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## RESEARCH ARTICLES

# Biosecurity, Investor-State Dispute Settlement and Corporatogenic Climate Change: A Challenge for Australian Public Health Regulation and Human Rights

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### Abstract

It is a politically controversial but by no means scientifically contentious hypothesis that many of the root causes of contemporary climate change emerge from the profit-seeking activities of multinational corporations – for instance in the oil, coal, deforestation and livestock industries. Contemporary corporatogenic warming of the climate is recognised scientifically as not only having tragic environmental consequences, but also creating significant biosecurity risks. Using the 2008 Dengue Fever outbreak in Northern Queensland as a critical focal point, this article explores the implications of corporatogenic climate change to Australian biosecurity in the context both of Australia's new federal biosecurity legislation (*Biosecurity Act 2015 (Cth)*) and the investor-State dispute settlement provisions of the *Comprehensive and Progressive Trans-Pacific Partnership (CPTPP)* particularly as they may impact the health and international human rights of Australia's northerly indigenous populations.

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### The 2008 Queensland Dengue Fever Outbreak

The idea that the Earth has moved from the Holocene into a subset of such warming period more appropriately termed the Anthropocene was first proposed in 2002 by Crutzen. Crutzen's basic idea was that increased numbers of people using more land for agriculture and urban dwelling, depositing their waste into land, sea and air, depleting the fixed resource of the natural environment, were having a deleterious influence on terrestrial, coastal and maritime ecosystems, atmospheric gas composition, nitrogen, carbon and phosphorus cycles, basic climatic parameters, food chains, biological diversity and natural resources (1). Increasingly it has become apparent, however, that the dominant portion of these potentially catastrophic impacts, particularly those that continue to increase despite scientific evidence of their harm to other species and ecosystems as well as human health, are driven by the present legally required dominant focus on profit-seeking by multinational corporations; hence introduction of the concept of 'corporatogenic' climate change and the substitution of 'Corporatocene' for 'Anthropocene' (2). A recent work of speculative fiction evaluates the possibility that an *Ecocide Truth and Reconciliation Court* may eventually hear cases brought against such miscreant corporate stakeholders in Earth's ecosystems (3).

One of the major deleterious biosecurity impacts of corporatogenic climate change is likely to be the spread to hitherto temperate regions of vector-borne infectious disease. Dengue is a viral infectious disease

spread by the mosquito *Aedes aegypti*. Approximately 50–100 million people are infected with the dengue virus each year, suffering significant morbidity and mortality; causing the World Health Organization to designate it a major international public health problem (4).

In 2008, several geographic areas of Queensland, including Townsville, Port Douglas, Mossman and Cairns, were severely impacted by an outbreak of Dengue Fever (5). While Dengue Fever has been comparatively rare in Queensland, the temporal conditions at the time, a combination of warm and humid with rainfall, created the perfect environment for the relatively large scale spread of the disease by creating an ideal breeding ground for unintentionally imported vector mosquito. Dengue Fever is generally manageable, with many infected patients advised to rest and stay hydrated. It is only in rare and severe cases that a patient is admitted to hospital for recovery from the disease. In some circumstances, Dengue Fever may result in long term disability and lethargy as well as haemorrhagic fever and fatal Dengue Shock Syndrome (6).

The epidemic lasted until May of 2009 and was one of the most severe Dengue Fever epidemics to plague Australia. While only one death was confirmed to have resulted from the outbreak, the health implication on the Australian public were far from trivial. The rapid spread of the Dengue Fever and an incubation period which made the disease undetectable or latent within the infected individual, limited the effectiveness of preventing spread of the disease by restricting

mosquito breeding and the social interactions of infected individuals, as well as potentially infected individuals, including from donating blood to the Australian Red Cross for use in blood transfusions (7). Accordingly, the donor pool providing supply to Queensland blood banks is likely to become limited during such an outbreak of Dengue Fever (8). This results in less eligible donors being able to legally give blood, which in turn burdens the health system by creating a depletion on blood resources to be used to administer to sick patients suffering from unrelated illness or injury.

During the 2008 Dengue Fever Outbreak, the depletion of Queensland bloody supply became a critical health issue and forced the Queensland state government to make pleas to members of the public residing in non-infected areas of Queensland and even interstate to donate blood if eligible. In January 2009, during the early stages of the epidemic, the Red Cross confirmed that over 14% of their regular state blood supply had been lost to restrictions imposed on the eligibility of regular donors from giving blood if they had been in contact with infected areas of persons, with the ban remaining in place until there had been no new recorded outbreaks within the last 3 months (9). The public were well-informed (i.e., by media, SMS-texting and door-knocking) to implement preventative strategies such as removal of water-holding containers, use of pyrethroid indoor surface sprays (delivered by the Queensland State Emergency Service) and expert treatment of larger water-holding containers with *s*-methoprene pellets. Companies involved in the tourism, transport and media industries had their investments restricted by these public health regulations. This Dengue Fever outbreak consisted of 931 confirmed cases and one death, at a cost to Queensland Health of approximately \$AUS 3 million (10). It was not the first epidemic of Dengue Fever in Queensland.

In Australia, such recent outbreaks of Dengue Fever in the northerly regions are an outcome of corporatogenic climate change-initiated increased temperatures (11). Studies monitoring the spread of Dengue Fever in Queensland, for instance, demonstrate that the climatic conditions associated with Queensland's tropical climate, including higher temperatures, increased rainfall and higher humidity, create an ideal environment for the spread of Dengue Fever by mosquitos once it has been introduced to the area (12). The years of 2000 to 2009 were the hottest years compared to any previous decade in Queensland, with more than a 0.5-degree Celsius increase in average temperatures in comparison to the recorded average temperature from 1961 to 1990 (13). Over the next 35 years, predictions in climate change reveal Queensland will suffer increased temperatures of up to 2.2 degrees Celsius and increased periods of tropical rainfall (13). Mosquitoes, the vector for the disease of Dengue Fever thrive in warm wet environments, such as those that characterised the

period of 2000 to 2008 in Queensland (14). With the climate getting wetter and hotter in Northern Queensland, the occurrence of mosquitos carrying the disease will increase (14). Some reports predict that with a 1-degree Celsius increase in average temperature and a 1mm increase in average monthly rainfall, at least a 6% increase in the prevalence of Dengue Fever in Queensland is likely to occur (15). Some public health studies show predictions of a 61% to 93% reduction in the Queensland blood supply due to Dengue infections by the end of the current century if the climate continues to warm at predicted rates (16).

In the incipient era of corporatogenic climate change air and boat travellers to Australia will be at higher high risk of carrying infectious diseases, such as Dengue Fever, from the increasing number of countries where it is endemic (17). Each year there are about ten million short term departures by Australian residents to Dengue Fever-plagued areas. Amongst such travellers reported incidence rates of Dengue Fever are higher than the incidence of other travel-related diseases (17). A major risk here is entry of the vector mosquito via quarantine breaches by legal and illegal international vessels arriving at Australian ports or other mainland sites, as well as mosquito eggs in cargo transported inland. This was probably the cause of the 2006 *A. aegypti* incursion at Groote Eylandt and the spread Dengue Fever to Tennant Creek, NT, in 2004 (18). So how do Australian Federal and State governments respond to such challenges, particularly given that much of this climate warming is driven by widespread human usage of carbon-rich (oil, coal and natural gas) fuels, as promoted by multinational corporations in those industries? The question is complicated by the significant amount those corporations donate to political parties, their capacity to hire lobbyists, the various regulatory carbon-lock-in tax subsidies and incentives they current enjoy and, as we shall see, the emergence of new trade and investment-based rights in multinational corporations to challenge legislation claimed to indirectly expropriate their investments.

### **Australian Quarantine and Public Health Regulation for Preventing Disease Epidemics**

Present-day prevention, control and treatment of vector-bourne disease, such as Dengue Fever, is coordinated by various State and Commonwealth legislation and guidelines. In Queensland, as an illustrative example, the current relevant state legislation for preventing the spread of disease such as Dengue Fever is the *Public Health Act 2005* (PHA) (19); with associated *Public Health Regulation 2003* (PRH) (20). The PHA allows the Queensland government to implement an Approved Inspection Program or an Authorised Prevention Control Program under s 36 of the PHA of the Act, in cases where pests are:

*“likely to be, hazardous to human health, or that contributes to, or is likely to contribute to, disease in humans or the transmission of an infectious condition to humans” (21).*

Mosquitos, as the vector for Dengue Fever, are a public health risk as described in the PHA and their due notification would enable the legal implementation of either program via s. 36 of the PHA in relation to disease control.

There is no effective vaccine registered in Australia for Dengue Fever. Prevention focuses on limiting mosquito breeding, restricting human exposure to mosquitos and rapid symptomatic and test proven expert case tracing to contain active areas especially in high-risk institutional settings such as offices, hospitals, schools, aged-care facilities, tourist accommodation and prisons (all likely to be areas of significant future multinational corporate investment) (22). The aim of identifying common breeding sites and elimination of both larval and adult populations of *Ae. aegypti* and *Ae. Albopictus* is detailed, for example, in the [Framework for surveillance and control of dengue virus infection in Australia](#) (23) and the Queensland Health Dengue Management Plan.

A specific Constitution authorisation exists for Australian federal legislation to control such population-focused infection-control problems. Section 51 (ix) of the *Constitution of Australia* grants the Commonwealth legislative power to create laws on the subject of quarantine. Since 1908, the *Quarantine Act* based on this constitutional power enabled the Commonwealth to take protection and prevention measures to ensure highly infectious diseases and agricultural pests did not enter and proliferate in Australia. Section 2A of the *Quarantine Act* established the *Australian Quarantine and Inspection Service* (AQIS) and initiated the federal takeover of all quarantine stations in Australia from state and territory hands. The *Quarantine Act* was drafted when most travellers and goods arrived in Australia by ship and its focus was to protect Australia from outbreaks of more readily ‘quarantinable diseases’ such as bubonic plague, small pox, yellow fever and cholera (24). Visitors to the Quarantine Station near the entrance to Sydney Harbour can still see the names of many of those quarantined there carved in sandstone rock.

There is a tradition of viewing quarantine law as “anti-commercial, anti-social and anti-Christian.” Nonetheless, Australia invested in regulating this area and developed one of the most strictly enforced quarantine systems in the world, amending the relevant legislation on numerous occasions in response to increasing trade and travel, technological advancements, agricultural expansion and emerging biosecurity threats (25). Yet, as Australia grew as a nation and increased its international trade, immigration and refugee programs throughout the late 20<sup>th</sup> century a number of highly politicised and

damaging incursions of exotic pests and diseases took place (26). This resulted in reviews to evaluate the efficiency and effectiveness of the quarantine system. The most significant of these were the 1996 report titled *Australian Quarantine a shared responsibility* (Nairn Report) (27) and the more recent *One Biosecurity* (Beale review) (28). One of the main areas of focus of such reviews was the potentially negative impact of strict quarantine on international trade in goods and services and so on corporate profits.

The Nairn Report provided 164 recommendations, of which the then federal labour government accepted 149. One of those rejected recommendations included the establishment of an independent statutory body to oversee the activities of what was then known as the Department of Primary Industries and Energy. The Nairn Report recommended staggering regulatory checkpoints at pre-border, border and post-border compliance monitoring stations, as well as continuous use and improvement of scientifically based risk analysis to drive a targeted, transparent, industry-friendly and cost-effective compliance monitoring programs. It highlighted the need for using databases and information technology to detect import threats, target staff resources to high risk border activities and establish quality assurance arrangements with low risk corporate importers. The improved risk analysis method promoted in the report ultimately comprised of risk assessment, risk management and risk communication (29).

### **Transition from Quarantine to Biosecurity Regulation**

A decade later, an independent review of Australia’s quarantine and biosecurity arrangements was conducted by an eminent four-person panel, led by former senior public servant Roger Beale (30). The Beale review found that Australia’s biosecurity system operated well and was the envy of many countries due to its comprehensiveness, transparency, acceptance by industry and scientific rigor. Yet the Beale review put forward 80 recommendations to the government which revolved around 3 principles: 1) an integrated biosecurity continuum involving risk assessment and monitoring, surveillance and response pre-border, at the border and post-border; 2) risk assessment reflecting scientific evidence and rigorous analysis; and 3) shared responsibility between the Commonwealth, state and territory governments and between businesses and the general community. It also responded in a pro-corporate manner to calls from the community activists for a zero-risk quarantine policy, by labelling it unattainable and undesirable. To operate this type of system would mean that every passenger, every bag and suitcase, and every container of cargo would need to be searched and even sampled and analysed. The Beale review acknowledged that this would not only be counterproductive, but also be impossible to resource.

The review recommended that it was time for the Australian Government to rid itself of the term 'quarantine' in favour of 'biosecurity'. The panel stated that 'quarantine' carried a negative and defensive connotation as opposed to 'biosecurity' supposedly being more pro-active and linked to the militarisation of borders that is another consequence of resource disruption and population movement due to corporatogenic climate change. The most influential recommendation to come out of the Beale review was the endorsement of new legislation to replace the *Quarantine Act 1908*. Among the supporting recommendations the panel insisted that the new Act draw on a much broader set of constitutional powers, many of which appear directly relevant to controlling an infectious disease outbreak such as Dengue Fever, including:

- provisions to deal with national biosecurity emergencies
- additional powers and resources to regulate post border biosecurity
- legislative power to deal with international and domestic water ballast regulation
- powers to override state and territory law (subject to the NBA)

The new biosecurity legislation would also be underpinned by a *National Biosecurity Agreement* (NBA) in order to improve communication and collaboration with all states and territories. The panel recommended the establishment of a *National Biosecurity Commission* (NBC), including a Director of Biosecurity. This office would be responsible for biosecurity policy determination, import risk analyses and state biosecurity controls. Second, the panel proposed to combine AQIS, Biosecurity Australia and the Product integrity, Animal and Plant Health Division to form a *National Biosecurity Authority* (NBA). The Authority would be responsible for administering the new *Biosecurity Act*. Third, the panel recommended an independent office of the *Inspector General of Biosecurity* (IGB) be established to conduct internal audits of the National Biosecurity Authority.

The government *initially* heeded the advice of the panel by agreeing in principle to adopt all 84 recommendations. The Commonwealth's response acknowledged that factors including Australia's ever-growing reliance on corporate-coordinated trade, increases in passenger numbers and cargo, and outbreaks of disease have exposed significant weaknesses in the current system. Furthermore, the threats of agriterrorism and climate change were areas of growing concern. In March 2012, the government published an internal departmental report stating that the establishment of the NBA and NBC with their powers of corporate control and investigation was rejected by the government but upholding its initial Beale review commitment to

create a statutory office of the *Inspector General of Biosecurity* to provide independent oversight of departmental biosecurity functions (31). The relevant government department received over 100 submissions providing comments and recommendations regarding the new law and the Biosecurity Legislation Implementation Program.

The report outlined an investment of \$481 million into the biosecurity reforms over the next four years and confirmed that an *Intergovernmental Agreement on Biosecurity* had been signed by the Prime Minister and all states and territories except Tasmania in January 2012. The agreement was designed to strengthen partnerships between the Commonwealth, state and territory governments as proposed in the Beale review. The *Biosecurity Bill 2014* finally passed both houses of Parliament on the 14<sup>th</sup> of May 2015 and became an Act that received royal assent on the 16<sup>th</sup> June 2015. It came into force on 16 June 2016.

The *Biosecurity Act 2015* is a 723-page document, more than two and half times the length of the *Quarantine Act 1908*. Under the *Biosecurity Act 2015* quarantine officers are now referred to as Biosecurity Officers and Biosecurity Enforcement Officers. Items and vehicles have been grouped together to avoid confusion and streamline inspection procedure. Imported cargo, plant and material (mostly multinational corporate-owned) have been categorised as 'goods', and aircraft, vessels and ships are now termed 'conveyances'. The *Quarantine Act 1908* grouped together vessels, persons and goods which made the requirements for individual biosecurity risks difficult to isolate and interpret.<sup>53</sup> The *Biosecurity Act 2015* has simplified this issue by dividing individual biosecurity risks and their requirements into four chapters comprising: human health; goods; conveyances and ballast water and sediment.

The biosecurity risk chapters are followed by supporting chapters outlining administrative tools including monitoring, control and response, and compliance and enforcement. Powers to manage biosecurity outbreaks and emergencies have also been closely defined in the new legislation. Where the *Quarantine Act 1908* has these powers littered throughout various parts of the Act, the *Biosecurity Act 2015* has collated them together by allocating an entire chapter to dealing with emergencies. The layout improvements to the *Biosecurity Act 2015* certainly warrant recognition. An important operational change within Chapter 9, Compliance and Enforcement, is the adoption of the *Regulatory Powers (Standard Provisions) Act 2014* (RP Act). Monitoring, investigation and warrant powers of biosecurity officers within the *Biosecurity Act 2015* must be carried out in accordance with the RP Act. The Parliament's aim here is to provide a standardised framework for federal compliance and enforcement powers that relate to regulatory schemes conducted under Commonwealth statutes (32).

The new Australian biosecurity regulation shifts to a model of risk-based regulation; it allocates resources in proportion to the risks to society, considering both the impacts themselves and the likelihood that they will occur, as recommended by the Nairn Report and the Beale Review. Goods that are imported into Australia (for example those that might contain mosquito eggs) are now required to be evaluated against *Biosecurity Import Risk Analysis* (BIRA). This system is designed to identify conditions that need to be met by the corporate importer in order to manage the level of risk associated with the goods (i.e., preventing infestation with mosquito eggs). The *Biosecurity Act 2015* in Chapter 1 defines the appropriate level of protection for Australia against biosecurity risks (such as Dengue Fever) as a 'high level of sanitary and phytosanitary protection aimed at reducing biosecurity risks to a very low level, but not to zero'. The *Biosecurity Act 2015 (Cth)* can be viewed as pro-corporate, particularly in not creating strong regulatory oversight mechanisms such as a *National Biosecurity Commission* or a *National Biosecurity Authority*. Consequently, it could have been stronger in facilitating the capacity of authorised officers under the legislation to impose restrictions on corporate investments in traded goods and services such as those necessarily imposed in cases of Dengue Fever outbreak, as that studied here.

### **Biosecurity Restrictions and Indigenous Populations**

Australia's indigenous populations have a significant density in Northern Australia. If climate change-initiated infectious disease epidemics occur in those regions, they are one group likely to be significantly impacted by biosecurity measures, particularly as such measures controlled by State enforcement apparatus are likely to be negatively viewed by such indigenous people as a recrudescence of colonial domination, discrimination and cultural oppression.

According to some climate change scientific models, the Dengue Fever-bearing mosquito *A. aegypti* could reach indigenous population areas such as Birdum in the NT (15.6°S) by 2020 and Daly Waters (16.3°S) by 2050. Indeed, *A. aegypti* previously has occurred further south, at Anthony Lagoon and Newcastle Waters and in 2004 became established in Tennant Creek (19.5°S), surviving the dry "winter" before being eliminated in 2006 by health authorities. Indeed, if there is a substantial increase in imported cases of dengue into Far North Queensland, the disease may become endemic in the region and amongst indigenous populations despite a strong control program. This would activate restrictive social control (quarantine) measures under the *Biosecurity Act 2015 (Cth)*.

Imposition of biosecurity controls under the new Federal legislation against Dengue Fever in indigenous communities could create much political

controversy. The health outcomes of Aboriginal and Torres Strait Islander peoples already are significantly worse than those for non-indigenous Australians (33). As a result, most Indigenous Australians experience lower overall life expectancies, higher age-specific mortality rates, higher incidence chronic diseases, and a high incidence of sleep-related disorders (33, 34). This gap is mostly due to systematic discrimination amidst several social determinants (33, 34). Some relevant key factors would be directly relevant to a future Dengue Fever outbreak: the lack of equal access to primary healthcare and the poor standard of health infrastructure (eg. housing, sanitation, food etc.) in Indigenous communities (35).

In 2013, following tireless Indigenous campaigning to 'Close the Gap' between Indigenous and non-Indigenous Australians with respect to health and life expectancy, the Federal Government initiated the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 (36). One of the plan's key priorities was to adopt a human rights focus in its approach towards reducing inequalities in health outcomes for Indigenous peoples. At a national level, human rights protections have yet to be enshrined into the Australian Constitution, let alone on a statutory basis. Problematically, this renders citizens defenceless against the government, particularly when it seeks to employ restrictive measures to prevent infectious disease spread such as those available under the *Biosecurity Act 2015 (Cth)*. Some Australian constitutional provisions could be argued to confer human rights-related protections, like Section 117, which essentially prohibits the forming of legislation with the effect of discriminating citizens based on their State of residence, in relation to inequities in funding for medical and other related health services (37). But those cases have yet to be successfully argued before the Australian High Court.

An Indigenous Australian engagement model on such emerging biosecurity issues has been developed from previous plant biosecurity operations of *Mimosa pigra* on Aboriginal land in the Northern Territory taking into account specific relevant values in Aboriginal culture. For the Warramirri, Mak Mak Marranunggu and other Yolŋu language groups, key values include Djakamirr (empowerment), Raypirri-Wadatj (discipline), Marri-Yulkthirr Ga Gurrutu (trust and relationships), Rom (authority), Nhama Manymakum (respect) and Gumurrkunhamirr (partnership) (38). Such values have a manifest disconnect with the core value of shareholder profit-making presently required by legislation to be central to corporate operations. Protecting such indigenous values, as discussed in the next section, will create significant human rights issues.

### **Balancing Biosecurity Powers with Corporate Investor, Individual and Community Rights**

Internationally, the United Nations Committee on Economic Social and Cultural Rights recognises

'health' to be a fundamental human right, which the *International Covenant on Economic Social and Cultural Rights* (ICESCR) defines as the right to enjoy the 'highest attainable standard of physical and mental health' (39). As it is a party to this covenant, the Australian government has an obligation to progressively realise these rights, and so must take steps within the maximum of its available resources' (39). In taking the necessary steps, the government is also under an obligation to not discriminate (39). This brings into view the health disadvantages suffered in Aboriginal and Torres Strait Islander communities, which are likely to be exacerbated in situations of Dengue Fever and other climate change-initiated infectious disease 'quarantine' under the new federal biosecurity legislation.

In 2009, Australia adopted UN's *Declaration on the Rights of Indigenous Peoples*, which also contains rights pertaining to health, similar to those in the ICESCR. Furthermore, the UN Committee has stated that Indigenous peoples have right to specific measures to improve their health outcomes that are consistent with traditional cultural values (40). However, a key problem is that these obligations conferred by UNDRIP are not legally binding (41). This leaves indigenous communities in Australia particularly vulnerable, if Australian biosecurity legislation is used to:

- Abate public health nuisances and destroy dangerous or contaminated materials;
- Collect data and records to facilitate the early detection of a health emergency;
- Take private property with just compensation as needed to care for patients or protect the public's health;
- Close roads, implement curfews, and evacuate populations where justified;
- Collect specimens and implement safe handling procedures for the disposal of human remains or infectious wastes;
- Test, screen, vaccinate, and treat exposed or infected persons;
- Separate exposed or infected individuals from the population at large to prevent further transmission of communicable conditions;
- Seek the assistance of out-of-state healthcare volunteers through licensure reciprocity; and
- Inform the population of public health threats through media and language that are accessible and understandable across cultures (42).

Indeed, the application of the new Australian biosecurity legislation could become a "...stark expression of the view that a public health emergency might necessitate the abrogation of privacy rights, the imposition of medical interventions, and the

deprivation of freedom itself." This is particularly so with respect to indigenous populations (43). Indeed, it could become an important issue whether medical practitioners that are legally obligated to apply powers under the *Biosecurity Act 2015 (Cth)* through their conditions of employment would have protection from legal liability for infringing the rights of individuals and communities (44).

The UN have suggested that the scope of the 'right to health' in the ICESCR extends beyond a disease prevention model, to recognise community rights to the basic preconditions of health (eg. food, water, housing, healthy environment) (45). This obligation also involves the right to access the necessary conditions or healthcare services required for delivering the highest attainable standard of care (45). This would include access to medical services necessary to treat a Dengue Fever outbreak.

The United Nations Declaration on Indigenous Rights (UNDRIP) also contains similar protections for the Health of Indigenous peoples (46). More specifically, with regards to the content of Article 12.1, UNCESCR clarifies the three main elements which comprise the 'right to health': availability, acceptability and quality (47). This element requires health facilities, programs and services to be delivered in a culturally sensitive manner, which protects the human dignity of traditional practices (48). The availability of these health-related goods and services is also essential for these Indigenous communities exposed to infectious disease pandemics regulated by the new *Biosecurity Act 2015 (Cth)*, as they are geographically disadvantaged, compared to non-indigenous metropolitan regions in Australia (49). Following this line of reasoning, health rights for Aboriginal and Torres Strait Islander peoples ought to allow for the conditions necessary to equal treatment and to advance wellbeing on their terms (50). They should also allow biosecurity measures to be applied in a way that respects indigenous law, culture and traditions. This could be viewed as an aspect of the right to self-determination, recognised internationally (51) and within domestic jurisdiction (52). It would emphasise empowerment to ensure that Aboriginal and Torres Strait Islanders have the maximum opportunity to partake in the planning and implementation of their own response to an infectious disease pandemic or Dengue Fever outbreak. Aboriginal controlled health services could play a major role in negotiating such arrangements (53). They could ensure that even in biosecurity emergencies, holistic and comprehensive and culturally appropriate health care is still delivered to the affected communities (54).

Yet alongside such considerations must now be placed the right of multinational corporations operating in Australia to bring investor-State dispute Settlement actions before a panel of private arbitrators not subject to standard rule of law mechanisms such as *stare decisis* (following precedent), an appeals process or restrictions on conflict of interest. The most

recent iteration of the ‘friendly,’ ‘relax-nothing is happening here’ title of this multinational corporate power grab terms this the Comprehensive and Progressive Trans Pacific Partnership’ (CPTPP). Chapter 9.16 of the CPTPP provides:

*“Nothing in this Chapter shall be construed to prevent a Party from adopting, maintaining or enforcing any measure otherwise consistent with this Chapter that it considers appropriate to ensure that investment activity in its territory is undertaken in a manner sensitive to environmental, health or other regulatory objectives” (55).*

Yet, the word ‘sensitive’ is soft in a legal sense; it must be massaged in proceedings to create a hard obligation. The same is true of the requirement for ‘corporate responsibility’ in 9.17. The harder edged provision:

*“Non-discriminatory regulatory actions by a Party that are designed and applied to protect legitimate public welfare objectives, such as public health, safety and the environment, do not constitute indirect expropriations, except in rare circumstances” (56)*

is relegated to (3(b) of Annex 9B – an annex in such an agreement being notable for its restricted capacity to apply to all parties. It is, further, edged with the exclusion ‘except in rare circumstances.’ The United States though not part of the CPTPP at inception will no doubt join it (giving US companies access to its mechanisms) once President Trump is removed from office. Interestingly Australia and New Zealand appear to have agreed not to all their own companies to bring investor state actions against each (57).

The risk here, as the looming public health and environment catastrophe of corporatogenic climate change becomes apparent is that multinational corporations will use mechanisms such as investor-State dispute settlement in the CPTPP to in effect bully governments at the pre-legislative policy stage against taking biosecurity measures likely to impede their profits.

## Conclusion

Dengue Fever activity is increasing in many parts of the tropical and subtropical world as a result of not only rapid urbanisation in developing countries and increased international travel, but also the decisions of multinational corporations, particularly the oil, coal and gas industries and those benefitting financially from them, to continue burning carbon-rich fuels that atmospherically trap the sun’s heat. The potential for the Dengue Fever outbreaks is likely to rise in this era of corporatogenic climate change as breeding conditions for the relevant mosquito expand. In such situations the application of Australia’s *Biosecurity*

*Act 2015 (Cth)* may create human rights issues not just for medical practitioners employed by public health authorities governed by the legislation, but also for indigenous communities in Northern Australian regions. Further, the capacity of Australian governments to taking legislative biosecurity actions against such threats in the interest of public health and the environment itself may be impeded by new corporate investor dispute rights incorporated in agreements such as the CPTPP.

## Conflict of interests

The authors have no conflicts of interest to declare.

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