19 Mandatory Vaccination (Specified Workers) Order 2021 (No. 1)</i>	<p>Translate above vaccination directions to an Order.</p> <p>Add Disability Worker to the list of Specified Workers.</p> <p>In line with passing of all full dose deadlines, require all persons attending specified facilities for work to be:</p> <ul style="list-style-type: none"> • Fully vaccinated; • Excepted from vaccination. <p>Remove exception for unvaccinated people to attend work who were unable to be vaccinated due to being in self-quarantine.</p>
15 Dec 2021	<i>COVID-19 Mandatory Vaccination (General Workers) Order 2021 (No. 1)</i>	Translate above vaccination directions to an Order.

Date	CHO Direction/Order	Change Made
15 Dec 2021	<i>COVID-19 Mandatory Vaccination (Specified Facilities) Order 2021 (No. 1)</i>	<p>Translate above vaccination directions to an Order.</p> <p>In line with passing of all full dose deadlines, require all persons attending specified facilities for work to be:</p> <ul style="list-style-type: none"> • Fully vaccinated; • Excepted from vaccination. <p>Remove exception for unvaccinated people to attend work who were unable to be vaccinated due to being in self-quarantine.</p>
15 Dec 2021	<i>Movement and Gathering Order 2021 (No. 1)</i>	<p>Translate directions which require persons working at a ceremonial space to be fully vaccinated or excepted persons, unless above noted exceptions apply, to an Order.</p>
23 Dec 2021	<i>Movement and Gathering Order 2021 (No. 2)</i>	<p>Retain restrictions which require persons working at a ceremonial space to be fully vaccinated or excepted persons, unless above noted exceptions apply.</p>
12 Jan 2022	<i>COVID-19 Mandatory Vaccination (Specified Workers) Order 2022 (No. 2)</i>	<p>Impose booster deadline on certain specified worker cohorts – custodial workers, disability workers, emergency service workers, food distribution workers, meat and seafood processing workers, and quarantine accommodation workers;</p> <ul style="list-style-type: none"> • For workers fully vaccinated on/before 12 Sept 2021 – 12 Feb 2022. • For workers fully vaccinated after 12 Sept 2021 – 12 March 2022. <p>Require employers to collect information about when a worker received a booster dose of a COVID-19 vaccine, and bar workers who are not boosted/excepted persons from attending work after above deadlines passed.</p> <p>Introduce exception from booster requirement for workers unable to become boosted by the relevant deadline, due to being in self-quarantine or self-isolation, provided they had a booking within a week of the end of their period of self-quarantine or self-isolation to receive a booster dose.</p>
12 Jan 2022	<i>COVID-19 Mandatory Vaccination (General Workers) Order 2022 (No. 2)</i>	<p>Retain above vaccination restrictions but bar an employer from using a worker's Individual Healthcare Identifier for the purpose of complying with the Order.</p>

Date	CHO Direction/Order	Change Made
12 Jan 2022	<i>COVID-19 Mandatory Vaccination (Specified Facilities) Order 2022 (No. 2)</i>	<p>Impose booster deadline on workers at residential aged care facilities and healthcare facilities:</p> <p>Residential Aged Care facilities:</p> <p>For workers fully vaccinated on/before 12 Sept 2021 – 12 Feb 2022.</p> <p>For workers fully vaccinated after 12 Sept 2021 – 1 March 2022.</p> <p>Healthcare facilities:</p> <p>For workers fully vaccinated on/before 12 Sept 2021 – 12 Feb 2022.</p> <p>For workers full vaccinated after 12 Sept 2021 – 29 March 2022.</p> <p>Require employers to collect information about when a worker received a booster dose of a COVID-19 vaccine, and bar workers who are not boosted/excepted persons from attending work after above deadlines passed.</p> <p>Introduce exception from booster requirement for workers unable to become boosted by the relevant deadline, due to being in self-quarantine or self-isolation, provided they had a booking within a week of the end of their period of self-quarantine or self-isolation to receive a booster dose.</p>
12 Jan 2022	<i>Movement and Gathering Order 2022 (No. 3)</i>	Retain restrictions which require persons working at a ceremonial space to be fully vaccinated or excepted persons, unless above noted exceptions apply.
25 Jan 2022	<i>COVID-19 Mandatory Vaccination (Specified Facilities) Order 2022 (No. 3)</i>	<p>Impose booster deadline on workers at education facilities:</p> <p>For workers fully vaccinated on/before 25 Oct 2021 – 25 Feb 2022.</p> <p>For workers fully vaccinated after 25 Oct 2021 – 15 March 2022.</p>
4 Feb 2022	<i>COVID-19 Mandatory Vaccination (Specified Workers) Order 2022 (No. 3)</i>	<p>Limit booster deadline to persons aged 18 years or over.</p> <p>Extend exception from booster requirement for workers unable to become boosted by the relevant deadline, due to being in self-quarantine or self-isolation, provided they:</p> <p>Have a booking within 2 weeks of the end of their period of self-quarantine to receive a booster dose; or</p> <p>Have a booking within 4 months of the end of their period of self-isolation to receive a booster dose.</p>
4 Feb 2022	<i>COVID-19 Mandatory Vaccination (General Workers) Order 2022 (No. 3)</i>	Retain above vaccination restrictions, noting non-substantive amendments made to definition of two-dose COVID-19 vaccine.

Date	CHO Direction/Order	Change Made
4 Feb 2022	<i>COVID-19 Mandatory Vaccination (Specified Facilities) Order 2022 (No. 4)</i>	<p>Limit booster deadline to persons aged 18 years or over.</p> <p>Extend exception from booster requirement for workers unable to become boosted by the relevant deadline, due to being in self-quarantine or self-isolation, provided they:</p> <ul style="list-style-type: none"> Have a booking within 2 weeks of the end of their period of self-quarantine to receive a booster dose; or Have a booking within 4 months of the end of their period of self-isolation to receive a booster dose.
11 Feb 2022	<i>COVID-19 Mandatory Vaccination (Specified Workers) Order 2022 (No. 4)</i>	<p>Amend booster deadline for certain specified worker cohorts – custodial workers, disability workers, emergency service workers, food distribution workers, meat and seafood processing workers, and quarantine accommodation workers;</p> <p>For all workers in these cohorts – 12 March 2022.</p> <p>Limit exception for workers unable to become boosted by the relevant deadline, due to being in self-quarantine or self-isolation, to those who have a booking to receive a booster dose within 2 weeks of the end of their period of isolation or quarantine.</p> <p>Introduce exception for confirmed cases of COVID-19 to attend work without being boosted for 4 months after the end of their period of isolation.</p>
11 Feb 2022	<i>COVID-19 Mandatory Vaccination (Specified Facilities) Order 2022 (No. 5)</i>	<p>Amend booster deadline for residential aged care facility and healthcare facility workers:</p> <ul style="list-style-type: none"> For all residential aged care facility workers – 12 March 2022. For healthcare facility workers fully vaccinated on/before 12 Sept 2021 – 12 March 2022. For healthcare facility workers full vaccinated after 12 Sept 2021 – 29 March 2022 <p>Limit exception for workers unable to become boosted by the relevant deadline, due to being in self-quarantine or self-isolation, to those who have a booking to receive a booster dose within 2 weeks of the end of their period of isolation or quarantine.</p> <p>Introduce exception for confirmed cases of COVID-19 to attend work without being boosted for 4 months after the end of their period of isolation.</p>
25 Feb 2022	<i>COVID-19 Mandatory Vaccination (Specified Workers) Order 2022 (No. 5)</i>	<p>Introduce exception for workers who became fully vaccinated in previous 3 months and 2 weeks, to attend work.</p> <p>Introduce exception for fully vaccinated workers who arrived in Australia in the past 4 weeks and had a booking to receive a booster dose within 4 weeks of entry, to attend work.</p> <p>Introduce exception for fully vaccinated worker who ceased to be an excepted person in the past 14 days to attend work.</p>
25 Feb 2022	<i>COVID-19 Mandatory Vaccination</i>	Amend booster deadline for all education facility workers to 25 March 2022.

Date	CHO Direction/Order	Change Made
	<i>(Specified Facilities) Order 2022 (No. 6)</i>	<p>Introduce exception for workers who became fully vaccinated in previous 3 months and 2 weeks, to attend work.</p> <p>Introduce exception for fully vaccinated workers who arrived in Australia in the past 4 weeks and had a booking to receive a booster dose within 4 weeks of entry, to attend work.</p> <p>Introduce exception for fully vaccinated worker who ceased to be an excepted person in the past 14 days to attend work.</p>
25 Feb 2022	<i>Movement and Gathering Order 2022 (No. 4)</i>	Retain restrictions which require persons working at a ceremonial space to be fully vaccinated or excepted persons, unless above noted exceptions apply.
12 April 2022	<i>COVID-19 Mandatory Vaccination (Specified Workers) Order 2022 (No. 6)</i>	Retain above vaccination requirements, noting non-substantive amendments made to the Order, in line with passing of booster deadlines.
12 April 2022	<i>COVID-19 Mandatory Vaccination (General Workers) Order 2022 (No. 4)</i>	Retain above vaccination requirements, noting non-substantive amendments made to definitions under Order.
12 April 2022	<i>COVID-19 Mandatory Vaccination (Specified Facilities) Order 2022 (No. 7)</i>	<p>Retain above vaccination requirements, noting non-substantive amendments made to the Order, in line with passing of booster deadlines.</p> <p>Amend booster deadline for all healthcare facility workers to 29 March 2022.</p>
12 April 2022	<i>Movement and Gathering Order 2022 (No. 5)</i>	Retain requirements which require persons working at a ceremonial space to be fully vaccinated or excepted persons, unless above noted exceptions apply.
22 April 2022	<i>Pandemic (Workplace) Order 2022 (No. 8)</i>	Consolidation of worker vaccination requirements under the <i>COVID-19 Mandatory Vaccination (General Workers) Order 2022 (No. 4)</i> , <i>COVID-19 Mandatory Vaccination (Specified Workers) Order 2022 (No. 6)</i> , <i>COVID-19 Mandatory Vaccination (Specified Facilities) Order 2022 (No. 7)</i> and <i>Movement and Gathering Order 2022 (No. 5)</i> .

Date	CHO Direction/Order	Change Made
24 June 2022	<i>Pandemic (Workplace) Order 2022 (No. 9)</i>	<p>Remove vaccination requirements for general workers and workers in a ceremonial space.</p> <p>Only retain vaccination requirements for custodial workers, disability workers, emergency service workers, healthcare facility workers and residential aged care facility workers. Introduce vaccination requirements for specialist school facility workers.</p> <p>To attend work, these worker cohorts must be an excepted person, or:</p> <p>Fully vaccinated for workers under 18; or</p> <p>Fully vaccinated and boosted for workers 18 and over.</p> <p>Remove above exception from vaccination requirements for agricultural and forestry workers. Remove above exception from booster requirements for persons in self-quarantine or self-isolation. Add exception from vaccination requirements for persons unable to work from home, due to risk of harm.</p>
12 July 2022	<i>Pandemic (Workplace) Order 2022 (No. 10)</i>	Non-substantive amendments, retaining above vaccination requirements.