A discourse analysis of the Aboriginal and Torres Strait Islander COVID-19 policy response

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Abstract

Objective: To analyse the implicit discourses within the COVID-19 policy response for Aboriginal and Torres Strait Islander remote communities.

Method: This paper uses Bacchi's 'What is the Problem Represented to Be' framework to analyse the Emergency Requirements for Remote Communities Determination under Subsection 477(1) of the Biosecurity Act 2015 (Cth).

Results: Despite the leadership of community-controlled health services and regional councils, and the actions of Aboriginal and Torres Strait Islander communities, the policy response constructs Aboriginal and Torres Strait Islander people as vulnerable and mobility as a problem that needs a law and order response.

Conclusions: The policy response perpetuates an ongoing paternalistic discourse where Aboriginal and Torres Strait Islander people must be controlled for the sake of their health, informed by notions of Indigeneity as deficient. This stands in contrast with the work of community-controlled health organisations, advocacy by Aboriginal and Torres Strait Islander people for and against restrictions, and examples of communities protecting themselves.

Implications for public health: Unilateral government intervention creates limiting discourses of Aboriginal and Torres Strait Islander people. In contrast, ongoing COVID-19 responses can build on the strengths of and work done by Aboriginal and Torres Strait Islander families, leaders, and communities.

Key words: COVID-19, Aboriginal and Torres Strait Islander health, public health policy, remote communities, WPR analysis

On 12 December 2019, a novel coronavirus was detected in Wuhan, China. In the following weeks the disease later called COVID-19 rapidly spread through the community and around the world. The World Health Organization (WHO) declared a Public Health Emergency of Global Concern on 30 January 2020, and by 11 March were characterising the outbreak as a pandemic.[1] In Australia, governments implemented various measures to restrict the spread, including 'social distancing' measures such as limiting gatherings, shutting non-essential businesses, schools and universities and closing borders. Aboriginal and Torres Strait Islander people over 50 years of age were warned they were particularly vulnerable. There was a quick and firm response from Aboriginal and Torres Strait Islander organisations and health services. Within days of the March pandemic declaration, regional bodies such as the Northern Land Council (NLC) in the Northern Territory (NT) and Anangu Pitjantjatjara Yankunytjatjara (APY) Lands in South Australia (SA) suspended non-essential permits for travel into Aboriginal communities.[2,3] The peak body representing Aboriginal community-controlled health services, the National Aboriginal Community Controlled Health Organisation (NACCHO), called on the Federal Government to put into place a range of measures to protect communities, including restricting travel into remote communities.[4] NACCHO representatives, leaders from Aboriginal and Torres Strait Islander health councils and services, medical experts, and federal, state and territory government representatives, including from the National Indigenous Australians Agency, formed the Federal Government's 'Aboriginal and Torres Strait Islander Advisory Group on COVID-19' to develop a national 'Management Plan for Aboriginal and Torres Strait Islander populations' to inform the health response.[5]

In response to calls from NACCHO and others, Federal Health Minister Greg Hunt with support from the Minister for Indigenous Australians, Ken Wyatt, used his expanded powers to make a new Determination under Subsection 477(1) of the Biosecurity Act 2015 (Cth). The 'Emergency Requirements for Remote Communities' Determination (henceforth, the Determination) came into effect on 26 March.[6] The Determination required people to remain outside designated remote communities in Queensland (QLD), Western Australia (WA), SA and the NT unless they had been 'isolated from the general community' (in technical terms, quarantined) for 14 days. There were exceptions for staff conducting essential activities such as healthcare, food production and mining, as well as certain officials and Australian Defence Force personnel.[7]

Communities, land councils and state governments worked together to assist Aboriginal people to return to their homelands as these new measures came into force, with the Federal Government allocating

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$10 million to assist with this process.[8] Larrakia Nation in Darwin and Tangentyere Council in the Tiwi Islands implemented 'Return to Country' programs, in which they covered costs for Aboriginal people wishing to return to Country.[9] Police were given powers to enforce the Determination, including arresting and fining those who broke restrictions, and setting up biosecurity checkpoints in towns. In WA those entering or leaving a remote Aboriginal community without a permitted exception could be fined up to $50,000[10] and more than 100 additional police officers were deployed to the NT.[11] As restrictions across Australia began to ease, governments came under increasing pressure to loosen restrictions on remote communities. The Determination was repealed on 10 July 2020, with state and territory governments still able to impose local controls if an outbreak occurred.[12,13]

The aim of this paper is to analyse the implicit discourses within the Determination. To do this, we apply Bacchi's 'What is the Problem Represented to Be' (WPR) framework.[14] This framework was developed with a critical social justice agenda. It draws on Foucauldian theory to critique how government practices produce governmentalities: how they construct discourses of who particular groups of people 'are', and therefore govern people's actions and dispositions. Rather than *describing* problems that exist independently of policy, WPR analyses examine how some ideas, or some people, are *constructed* as problems by policy. Australian governments have long constructed Aboriginal and Torres Strait Islander people as 'problems'; despite the work of Aboriginal and Torres Strait Islander researchers, politicians, families and communities who work against this discourse. Here, we consider how the Determination and subsequent practices give insight into the particular types of 'problems' constructed in response to the possible impacts of COVID-19 on Aboriginal and Torres Strait Islander people in Australia. WPR analyses aim to imagine the subjects of policy (e.g. Aboriginal and Torres Strait Islander health) differently, rather than relying on the usual 'problems'.

Literature review

The outbreak of COVID-19 has had a global impact. There has been an explosion of research into various aspects of the pandemic, with more than 7,000 papers published by early May 2020.[15] In Australia, national advice identified Aboriginal and Torres Strait Islander people in remote communities as a population disproportionately at risk from an outbreak due to a high burden of chronic disease, high mobility between communities, lack of access to healthcare and reliance on outreach services.[16] This position is reflected in the literature about Indigenous communities globally.[17] However, there is limited literature on the Australian Aboriginal and Torres Strait Islander policy response in relation to remote communities. Opinion pieces, journalism, editorials and government reports shape the current literature, with the Determination still recent and the pandemic ongoing.

Government and community-controlled health response

Analyses of the Federal Government policy responses to COVID-19 suggests it has been highly successful, with few reported cases of COVID-19 in Aboriginal and Torres Strait Islander people compared to the rest of the Australian population. The scant literature suggests that this success can be attributed to the early response and leadership of the Aboriginal Community Controlled Health Organisation (ACCHO) sector.[18] Indigenous clinicians, public health experts and researchers advised the Federal Government response as part of the Aboriginal and Torres Strait Islander Advisory Group on COVID-19. The group led the response by advising on the National Guidelines on COVID-19, the enactment of the Determination and strategic planning for services and virus testing.[19]

Compared to the ACCHO response, the early Government response was identified as erratically implemented across state and territory jurisdictions. Smith argues that governments enacted "poorly coordinated unilateral interventions, where decision making and control is firmly retained in government hands"[9]; particularly criticising the lack of targeted, culturally appropriate health communication for Aboriginal and Torres Strait Islander communities. This Government response presented both challenges and opportunities for Aboriginal and Torres Strait Islander self-determination: while governments attempted unilateral interventionist responses, the inconsistency enabled communities to act on their own accord.[9] The criticism of health communication is supported by Kerrigan et al.[20] who argued it was inadequate to simply translate the initial Federal Government information campaign for the general population. Radio advertisements were initially translated into only four Aboriginal and Torres Strait Islander languages out of the 150 spoken in Australia. There was also a lack of targeted materials for the most vulnerable – Aboriginal and Torres Strait Islander people with chronic health conditions. ACCHOs filled the governmental information gap, developing new resources that included Aboriginal vernacular, Kriol, Indigenous art and promoted values of caring for family and kin.[21] These resources were provided using existing funding and in addition to usual services. Messages were disseminated via online platforms such as Facebook, Twitter and TikTok as well as in print form. Long-term trust between communities and ACCHOs meant these messages were accepted and shared locally.[21]

Method

What is the problem represented to be?

In this research, we used Bacchi's WPR framework to analyse how the COVID-19 response constructs Aboriginal and Torres Strait Islander people. This framework has been used previously to analyse Australian Aboriginal and Torres Strait Islander policy, including an examination of the Closing the Gap[22] and media representations of nutrition.[23] This approach does not measure the effectiveness of a policy. Instead, a Bacchian WPR analysis enables researchers to consider how policies produce particular 'truths' about the world and the 'problems' that exist. A policy – and the way it is represented by policy-writers, media, and the public – shapes what we understand to be the problem, known as a 'problem representation'.[14] Policies represent certain factors as the 'problem' to be solved, while others are silenced. This frames our knowledge of both the concepts involved and the people affected.

Bacchi established a series of interrelated questions that allow the researcher to interrogate how a policy produces specific problem representations; how these problem representations come to be and the concepts that are drawn on; and the silences within the problem representation.[14] The questions are:

- What is the 'problem' represented to be in a specific policy?

- What presuppositions or assumptions underlie this representation of the 'problem'?
- How has this representation of the 'problem' come about?
- What is left unproblematic in this problem representation? Can the 'problem' be thought about differently?
- What effects are produced by this representation of the 'problem'?
- How/where has this representation of the 'problem' been produced, disseminated and defended? How could it be questioned, disrupted and replaced?

Sources

In this research, we drew on a range of recently published policy and position papers, organisational and governmental reports, explanatory notes to the Biosecurity Act, media, as well as editorials and perspective pieces, to understand how Aboriginal and Torres Strait Islander people were being represented within the narrative of COVID-19. These sources were accessed via internet searches (Google and Google Scholar), as well as searching the Analysis and Policy Observatory (APO) website.

Analysis

A problem of vulnerability and mobility

The primary problem constructed by the Determination is that Aboriginal and Torres Strait Islander people in remote communities across the board are more vulnerable to COVID-19 and thus need to be protected. The policy response encouraged individuals to return to remote communities and prevented entry without a period of isolation, thus deterring movement. This Determination was controlled by police. It presents Aboriginal and Torres Strait Islander people's mobility as a problem of law and order.

Two key assumptions shape this problem representation. The first is that residents of remote Aboriginal and Torres Strait Islander communities listed in the Determination are 'vulnerable' as a whole. Western biomedical models of health, focusing on individual sickness and a curative focus, are often at odds with the social models of health and wellbeing promoted by ACCHOs.[24] Public health interventions draw on epidemiological understandings of disease patterns, risk factors and treatment options.[25] A long-term practice in epidemiology has been identifying at-risk or vulnerable groups within a larger population, based on shared risk factors or social identity.[26] In the COVID-19 pandemic, Aboriginal and Torres Strait Islander people living in remote communities were categorised as a 'vulnerable group' by the Federal Government. One reason for the categorisation was higher rates of other health issues; complex factors that are specific to individuals and vary from community to community. However, epidemiology operates using group-level statistical datasets, producing knowledge of a particular type.[27] For Aboriginal and Torres Strait Islander people(s), statistics and comparative data practices have frequently been used to produce discourses of deficit and dysfunction.[28] This disciplinary approach erases the diversity of contemporary Aboriginal and Torres Strait Islander communities, categorising all as 'vulnerable'. Health policies and comparative statistics also create a sub-category of 'remote' Aboriginal and Torres Strait Islander people.[26] This category, and its use within the Determination, homogenises people with localised histories, experiences of colonisation, demographics, cultural practices and council arrangements. Remoteness itself was homogenised: Yarrabah, a QLD community an hour's drive from the city of Cairns, was included in the Determination alongside Borroloola, a NT community approximately seven hours drive from the regional centre of Katherine. In the Determination, 'vulnerable people' operates in the same way for these diverse communities.

The second key assumption shaping this problem representation is that remote communities are safer for Aboriginal people due to their isolated location. This can be seen in the encouragement of residents to return home and the indirect prevention of anyone leaving. The NLC rolled out a COVID-19 information campaign and advised people not to leave their communities well before the Determination restrictions came into force.[29] YouTube videos in multiple Aboriginal languages were produced by the NT Government and NLC[30] and had a clear moral message that staying on country would protect family members and Elders.[31] Statements by the Minister for Indigenous Australians, the Honourable Ken Wyatt, defend this assumption. He claimed that the isolation of remote communities is "our greatest asset" and "you're better off in your own community, where you control it, where you know who is coming in" than a capital city.[32] The concept of 'mobility' gives shape to this assumption, with movement between towns or communities constructed as risking safety.

Police were brought in to enforce restriction of movement, via police checkpoints and roadblocks that prevented access to and from communities.[33] Law and order responses suggest that there is an inherent problem in movement, and that control is required to respond to irresponsible individual behaviours. This response limited individuals' and communities' freedom and self-determination, as detailed later in this analysis. Connected to this, the practice of police enforcement has constructed people who leave remote communities designated under the Determination and then return as 'reckless' and 'criminals'. Aboriginal men returning to Palm Island in QLD without undergoing quarantine were arrested and charged by police, as well as accused of drug offences,[34] as were a group returning to the Tiwi Islands from Darwin.[35] This is a pervasive national discourse which criminalises COVID-19 breaches on racialised lines. In New South Wales (NSW), which was not subject to the Determination, large numbers of fines were issued in towns with high Aboriginal populations despite low levels of COVID-19. For example, the town of Coonamble received 10% of the total number of infringements in NSW despite containing only 0.04% of the state's population. Residents of Tennant Creek in the NT reported military personnel issuing fines to residents for gathering illegally while staying in their own homes, which were overcrowded. The large fines for breaching public health orders (up to $13,000 in QLD) and subsequent possible gaol time impact people's lives far longer than the restrictions.[36]

Genealogy: how this representation came to be

A genealogical analysis is used to understand how it is that current policies produce discourses around vulnerability, and the 'risk' of mobility, rather than discourses of strength, resilience, and self-sufficiency. There is a long history of the colonial government utilising ideas of vulnerability and mobility to control Aboriginal and Torres Strait Islander people; as well as a history of Aboriginal and Torres Strait Islander contestation to these ideas. From the arrival of the British colonisers on Australian shores, the movement of

Aboriginal people on the mainland across and between ancestral territories formed part of the colonial government constructing Aboriginal and Torres Strait Islander people as 'uncivilised'. This shaped the government's justification of *terra nullius,* land belonging to no-one (later overturned in the landmark 1992 Mabo v State of Queensland (no 2) case).[37] In the late 1800s, Aboriginal people in particular began to move more rapidly around the country as a survival tool from the advancing frontier.[38] Throughout the 19th and 20th centuries, state governments used policy to control both Aboriginal and Torres Strait Islander peoples' movements[39]; forcibly removing families and individuals from land and restricting movement through permits.[26] The governments used the narrative of a 'dying race' to govern policy responses, and linked mobility with disease control. These health policies did not respond to the needs of Aboriginal and Torres Strait Islander people, rather were motivated by government officials 'protecting' the white population from 'contagion'.[26] These early discourses of 'vulnerability' and 'risky mobility' suggest continuities in government representations of Aboriginal and Torres Strait Islander people in health policy.

The 1967 Referendum represented a turning point in healthcare, by enabling the Commonwealth to make laws for Aboriginal and Torres Strait Islander people. In 1972 the Office of Aboriginal Affairs was created, which funded and directed States and Territories in Aboriginal and Torres Strait Islander health actions.[40] Government officials and medical professionals began to collect epidemiological data about Aboriginal and Torres Strait Islander people for the first time. This data was often incomplete or focused on subjects seen by officials as more 'deserving', such as infant mortality rates.[26] Epidemiological practices intersected with pseudo-scientific ideas of biological race, with some health professionals claiming that Aboriginal 'racial temperament' and susceptibility to disease made worse health inevitable and comparison with the general public impossible.[26,28] Yet the slow emergence of epidemiological data also made stark inequalities in health and mortality rates for Aboriginal and Torres Strait Islander people apparent. Such findings increased political and social pressure about the 'problem' of Aboriginal and Torres Strait Islander health, leading to the funding of research and programs aimed at improving health outcomes, and simultaneously constructing Aboriginal and Torres Strait Islander people as 'at-risk'.[26] This changing awareness was accompanied by Aboriginal and Torres Strait Islander activists fighting for self-determination, and the first Aboriginal-controlled health organisations were formed under the Whitlam Government.[40] Activists and community leaders pushed the limits of official policies of self-determination[41] using significant funding increases to establish community-controlled health organisations, which would provide holistic healthcare and non-discriminatory services responsive to evolving community needs.[42]

The 1990s onward saw a series of paternalistic 'interventions' into Aboriginal and Torres Strait Islander health, including the Northern Territory National Emergency Response and associated programs of welfare reform, alcohol management and other regulations.[43] This shift in health policy removed decision-making powers from Aboriginal and Torres Strait Islander people in favour of top-down government control. Matters of public health, such as sexual health, became law and order issues, regulated by the Australian Defence Force and state police.[6] Aboriginal women and children in particular were positioned as vulnerable and in need of government intervention. Later, the 2009 H1N1 influenza pandemic proved a difficult lesson for health organisations and governments, influencing the 2020 Determination. Aboriginal and Torres Strait Islander people were disproportionately affected, partly because the Federal Government had originally omitted them from the National Action Plan. It was not until community transmission was evident that Aboriginal and Torres Strait Islander people were included in the 'Protect' phase of the policy response.[44] Aboriginal and Torres Strait Islander people accounted for 11% of H1N1 cases, 20% of hospitalisations and 13% of deaths despite making up only 3% of Australia's population.[45] This genealogy helps to explain the formation of the COVID-19 response for Aboriginal and Torres Strait Islander people.

Silences

Assumptions that remote communities are a safe haven ignore multiple issues that pose greater risks to Aboriginal and Torres Strait Islander people if an outbreak occurs.[4] The national Management Plan for Aboriginal and Torres Strait Islander Populations that was developed by the Aboriginal and Torres Strait Islander Advisory Group on COVID-19 in the early days of the pandemic evaluated many of these risks,[5] however, not all of these were mitigated in the response initiated by the Determination. Chief among these issues is malfunctioning and crowded housing, with 34% of households in 'very remote' communities meeting the criteria for 'overcrowded'.[46] An inadequate amount and quality of housing is a long-existing and complex problem in remote communities, making both social distancing and hygiene practices difficult. Reasons for overcrowding include barriers to home ownership, and social housing models provided by government that do not reflect fluid Aboriginal and Torres Strait Islander kinship structures.[39,46] Generations of government inaction were identified early by NACHHO as a risk if isolation of infected individuals was required.[4] Crowding also places pressure on 'health hardware' such as bathrooms, washing machines and toilets. Social housing residents often report long waits for the Department of Housing to repair broken infrastructure. Without the ability to wash hands or bathe, infections increase. Already some remote Aboriginal and Torres Strait Islander communities see very high rates of skin sores, respiratory infections and throat infections.[46] The return of Aboriginal people to communities during the lockdown exacerbated these problems and scarce facilities, prompting fears of rapid spread of COVID-19.[47] A lack of adequate health services presents another risk for Aboriginal and Torres Strait Islander people urged to return to 'safer' remote communities. Remote communities experience barriers to healthcare due to distance, often relying on 'fly-in fly-out' (FIFO) healthcare providers or requiring sick residents to travel long distances to metropolitan centres.[48]

Treating mobility as a 'problem' requiring policing ignores the importance of mobility for Aboriginal and Torres Strait Islander residents' wellbeing. Residents of remote communities frequently visit larger towns to access resources and services, move for ceremonies (such as funerals) and community events, go out on Country to hunt or gather traditional foods and perform cultural obligations. Visiting family members and generous accommodation of extended relatives are understood by some as fundamental to Aboriginal and Torres Strait Islander identity. Government policies which seek to confine movement have been shown

to have questionable efficacy, and Aboriginal and Torres Strait Islander people continually challenge these; re-shaping their own position within government legislation.[39]

Effects

These silences illuminate the effects of the Determination and subsequent movement restrictions on residents' everyday lives. Australia-wide restrictions and, arguably, the Biosecurity measures and the work of individuals, communities and the ACCHO sector who responded quickly and efficiently, have stalled a potentially devastating outbreak of COVID-19 in remote communities. The response and coordination by Aboriginal organisations reassured community members and bolstered trust in the government. In some communities like Borroloola and Buranga in the NT, older community members saw positives. They were happy to see people practising social distancing by 'going out bush' and camping. Youth learned traditional skills like hunting and fishing, and had less access to alcohol.[49]

Other communities reported negative impacts to their lives. Along with overcrowding due to a returning population,[47] the mobility restrictions forced residents who usually travelled to larger towns for supplies to rely on community stores, where freighted-in fresh food is significantly more expensive. Despite a government taskforce that attempted to respond to these issues, fresh food and other essentials such as warm clothing, blankets, nappies and baby formula became increasingly expensive and scarce, as detailed in a recent report to parliament.[50] Families were less likely to have food storage facilities like fridges, meaning that many people could not store or stockpile fresh food. This exacerbated conditions for those with chronic illnesses such as diabetes. However, in some communities traditional hunting and an increase in locally-led food production such as market gardens supplemented the store-bought food that is exposed to supply chain logistics, a potential positive outcome.[50]

The need to isolate caused hardship. Aboriginal and Torres Strait Islander culture centres around family and personal connection, and social distancing goes against cultural protocols.[4] Those who had to leave their communities for health or family commitments struggled. For instance, pregnant women who travelled to regional hospitals to give birth could not be visited by family nor leave the hospital to buy necessary clothes, food and items if they wanted to return home without the 14-day quarantine period.[49] The Australian Broadcasting Corporation (ABC) reported that some people placed in government-paid quarantine in order to return to communities did not complete the full 14 days.[51] Additionally, many children in remote communities attend distant boarding schools. As communities entered lockdown and schools began to close, these children had to return to their communities. This process was often hampered by the quarantine process and limited travel options. When schools began to re-open in May these students experienced difficulty returning to school. Quarantine restrictions, plus limited access to internet and technology for home schooling in remote communities negatively impacted students' learning. Anecdotal reports suggest some young people intend to never go back to school.[4]

Biosecurity restrictions also affect mental health. Prior to COVID-19, Aboriginal and Torres Strait Islander communities were already providing support to a mental health crisis, arising from intergenerational trauma, economic disadvantage and lack of access to services. As a result of the increased isolation and stress caused by the pandemic and government response, these issues may be compounded.[18] Long and indefinite isolation is related to poorer mental health outcomes.[52] There are concerns among the medical community that already high suicide rates may rise, as lockdowns are likely to increase precipitants of suicide such as domestic violence and alcohol abuse.[4,53]

A report for Women's Safety NSW found that frontline domestic violence workers were seeing an increase in Aboriginal women seeking help since the COVID-19 outbreak began. Surveyed social workers attributed this increase to an inability to attend cultural support groups or access services and the pressure of being confined to the home.[54] In the NT, there were fears that isolation in remote communities would leave women experiencing family violence cut off from their support networks and unable to access emergency services due to poor phone coverage and distance from service centres. Police enforcement of restrictions may make it more difficult for Aboriginal women to leave and seek help from authorities.[55]

In addition to these lived effects, the problem representations inherent within the COVID-19 Aboriginal and Torres Strait Islander health response promote particular discourses. Although the ACCHO sector contributed to the planning and implementation of the government response, the notion that Aboriginal and Torres Strait Islander people need to be separated from mainstream society for their health and safety may work to reinforce historical paternalistic discourses. Like other health interventions, controlling Aboriginal and Torres Strait Islander people's movement constructs them as "a group of people who just don't know what is good for [themselves]".[43] A second discursive effect is the pathologising of Indigeneity. Using Indigenous status as a 'risk factor' for COVID-19 and other infections implies that illness among Aboriginal and Torres Strait Islander people is normal and inevitable.[43] Other studies have called this issue in public health a 'deficit discourse'.[56] Use of the words 'vulnerable' and 'at risk' for people in remote communities and Aboriginal and Torres Strait Islander people over 50 has been ubiquitous in government announcements, websites and pieces by the media.[16]

The ways that Aboriginal and Torres Strait Islander people are framed in COVID-19 policies change how people – subjects – come to understand who they are: a subjectification effect. An example of such subjectification effects is the idea that staying in communities is the moral and responsible thing to do; creating categories of moral/responsible and immoral/irresponsible Aboriginal and Torres Strait Islander people. The suggestion of a need to take responsibility can also be seen in social media hashtags developed by NACCHO such as #OurJobProtectOurMob and #KeepOurMobSafe.[4] Anecdotally, community members appear to have absorbed this message, saying those who stay in their area are 'doing the right thing'.[49,57]

Questioning the Problem Representation

The safety of remote communities has been contested by several groups. In early April, a coalition of seven Central Australian organisations called for the creation of 'Elder Protected Areas' to relocate vulnerable Elders if the virus reached communities. The group identified a hotel which would be available to all communities in the area if needed. The Anangu-Pitjantjatjara-Yankunytjatjara art centres (APYACC) in SA also made a sustained effort to relocate 30 vulnerable

community members who wanted to leave amid fears that the medical services in their region were inadequate. SA Health denied their application to move to a vacant boarding house at the Wiltja Anangu school in Adelaide. Minister Wyatt responded to the request by APYACC by emphasising the safety of remote communities, saying that instead of moving from a remote area to isolate in a capital city, he would rather "do the reverse".[32]

Unrest about the policy also occurred within communities. By mid-May, restrictions across the NT eased following low infection rates, yet 76 remote Aboriginal communities remained under lockdown. ABC News reported that residents were 'sick and tired' of the laws, and in need of warm clothing as winter approached. The NT Chief Minister called on the Commonwealth to lift the Biosecurity Act early, on 5 June.[58] In Yarrabah, south of Cairns in QLD, around 30 residents protested outside council offices and the police roadblock. The protesters' main grievance was that they were unable to travel to Cairns to shop for essentials and suggested the lockdown breached their human rights.[57] Federal MP Bob Katter was widely covered in local newspapers for joining the Yarrabah demonstrations. Katter criticised the restrictions as 'brutal paternalism', 'overkill' and evoking protection policies from the early 1900s.[59] Some areas like Cherbourg, QLD had no protests, but decision-makers slightly relaxed restrictions to allow travel to nearby towns for shopping.[57] Coverage by news agencies such as ABC News and National Indigenous Television (NITV) of such discontent helped to disrupt the problem representation.

Conclusion

The COVID-19 policy response risks perpetuating a paternalistic discourse where Aboriginal and Torres Strait Islander people must be controlled and regulated for the sake of their health, informed by notions of Indigeneity as deficient. This stands in stark contrast to the work of ACCHOs, advocacy by Aboriginal and Torres Strait Islander people for and against lockdowns, and the various examples of communities protecting themselves.

There are several implications for public health policy. Analysing how policies create representations of 'problems' – in this case Aboriginal and Torres Strait Islander mobility being a law and order problem – reminds us that policies which seek to protect people's health can also limit them. The responses developed by different Aboriginal and Torres Strait Islander communities highlight different types of 'problems' than those developed by government. Health policy should:

- Foreground Indigenous agency and self-determination, and work closely with local leaders and council authorities;
- Reflect on the 'problems' constructed by previous policies in order to imagine new responses to complex situations;
- Respond to the 'problems' that the government has control over, not only individual behaviour: overcrowding, poor standards of housing, social determinants of chronic illness (e.g. affordable nutrition, health education), and limited medical infrastructure.[60]

It is too early to assess the long-term implications of the COVID-19 Biosecurity Determination on how we understand Aboriginal and Torres Strait Islander health. Future research could consider whether the ACCHO response shifted the health discourse to one of self-determination, where Aboriginal and Torres Strait Islander people are recognised as best placed to both develop and implement health policy, or whether the law and order response facilitated increased government intervention into Aboriginal and Torres Strait Islander people's lives.

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