CHAPTER 1

UNPRECEDENTED? PANDEMIC MEMORY AND RESPONSES TO COVID-19 IN AUSTRALIA AND NEW ZEALAND

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ABSTRACT

The 1918-1920 global influenza pandemic and the global coronavirus pandemic which began in 2019 are separated by almost exactly a century, but in Australia and New Zealand there have been eerie similarities in the way they have unfolded, and in the responses used to combat them. Despite these similarities, early in the covid-19 crisis the virus and its impacts were widely described as 'unprecedented'. This chapter explores the common collective amnesia that surrounds pandemics, and compares the level of collective memory of the 1918-1920 influenza pandemic in Australia and New Zealand before the arrival of covid-19. It examines government statements and actions while preparing for and responding to pandemics, the nurturing of historical knowledge among medical experts, and the actions of groups of citizens. Additionally, this chapter analyzes the significance of collective memory in devising effective responses to covid-19 in these two countries. In neither country has history been allowed to repeat itself exactly, but in New Zealand, action has been taken in the present with the intention of avoiding a reoccurrence of the events of the past.

Keywords: Covid-19, 1918-1920 influenza pandemic, disaster memory, Australia, New Zealand

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1. Introduction

In Australia and New Zealand by late March 2020 covid-19 had been recognized as a significant threat to health, and public behaviour started to change as restrictions began to be imposed. At that time, the term 'unprecedented' was regularly used to describe the unfolding crisis: those using it included the Australian Broadcasting Corporation, (Spears, 2020) and the New Zealand Prime Minister, as reported in the nation's largest newspaper ("Coronavirus: Everyone travelling to NZ from overseas to self-isolate", 2020). However, the Australian and New Zealand experiences of covid-19 were not without precedent. Restrictions on public gatherings, and even border closures, had been enacted just over a century earlier in response to a global pandemic caused by another viral disease. And, writing in July 2020 as the global pandemic rolls on and Australia faces a new wave of infections emerging from the city of Melbourne, much current coverage of the pandemic incorporates some reference to experiences with influenza a century earlier, while publicly-discussed fears about what might lie ahead now draw on historical knowledge. However, the 1918-1920 influenza pandemic has few memorials, its history was ignored in the early stages of the covid-19 outbreak, and the recent increase in its notoriety raises questions about how pandemics are perceived and remembered. How was it possible for the history of pandemic disease to slip from collective memory before the arrival of covid-19? And, in the few places where that memory survived, how has that memory informed and directed responses to the current crisis?

The 1918-1920 and 2020-ongoing pandemics involve different viruses, but their observed effects are similar. The basic reproductive rate of covid-19 (2.5) and the 1918-1920 pandemic influenza (2.0) are both high, indicating that both viruses are easily transmitted. The viruses are also similar in causing mostly mild illness (Petersen et al, 2020). These two factors interact to create high death tolls. While most people infected with either virus experience only mild symptoms, the large numbers of people infected lead to a significant number of total deaths. The most obvious difference between the two viruses is in their age-mortality patterns. The virus that caused the 1918-1920 pandemic exacted a heavy toll on young adults (although it also killed very young children and the elderly), covid-19 has a more normal mortality pattern, and most of its victims are elderly (Shanks, 2020). While covid-19 has a longer incubation period than the 1918-1920 influenza (making it easier for early isolation and quarantine to prevent transmission (Petersen et al, 2020)), the speed and volume of international travel has greatly increased in the last 100 years, meaning both viruses have led to global pandemics. As occurred in 1918, Australia and New Zealand were relatively late to experience the unfolding global pandemic. As a result, governments in each country were able to react to the virus with knowledge of its impacts elsewhere.

2. The 1918-1920 Influenza Pandemic

During the last quarter of the twentieth century historians paid attention to the 1918-1920 influenza pandemic, exploring its significance as an historical event of global proportions. That pandemic is widely held to have originated in the United States of America (Hodgson, 2017), although a Chinese origin has also been suggested (Humphries, 2014), and at this distance in time no definitive origin can be identified (Oxford, 2018). Wherever it originated, the virus was carried to the battlefields of Europe and from there it spread around the world. The first wave of influenza circumnavigated the globe within six months, and a second wave, with significantly enhanced virulence, spread using the same networks (Hodgson, 2017). The scale of the event was aptly described by Major George Soper in May 1919: "The pandemic which has just swept round the earth has been without precedent. There have been more deadly epidemics, but they have been more circumscribed; there, have been epidemics almost as widespread, but they have been less deadly. Floods, famines, earthquakes and volcanic eruptions have all written their stories in terms of human destruction almost too terrible for comprehension, yet never before had there been a catastrophe at once so sudden, so devastating and so universal" (p.501).

Population mobility played a significant role in facilitating the transmission of the influenza pandemic. Helped by its advent during the closing stages of World War I, the virus moved between continents as soldiers filled liners and cargo ships to overflowing in order to get home at the end of the war. It then spread within countries, travelling by railway and coastal shipping (Oxford, 2003). The virus arrived in New Zealand in 1918, where it spread widely quickly. Its arrival in Australia was delayed by the elementary public health measures undertaken by authorities there. However, not all cases were identified before arrival, and by the end of January 1919 the pandemic influenza had penetrated Australian maritime quarantine and spread through the country. In both New Zealand and Australia, influenza arrived through international ports, reached other metropolitan areas and towns by ship and rail, and infiltrated more remote communities as people travelled by car, bicycle, horse and cart, and foot (Hodgson, 2017, pp.186-227).

In both New Zealand and Australia, a mild flu-like illness was present from the middle of 1918. In October and November, the far more lethal second wave of influenza spread through New Zealand killing at least 8000 people. From New Zealand it spread into the Pacific where it exacted a heavy toll, including killing one fifth of the population of Western Samoa (Shanks et al, 2018, p.323). In Australia, the virus reached different states at different times. Victoria

suffered first, and the disease assumed epidemic proportions there for a period of eight weeks, from the end of January until the middle of March 1919. Influenza reached New South Wales soon after its arrival in Victoria, but only reached epidemic proportions in mid-March 1919. New South Wales then experienced a second epidemic from 28 May to 25 August 1919. In the space of twenty weeks, at least 5,885 people in New South Wales died of the disease. In the end, the official influenza death toll in New South Wales was 6,387, although the actual toll was undoubtedly greater (Director-General Public Health, New South Wales, 1920, pp.141-142). The influenza was in South Australia by April 1919, and Queensland diagnosed its first official case on 2 May 1919. However, this timing is suspect: Queensland's first case was a wardsmaid at the Kangaroo Point Military Hospital, a Commonwealth facility in Brisbane, and 'suspicious' cases of influenza, well away from Brisbane, had previously been reported to the Commissioner of Public Health. Almost instantaneous outbreak of the epidemic across the state suggests the virus could have been seeded and diffused throughout Queensland over several months before the epidemic exploded, and local outbreaks continued to occur in Queensland into 1920. The influenza pandemic reached every state of Australia, arriving in Western Australia in June 1919 and in Tasmania in August 1919 (Hodsgon, 2017; Shanks et al, 2018).

The exact extent of the 1918-1920 pandemic's morbidity and mortality rate in New Zealand and Australia will never be known. In many towns and even in capital cities, there were breakdowns in the official recording process. Even allowing for this, large numbers of cases simply went unreported–through ignorance, lack of communication, or people being just too busy surviving to worry about anything else. Doctors were too busy attending to the sick to report any but the most serious cases. The New South Wales Deputy Director-General of Public Health later estimated that in the Sydney alone 290,000 people or over 36% of the population contracted the disease in a more or less virulent form (Director-General Public Health, New South Wales, 1920, p.141). Populations whose immune systems had experienced few variants of the influenza virus were overwhelmed. This was true for indigenous Americans, Pacific Islanders, Aboriginal Australians and sub-Saharan Africans. In Australia, Aboriginal people suffered disproportionately, and a recent estimate suggests at least one third of influenza deaths in the state of Queensland were of Aboriginal people, despite Aboriginal people making up only a small proportion of the state's population. The full toll cannot be accurately calculated as Aboriginal people were largely absent from census data at the time (Shanks et al, 2018, p.326). In New Zealand deaths were similarly differentiated by ethnicity: Pakeha (New Zealanders of European descent) suffered a death rate of 5.8 per 1000 people, Māori suffered a rate seven times higher (Rice, 2003, p. 74).

3. Disaster Memory (or Disaster Amnesia)

Despite the high mortality rate, the 1918-1920 flu pandemic has few memorials. In New Zealand there are only seven publicly accessible memorials that refer to multiple deaths or the deaths of health workers resulting from the crisis. In contrast, other types of disasters (including rail disasters and wars) are far better represented relative to the number of people who died as a result (Wilson et al, 2017). In Australia, the situation is even more pronounced: despite its larger population there are only five public memorials relating to the 1918-1920 pandemic listed on an extensive, private, web-based database of monuments. In contrast, that database records eleven monuments associated with HIV/AIDS, four commemorating the 1840 arrival of the Glen Huntly, a fever-afflicted migrant ship, and many commemorating disasters including industrial accidents and wars (https://www.monumentaustralia.org.au/). As in New Zealand, some private memorials to influenza victims exist within cemeteries, but while gravestones mark individual influenza deaths, often even they do not record that death's association with the influenza pandemic (Hobbins, 2019).

Lack of memorialization of such a significant pandemic might seem strange, but while disasters are compelling and consuming at the time they occur (particularly to those caught up in them), historians have noted the swiftness with which collective memory of disasters fades, and the speed with which disastrous events are consigned to the 'dead past' (Lloyd et al, 2020). In Australia, such 'unprecedented' (and often unmemorialized and unremembered) disasters tend to be environmental, and include bushfires, droughts, and floods (Griffiths, 2009; McKinnon, 2019; Wilhite, 2012). In Australia in 2019 the word 'unprecedented' was widely used to describe both flood and fire. Its use to describe the Townsville flood of that year went unchallenged, although its application to the extreme bushfire events that occurred in the southeast of the continent (and that continued into 2020) was contentious because of its suggestion of changing climate conditions (Townsville City Council, 2019; Morton et al., 2019). Writing of the response to a catastrophic bushfire in Victoria in 2009, historian Tom Griffiths noted the significance of the term 'unprecedented' in rejecting the on-going ability of natural disasters to complicate human lives: "Black Saturday, we quickly reassured ourselves, was 'unique', 'unprecedented', 'unnatural'—and it was a 'disaster'. We must never let it happen again! Culture can—and will—triumph over nature" (2012, p.53). Thus the use of the descriptor 'unprecedented' is an indication of uneasiness with the event being described, and may be an indication that it will not be committed to collective memory.

Accepting that human lives are constrained by the natural world, and by events beyond human control, is difficult. Western societies in particular tend to see disasters as things that happen elsewhere, and as events that can be mitigated with sufficient planning (Lloyd et al, 2020). In 2020, the shock of the global human population being threatened by a highly infectious disease has made many people uncomfortable about human frailty in the face of nature. For some, that realization remains too difficult to accept. Misinformation about covid-19 tends to mark an attempt to cling to a sense of human agency. Its common forms include: a simple refusal to accept that a global catastrophe is unfolding (including the description of covid-19 as a 'scam-demic'), the promotion of items and actions as cures and prophylactics (allowing for human control), and the assertion that the virus has been engineered as a biological weapon (making the pandemic a reflection of human power rather than a natural disaster) (Mian & Khan, 2020).

4. Historians and collective memory

In both New Zealand and Australia, historians have addressed the challenge of maintaining the collective memory of pandemics. Since the 1988 publication of *Black November: The 1918 Influenza Epidemic in New Zealand* Geoffrey Rice has sustained academic analysis of that pandemic in New Zealand, and repeatedly sought to draw both expert and public attention to the menace of future devastating global pandemics. Awareness of New Zealand's role in Samoa's experience of the 1918-1920 influenza pandemic increased in 2002 when Prime Minister Helen Clark apologized for aspects of New Zealand's administration of Western Samoa, including its inadequate response to the risk of influenza arriving in Samoa aboard the *SS Talune* (Clark, 2002). Commentary about the 1918-1920 influenza pandemic and the impact of the *Talune* on the Pacific remains a live topic as New Zealand actively seeks to deal with its colonial past both within New Zealand and more broadly.[1]

However, New Zealand remains the only country to have a national study of influenza deaths based on death certificates (Rice, 2018). In Australia, influenza scholarship does not yet have as dedicated and effective a representative, and historical analysis of the 1918-1920 pandemic remains fragmented. Existing Australian analysis includes Peter Hobbins' and Alison Bashford's work on quarantine, and a variety of studies of the impact of the pandemic on particular regions or groups of people. Patrick Hodgson's 2017 thesis on the 1918-1920

1 In New Zealand the on-going process of Treaty settlement (recognizing and enacting the provisions of the 1840 Treaty of Waitangi), and the effective political voices of Māori and Pasifica populations makes the histories of settler colonialism and of New Zealand's behavior towards its Pacific neighbours matters of regular public debate.

influenza pandemic in Queensland is the most recent and thorough of these. Since the arrival of covid-19 in Australia, Hobbins and Hodgson have become the most visible public faces of historical pandemic scholarship, each speaking on radio, appearing on television, and commenting in print on the similarities between the current and past global pandemics. Hodgson's thesis has been downloaded over 3000 times across 89 countries, in the first six months of 2020. Other historians have also provided informed commentary as the Australian public has rediscovered the 1918-1920 influenza pandemic. In particular, in June 2020 the History Council of New South Wales hosted a seminar series on the Spanish Flu in Australia.

5. Government pandemic plans

Despite collective memory allowing covid-19 to be widely described as 'unprecedented', in some circles past pandemics are well studied and their histories regularly discussed. Internationally, reports produced by government planners and medical professionals regularly reference the 1918-1920 influenza pandemic, as well as more recent pandemics. Both the New Zealand and Australian governments have influenza pandemic plans (one last updated in 2017, the other in 2019). In addition, professional medical journals frequently carry commentary on the risk of global pandemics and display a greater awareness of pandemic history than that in the public sphere.

The New Zealand government's 2017 *New Zealand Influenza Pandemic Plan* begins with an acknowledgement of the work of Rice and its significance in government planning (p.ii, inside cover). It also notes the significance of the 2009 influenza pandemic in promoting pandemic planning by governments. The Australian *Health Management Plan for Pandemic Influenza* demonstrates less historical awareness, although the Ministerial foreword refers to the 2009 influenza pandemic. Indeed, while the Australian report notes the severity of the 1918-1920 influenza pandemic, it dismisses its usefulness in planning for future pandemics. Noting the milder nature of the 2009 influenza pandemic, the report suggests that the 1918-1920 influenza pandemic might represent too dire a worst-case scenario to be valuable. Instead, the plan aims to facilitate a proportionate response to a milder influenza pandemic. Thus, while the Australian report recognizes a historical pandemic precedent for planning purposes, that precedent is the milder influenza pandemic of 2009, rather than that of 1918-1920.

While both New Zealand and Australian government response plans demonstrate an awareness of precedent, different past pandemics are accorded different priorities. Both plans include a list of previous influenza pandemics, and both lists include the pandemics of

1918-9, 1957-8, 1968-9, and 2009-10 (Ministry of Health, 2017, p.5; Australian Government Department of Health, 2019, p. 21). The Australian report also notes the 1997 H5N1 influenza as being of on-going concern, while noting it does not meet the qualifications of a 'pandemic'. In contrast to this awareness of past influenza pandemics among government planners, only the 1918-1920 influenza pandemic has featured in public discussions of pandemic precedents for covid-19 in Australia and New Zealand. The other influenza pandemics of the twentieth century were much less severe, and have likely been absorbed by the annual experience of seasonal influenza. The 1997-ongoing H5N1 influenza is comparable in severity to the 1918-1920 influenza, but as its transmissibility is much lower it has not entered public consciousness to the same degree.

6. Historical Awareness of Government and the Medical Profession

The two government plans may recognize the same historical influenza pandemics, but they differ markedly in their treatment of them. The New Zealand plan differs from the Australian in containing a statement about the impact of the 1918-1920 influenza pandemic on indigenous peoples, recognizing that Māori suffered a death rate five to seven times higher than non-Māori (p.6). In addition, the New Zealand report notes that during the 2009 influenza pandemic Māori and Pacifica suffered higher morbidity rates than the general population, possibly indicating a greater susceptibility to pandemic influenza. As a result, the New Zealand pandemic plan emphasizes the importance of cultural awareness, the need to communicate pandemic measures to all communities, and the fact that Māori face greater impacts than other New Zealanders (p.17). In contrast, the Australian report does not discuss the experiences of 1918-1920 in any detail and does not recognize the Aboriginal experience of 1918-1920 or subsequent pandemics. Instead, its list of groups at risk is exhaustive, beginning with pregnant women, including those suffering from a range of chronic illnesses and disabilities, and only recognizing Aboriginal and Torres Strait Islander peoples before finishing with the very young and the old (p.19). The memory of the 1918-1920 pandemic is barely present. This absence of planning for the needs of Australian indigenous groups is all the more significant as the previous Australian pandemic plan (2010) was criticised for not considering the needs of Aboriginal and Torres Strait Islander people and communities given their greater susceptibility to the 2009 pandemic (Miller & Durrheim, 2010).

Like government health planners, medical professionals have recognized the potential for new pandemics to emerge, and have sought to use the past as a guide when preparing from them. The *British Medical Journal*, the *Medical Journal of Australia*, and the

New Zealand Medical Journal (*NZMJ*), all responded to the 2003 and 2009 influenza pandemics with articles that addressed the prevailing crisis, followed by (as each crisis waned) historical analysis. Most emphasis was placed on the influenza pandemics of the twenty-first century, but assessment of the 1918-1920 influenza pandemic also took place. The *NZMJ* was unusual in the depth of coverage it carried, and in April 2020 that journal demonstrated outstanding historical awareness by publishing an editorial written by Rice that placed responses to covid-19 in the context of the experiences of 1918 (Rice, 2020). Awareness by medical planners of past pandemics is not limited to these journals. The second chapter of an American guide to preparing for influenza pandemics is devoted to the 1918-1920 pandemic (Olson, 2009) and the World Health Organisation's guide to pandemic influenza and appropriate responses mentions the longer history of pandemic disease and notes the 1918-1920 influenza pandemic as a historical precedent (World Health Organization, 2009).

Recognizing precedents is important in staging effective responses. While covid-19 was described as 'unprecedented' in both New Zealand and Australia, both countries were late to experience its arrival, and were able to learn from the experiences of regions already coping with the virus. As a result, the spread of the virus has, to date, been successfully slowed and widespread community transmission avoided. However, some regions closer to the viral epicentre of Wuhan province also escaped early widespread community transmission. South Korea, Taiwan, Hong Kong, Singapore, and Japan are all notable for their proximity to China, dense urban populations, and successful early control of covid-19. In those countries, recent pandemics provided government planners with useful precedents. Memory of the 2003 outbreak of Severe Acute Respiratory Syndrome (SARS) and the 2015 outbreak of Middle East Respiratory Syndrome (MERS) led to a swift response to covid-19, and community cooperation in containing the virus (Zhou, 2020). A similar response prevented the early arrival of covid-19 in Africa, despite close ties to China. Prompted by memory of the 2014 Ebola crisis in West Africa (as well as by experience with Lassa fever, polio, measles, tuberculosis and HIV/AIDS) African Union member states acted swiftly to prevent the arrival of covid-19 with aircraft passengers. Health ministers from across the continent met on 22 February 2020 and developed a joint strategy to respond to the virus (Massinga Loembé et al, 2020). Their actions were successful, in that covid-19 arrived in African countries via Europe rather than directly from China. Even so, it is difficult to assess whether covid-19 has been contained across Africa because of a lack of consistent and widespread testing (Bruce-Lockhart 2020; Makumeno et al, 2020; Massinga Loembé et al., 2020).

Even in 1918, the arrival of epidemic disease in New Zealand and Australia was not without recent precedent. Rice, despite stating that "officials had no precedents or established procedures" (2003, p.76), notes that New Zealand's response drew on an administrator's previous experience of a diphtheria epidemic that had occurred in South Africa during the South African War of 1899-1902 (2003, p.80), and reproduced travel restrictions imposed during a 1913 smallpox epidemic (2003, p.84). In Sydney, and elsewhere in Australia, the influenza pandemic might have escaped clear recall by becoming 'telescoped' with the experience of bubonic plague in 1900, in the same way the 1918 influenza epidemic in Senegal is not recorded in oral or written histories precisely because it was not unprecedented. Instead, in Senegal memory of the influenza pandemic has been conflated with that of bubonic plague epidemics in 1914 and 1917 (Echenberg, 2003). In the present, while collective memory of the 1918-1920 influenza pandemic has been revived, other precedents have not. The polio epidemics that caused widespread devastation, reaching Australia and New Zealand repeatedly before the development of a vaccine in 1956, have relevance when facing a novel coronavirus rather than an influenza pandemic (Johnston, 2018). While the 1918-1920 influenza pandemic left few memorials, polio's only memorials in New Zealand and Australia are in the form of permanent damage done to some survivors and in the memories of family members.

7. Government actions

The reaction to covid-19 has differed from the reaction to the 1918-1920 influenza pandemic, in part due to lingering institutional and collective memory. In contrast to events in 1918, in 2020 New Zealand responded more quickly and more decisively to the threat of a pandemic than did Australia. Unlike in 1919, Australia's federal system did not prove a barrier to concerted actions, with commonwealth and state leaders early in the pandemic generally presenting a united front, with the prime minister as spokesperson. However, within the constitution of Australia the responsibility for public health largely rests with state governments, and as the covid-19 crisis lengthened the states began exerting their influence. While the extent of any particular response or measure continues to vary from state to state depending upon local circumstances, nonetheless the actual measures imposed have been similar.

Whereas in 2020 the commonwealth has generally confined itself to protecting national borders and providing economic relief measures, during the 1918-1920 influenza pandemic the Commonwealth Government made extensive use of its powers under the *Quarantine Act 1908* and the *War Precautions Act 1914* (the dominant federal legislation of the period) and their associated regulations to impose its will in areas that were constitutionally the responsibilities

of state governments. This was particularly resented in Queensland. As a result, over the course of the first half of 1919, the Commonwealth and Queensland Governments contested each other's responses to the pandemic in the Police Court, the High Court and the court of public opinion (Hodgson, 2017).

Despite the different political contexts, many of the pandemic responses of 2020 repeat those of 1918-1920: closure of borders between states, outlawing of large gatherings, encouragement of face mask usage, and governments urging of citizens to support each other in practical ways. But, whereas in 1919 the federal government publicly ridiculed its state counterparts for strictly enforcing land borders closures, in 2020 federal criticism of state measures has been muted, being confined for the most part to where those measures are deemed to have had a detrimental impact on the Australian economy (Hodgson, 2017).

Some responses to covid-19 in New Zealand appear to be conscious efforts to avoid the history of 1918-1920 repeating itself. In 1918 the Australian federal government imposed strict maritime quarantine on 18 October, while New Zealand observed but did not act. The New Zealand administration of Western Samoa allowed the *Talune* to dock there on 7 November 1918, despite sickness on board. The ship then continued to Tonga. Between twenty-two and twenty-five percent of the population of Western Samoa died as a result of that decision, while American Samoa escaped unscathed because of a strict quarantine imposed by the United States authorities (Tahana, 2018). Those island groups connected by Australian steamers were protected by Australian quarantine protocols and escaped relatively lightly, but Tonga's connection to New Zealand meant the death rate there is estimated to have been sixteen percent (Kupu, 2006). In contrast, in 2020 the New Zealand government acted early and decisively to prevent the spread of covid-19 from New Zealand to islands in the Pacific, with the Prime Minister citing New Zealand's responsibilities as a "gateway to the Pacific" (Wade, 2020).

Pandemic responses guided by memory also appear to have occurred independently of government in New Zealand. In contrast to Australia, New Zealand does not have a federal system and has no internal borders to close. However, in New Zealand's Northland region some communities operated local roadblocks to protect their boundaries. While the involvement of prominent Māori politician and activist Hone Harawira lends some credence to suggestions the roadblocks marked an assertion of Māori sovereignty, those operating them cited the severe impact of the 1918-1920 pandemic on Māori communities (Vulnerable Far North community battens down the hatches to ward off coronavirus, 2020; Covid-19 coronavirus: Far North blockade will go ahead, Harawira pledges, 2020). In 1918, Northland Māori had suffered severe mortality from influenza. Collective memory, bolstered by graves and private

monuments, prompted Māori communities in the far north to act to isolate themselves, even before a government-mandated nation-wide lockdown came into effect.

In Australia, Tasmania took advantage of the quarantine potential of being an island, and on 20 March became the first state to close its borders in response to covid-19 (Tasmania to enforce 'toughest border measures in the country' amid coronavirus pandemic, 2020). Some other states quickly followed—South Australia, (Marshall, S., & Wade, S., 2020) the Northern Territory (Roberts, 2020), and Western Australia all closed their borders on 24 March (with a hard border to Western Australia coming into effect on 5 April) (Shepherd, 2020; Hamlyn & Manfield, 2020). Queensland shut its border one day later, on 25 March (Cansdale & staff, 2020). Other than Tasmania, those states that closed their borders are home to remote Aboriginal communities, (National Indigenous Australians Agency, 2016) and restrictions on internal travel within the Northern Territory acknowledged that those communities were particularly at risk from the new disease. In the Northern Territory, the Northern Land Council and Central Land Council (representing traditional landowners) have spoken in support of travel restrictions, as have Anangu Pitjantjatjara Yankunytjatjara traditional owners in South Australia (Hanifie, 2020; Gibson, 2020). However, the discourse around these closures is of recognition of the health challenges those communities face in the present, rather than memory of the heavy toll of the 1918-1920 pandemic that disproportionately killed Aboriginal people. The Federal government's *Pandemic Influenza Plan* refers only to the closure of the Australian national border, not to the ability to close the borders between Australian states, and border closure decisions reflect state concerns. Thus, it was not until 6 July 2020 that New South Wales closed its border with Victoria, severing free movement between Australia's two most populous states for the first time since 1919 (Kaye & Pandey, 2020).

8. Conclusion

While every epidemic is unique, the threat of large-scale morbidity makes them alike in many ways to those living through them. Covid-19 is a novel coronavirus, not a form of influenza, but the public health measures taken to contain it have made it seem, in Australia and New Zealand at least, as though a door has opened between 1919 and 2020. Similar government regulations have been put in place, similar attempts are being made to contain and manage a new disease, the impact on public health systems is of concern, and fears about the impact of the pandemic on the lives of loved ones are familiar. In Australia, there have also been familiar tensions between state and federal governments as the two levels of government seek to engage with their constitutional responsibilities.

The similarities that exist between human experiences of different pandemics make historical precedents significant in planning responses to the present and future. The 1918-1920 influenza pandemic, with its infectiousness and mortality rate, has emerged as an aid in understanding covid-19 and the disease's likely impact on society. Government pandemic plans and articles in medical journals indicate that a higher level of historical awareness has been cultivated in New Zealand than in Australia. In the current crisis, the New Zealand government acted more swiftly and decisively than the Australian federal or state governments. While it would be tempting to suggest that the work of Rice in maintaining collective memory of the 1918-1920 influenza pandemic was an element in this outcome, that cannot be definitively established. However, covid-19 is unlikely to be last pandemic of the twenty-first century, and Australian historians have work to do to ensure the pandemic of 2020 does not join that of 1918-1920 in collective oblivion. Maintaining the collective memory of pandemics will be important when responding to future crises. And collective memory may mobilize groups that have historically suffered more heavily than the general population from pandemic disease, preventing history from repeating itself.

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