Submission No: 021

Submission to Health and Community Services Committee Parliament of Queensland

Re: Public Health (Childcare Vaccination) and Other Legislation Amendment Bill 2015

Australian Vaccination-skeptics Network Incorporated

26th August 2015

avn.org.au
building responsibility into vaccination

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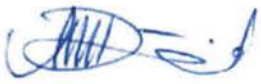

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26th August 2015

On behalf of the committee and the members of
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The Australian Vaccination-skeptics Network Inc. (AVN) welcomes the opportunity to make a submission in relation to this Bill, and in the event public hearings about the Bill are conducted, request that two nominated representatives of AVN be invited to appear as witnesses.

We note that an almost identical Bill was the subject of an extensive, and presumably costly parliamentary committee inquiry only two years ago, and as such, are extremely disappointed to see further taxpayers' funds being expended in pursuit of a sinister agenda to introduce an effective vaccination mandate for access to child care services in Queensland.

We acknowledge there is bipartisan support for vaccination but there is sufficient evidence that retaining freedom of choice represents the best public policy. Pro-vaccination and pro-choice positions are not mutually exclusive goals; both positions can be accommodated.

1.0 Scope

Our submission pertains only to those sections of the Bill which seek to amend the Public Health Act 2005, and not those which seek to amend the Health Ombudsman Act 2013. We have also stated our position on the government's intention to amend the Public Health Regulations.

2.0 Position Statement

We are opposed to the Bill. An immunisation requirement is unnecessary and unjustified to protect the public health.

We are also opposed to any amendments to the Public Health Regulations if the amendments will give effect to the exclusion of unvaccinated case contacts above and beyond current practice guidelines.

3.0 Recommendations

1) The committee should oppose the enactment of an immunisation requirement.

2) In the event the committee takes the decision to support the Bill's immunisation requirement, and in accordance with Recommendation 2 of the 2013 parliamentary committee which considered a similar Bill, we propose that any immunisation requirement provide for exemptions for conscientious objection on philosophical or religious grounds.

   (Report No. 29 Health and Community Services Committee September 2013, p. 2)
   http://rti.cabinet.qld.gov.au/documents/2014/feb/pmb%20unvaccinated%20children/Attachments/Committee%20Report.pdf

3) Further, we propose that a signed statement from a child's parents or legal guardians to the effect they have a conscientious objection to immunisation on philosophical or religious grounds should be sufficient to satisfy any immunisation requirement due to the difficulties in obtaining a signed objection form from a doctor.

4) Amendments to the Public Health Regulations should be consistent with current practice guidelines and should not provide for the mandatory exclusion of unvaccinated case contacts in the event of outbreaks of vaccine-preventable disease in excess of current practice.

   (2014, Time Out, Department of Health Queensland)
   https://www.health.qld.gov.au/ph/documents/cdb/timeout_poster.pdf

4.0 About AVN

AVN is a not-for-profit, incorporated association, founded in 1994 in New South Wales by a group of parents and health professionals who were concerned about the quality of scientific evidence purporting to support the effectiveness and safety of vaccination as a means to achieving good health and/or preventing disease.

AVN believes good health is vital for a functioning society. A healthy society translates directly into a happier, more peaceful social group. Australia is made up of many diverse groups – groups who follow different religions, speak different languages and those who raise their family in more liberal environments – and we as Australians are accepting of these behaviours. This tolerance is based on respect for the individual. In Australia people call it giving people a fair go.

However, AVN believes it is not giving people a fair go if they are ordered by higher powers to change their beliefs in the way they raise their family. It is not giving people a fair go if they are being coerced into following, what amounts to, a mandatory vaccination program under the threat of financial penalty.

AVN is campaigning for social health programs to be more transparent. We want government, pharmaceutical companies and the medical industry to show honesty in informing people about all aspects of vaccination, good and bad, and to support all individuals in their choice.

5.0 Vaccination – the scientific controversy

Former Senator, Australian Greens leader, and GP, Bob Brown stated in the Senate in 1997, *"there is very much contradictory evidence and debate, even in scientific and medical circles, about vaccination."*

(1997, Hansard, p. 8725)

http://www.aph.gov.au/binaries/hansard/senate/dailys/ds111197.pdf

5.1 Vaccines did not save us from high rates of death from infectious disease

The claim that mass vaccination was responsible for the decline in deaths from infectious disease in the 20th century, is disputed and runs contrary to the best available evidence.

> *"Vaccines are popularly thought to have saved more lives than any other intervention in human history other than clean water. They are frequently credited with conveying us from the days when children died in large numbers from infectious disease to the present day where such deaths are rare. Indeed it is this image that forms the fundamental marketing slogan for vaccination.*
>
> *An examination of the publicly available data, however, suggests these claims are lacking in evidence. The attached graphs (Appendices 1-4) provide pictorial representations of the limited role vaccines played in the reduction of deaths from infectious disease in Australia. It should be immediately obvious that if a role was played in the transition, it was small in comparison to other factors.*
>
> *The vast majority of the decline in infectious disease, for which vaccination is typically given credit by its promoters, occurred before the vaccines were even available. The real heroes of our past were those who brought about improvements in nutrition, sanitation, housing, education and the many other areas which have long been considered the primary determinants of health. It was through these efforts that our communities were forged into the robust and safe living environments they are today.*
>
> *The scenario represented in the graphs was identical to that found throughout the developed countries of the world."*

(Beattie, 2013, Submission to the Health and Community Services Committee Queensland Parliament, p.2)

https://www.parliament.qld.gov.au/documents/committees/HCSC/2013/PHunvaccinatedchildren/submissions/061.pdf

5.2 The alleged eradication of Smallpox and near-eradication of Poliomyelitis was achieved through improvements in living standards and diagnostic substitution

There is much evidence to suggest that the alleged eradication/near eradication of Smallpox and Poliomyelitis was achieved, not by vaccines, but rather, by changes to living standards, food standards such as pasteurisation, sanitation, and, just as importantly, diagnostic substitution via a shift from clinical to laboratory-based diagnosis.

5.2.1 Smallpox

"Smallpox vaccine was in use in England during the 19th and 20th centuries. During this time the illness declined in parallel with all other infectious illnesses, as can be seen from the attached graphs (Appendices 5-6). This was the period when industrialised communities were being built, as described above, and infectious illness deaths were declining across the board. The extent to which vaccination may have assisted this decline, if indeed it did, is impossible to ascertain."

(Beattie, 2013 ibid. p. 2-3)

It's not unreasonable to believe that Smallpox still afflicts human beings today. Smallpox, as a clinical entity, is still very much with us, but bearing alternative diagnostic labels such as Monkeypox and Chickenpox.

Prior to the declaration by the World Health Assembly that Smallpox had been eradicated, Monkeypox, a clinically identical disease to Smallpox, was first identified in humans.

(World Health Organization, 2011, Monkeypox)

"The differential diagnoses include usually smallpox, chickenpox, measles, bacterial skin infections, scabies, medicamentous allergies and syphilis. Monkeypox can only be diagnosed definitively in the laboratory where the infection can be diagnosed by a number of different tests"

http://www.who.int/mediacentre/factsheets/fs161/en/

The results of a Monkeypox study were reported in the science media during 2010. It was claimed that Monkeypox is not a rare disease, and in some parts of Africa, is commonplace. The study found that between 2006 and 2007, in regions of the Democratic Republic of Congo (DRC) where the virus is known to circulate, there were 760 active cases (approximately 14 per 10,000 people) of Monkeypox.

(Scientific American, 2010, Pox Swap: 30 Years After the End of Smallpox, Monkeypox Cases Are on the Rise)

http://www.scientificamerican.com/article/pox-swap-30-years-after-small-pox-monkey-pox-on-the-rise/

It is the existence of such clinically identical disease forms as Monkeypox which informs, in part, the scientific controversy surrounding the questionable eradication of Smallpox. A more detailed account of the Smallpox controversy is provided by medical researcher and specialist, Dr Suzanne Humphries. We encourage committee members to access the Smallpox sub-section as an entry point to the controversy.

(Humphries, 2012, "Herd Immunity." The flawed science and failures of mass vaccination)

http://www.vaccinationcouncil.org/2012/07/05/herd-immunity-the-flawed-science-and-failures-of-mass-vaccination-suzanne-humphries-md-3/

5.2.2 Poliomyelitis

What has been described as Poliomyelitis, is, in reality, a family of paralytic diseases of various names of similar or identical clinical presentation, many of which were classified as Polio in the pre-vaccine era when diagnosis was usually made on clinical signs only, and which are still commonly diagnosed in Australians today.

(Marks et al, 2000, Differential Diagnosis of Acute Flaccid Paralysis and Its Role in Poliomyelitis Surveillance)

http://epirev.oxfordjournals.org/content/22/2/298.full.pdf

Following the rollout of mass Polio vaccination in the 1950s, diagnostic criteria were immediately narrowed to more restrictive clinical indicators, and to require laboratory identification of one of the Polio viruses.

> *"This change meant that one could have expected to see a massive decline in case numbers whether there was a vaccine or not. The major element of the change was that we now require detection of the polio virus at a special polio reference laboratory before a case may be recorded as polio."*

(Beattie, 2013, ibid. P 3)

Acute Flaccid Paralysis (AFP) is an umbrella term given to many conditions which includes Poliomyelitis. AFP is still a notifiable condition in Australia, and outbreaks of paralysis continue to be identified in Australia under various labels including Enterovirus 71 (EV71), Enterovirus 68 (EV68), Guillain Barre Syndrome, and even Polio-like illness when a virus cannot be identified!

(The Age, 2013, Five children hit by polio-like paralysis)

http://www.theage.com.au/victoria/five-children-hit-by-poliolike-paralysis-20130601-2nipr.html

The following report details six cases of AFP in Western Australia, four of which were alleged to have been caused by EV71, the same virus alleged to be one of the causes of the now common, but historically rare Hand, Foot and Mouth Disease These cases were identified in a short time frame in Western Australia during 1999 and in three of the cases required ventilation with the modern equivalent of an iron lung.

(Communicable Diseases Intelligence Volume 23, 1999, Enterovirus 71 outbreak in Western Australia associated with acute flaccid paralysis: Preliminary report)

http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-pubs-cdi-1999-cdi2307-cdi2307e.htm

While India was recently declared Polio-free, it has become apparent that at the same time as Polio was alleged to be disappearing through vaccination programmes, there was a dramatic, parallel increase in Non-Polio Acute Flaccid Paralysis (NPAFP). This provides a more contemporary example of the type of diagnostic substitution which has been taking place since the advent of mass vaccination.

> *"Although the incidence of polio acute flaccid paralysis (AFP) has decreased in India, the nonpolio AFP (NPAFP) rate has increased. Nationwide, the NPAFP rate is 11.82 per 100 000 population, whereas the expected rate is 1 to 2 per 100 000 population. We examined the correlates of NPAFP to discern explanations for the increase. The incidence of polio AFP in India has decreased. However, the nonpolio AFP rate has increased since 2000. Follow-up of these cases of nonpolio AFP is not done routinely. However, one-fifth of these cases of nonpolio AFP in the state of Uttar Pradesh (UP) were followed up after 60 days in 2005; 35.2% of patients were found to have residual paralysis, and 8.5% had died. This suggests that the pathology in children being registered as having nonpolio AFP cannot be considered trivial. Therefore, there is a compelling reason to try to determine the underlying causes for the surge in nonpolio paralysis numbers."*

(Vashisht et al, 2015, Paediatrics, Trends in Nonpolio Acute Flaccid Paralysis Incidence in India 2000 to 2013)

http://pediatrics.aappublications.org/content/135/Supplement_1/S16.2.full

> *"In short, polio – the microbe – appears to be undergoing eradication. Polio – the illness – on the other hand, appears to be unaffected."*

(Beattie, 2013, ibid. p 3)

Similar questions about diagnostic substitution arise in relation to scientific claims about other so-called vaccine-preventable diseases such as Measles, but in the interests of brevity have not been included. Indeed, the submission would run to volumes if all matters relevant to the controversy were included.

5.3 Vaccine-Autism Controversy – vaccines can and have caused Autism

While there have been some published epidemiological studies purporting to show that vaccines are not a cause of Autism, all of them employ critically flawed statistical methods, and in most cases compare a population of children who have received 'x' number of vaccines, with one that has received 'y' number of vaccines. In these types of studies, the group which received only one less vaccine than the other group is deceptively described as unvaccinated. There have been no studies conducted to date which compare the rates of Autism, other disabilities and diseases in the completely unvaccinated with rates in the fully vaccinated.

The US Vaccine Injury Compensation Program (VICP) has been compensating cases of Autism since its inception in 1986. A preliminary study published in 2011, found 83 compensated cases of Autism under the alternative diagnostic labels of encephalopathy or residual seizure disorder. In other words, compensation was awarded for vaccine-related brain injury which lead to Autism.

(Holland et al., 2011, Unanswered Questions from the Vaccine Injury Compensation Program: A Review of Compensated Cases of Vaccine-Induced Brain Injury, Pace Environmental Law Review, p 3)

http://digitalcommons.pace.edu/cgi/viewcontent.cgi?article=1681&context=pelr

This study only represents the tip of the iceberg too – it isn't a question of if vaccines are one of the causes of Autism – that question has been answered in the positive. Rather, it's a question of how many cases of Autism have been caused by vaccines.

These articles report on other compensated Autism cases, and there have been others.

(Kirby, 2013, Vaccine Court Awards Millions to Two Children With Autism, Huffington Post)

http://www.huffingtonpost.com/david-kirby/post2468343_b_2468343.html

(Attkisson, 2010, Family to Receive $1.5 m in First Ever Vaccine-Autism Court Award, CBS News)

http://www.cbsnews.com/news/family-to-receive-15m-plus-in-first-ever-vaccine-autism-court-award/

5.4 Vaccination is at best, a zero-sum game, and does not reduce the net burden of infectious disease

Vaccination does not reduce the overall burden of infectious disease. Certainly, the overall hospitalisation rate of children arising from all-cause infectious diseases is still high. It would seem to us that those efforts to lower the death and hospitalisation rate from a single disease never results in an overall reduction in deaths or hospitalisation from all-cause infectious diseases. For example, is it any reason to celebrate a decline in hospitalisations from a so-called vaccine-preventable respiratory illness, if overall hospitalisations for all-cause respiratory illnesses are not reduced? We don't believe so, but this would seem to the approach favoured by public health experts. As soon as one disease is allegedly reduced there is an equally dangerous "emerging" disease to replace it, which inevitably requires yet another vaccine. We see this time and time again.

Respiratory Syncytial Virus (RSV) is a case in point, the latest in a long line of projected vaccine targets, and which is reported to cause significant numbers of hospitalisations of children in Australia each year.

(Drug Discovery and Development, 2015, Vaccine for Common Childhood Infection May Finally be Possible)

http://www.dddmag.com/news/2015/08/vaccine-common-childhood-infection-may-finally-be-possible

Do we really need to state the obvious that the taxpayer cannot continue to fund endless numbers of vaccines if the only result is that the infectious disease burden just shifts to another pathogen and never, ever results in overall savings from reduced hospitalisations due to an overall decrease in infectious diseases.

5.5 Vaccines have not reduced the overall burden of disability and chronic disease and have possibly contributed to its increase

Contrary to claims by proponents of vaccines – claims which have been ingrained in the public psyche over many decades – vaccines haven't lead to a decreased burden of disability in Australia. We acknowledge the existence of a public health emergency but that emergency doesn't reside in vaccination rates, but rather, in the disastrous levels of chronic disease and disability in the Australian population.

According to the ABS, as at 2012, approx 2.2 million people between the ages 15-64 have a disability with approx 25% of those having profound disability and 47% a moderate to mild disability. These figures don't even include a significant percentage of the population suffering from a chronic disease.

(ABS, 2012, Disability and Labour Force Participation)

http://www.abs.gov.au/ausstats/abs@.nsf/mf/4433.0.55.006

These statistics are alarming and cannot be explained by reference to the aging population or an increase in rates of Type 2 Diabetes, both of which are popular excuses to dismiss our high rates of disability. Surely people under 65 could not be said to be aged.

According to the National Commission of Audit (NCA), the National Disability Insurance Scheme (NDIS) will cost $22 billion per annum when fully rolled out in 2019/20. Eligibility for the NDIS is restricted to the young (15-64) so is not a function of an aging population, and that $22 billion doesn't even include income support payments such as the Disability Support Pension.

http://www.ncoa.gov.au/report/phase-one/part-b/7-2-the-national-disability-insurance-scheme.html

Of similar concern is the increasing rates of chronic disease and disability in children. The following conditions have recently been reported to be increasing in children.

- Allergy requiring hospitalisation
- Eczema requiring hospitalisation
- Multiple Sclerosis in Children
- Type 1 Diabetes
- Juvenile Arthritis
- Childhood Cancer

See following page for recommended links relevant to each of these conditions.

The following links, relevant to each of the six conditions, provide evidence of increasing rates of chronic disease and disability in children.

Allergy requiring hospitalisation

http://www.abc.net.au/news/2015-07-15/number-of-children-hospitalised-with-food-allergies-on-the-rise/6619752

Eczema requiring hospitalisation

http://www.abc.net.au/news/2011-09-07/eczema-on-the-rise-in-australia/2874462

Multiple Sclerosis in Children

http://www.msra.org.au/understanding-early-brain-inflammation-children-who-develop-multiple-sclerosis

Type 1 Diabetes

http://www.adelaide.edu.au/news/news74624.html

Juvenile Arthritis

http://www.hica.com.au/health-insurance-news/hospitalisation-rates-for-juvenile-arthritis-are-increasing-aihw-report

Childhood Cancer

http://www.nature.com/bjc/journal/v102/n3/fig_tab/6605503f1.html

5.6 Vaccines provide a plausible explanation for Australia's high rates of immune system mediated diseases

A 2013 report outlined some damning truths about the high level of immune system dysfunction in the Australian population.

1) Allergy and immune diseases (immunodeficiency and autoimmune diseases) are among the fastest growing chronic conditions in Australia.
2) Almost 20% of the Australian population has an allergic disease and this prevalence is increasing.
3) Hospital admissions for anaphylaxis (severe life threatening allergic reaction) have increased 4 fold in the last 20 years.
4) Food-induced anaphylaxis has doubled in the last 10 years and 10% of infants now have an immediate food allergy.
5) Immunodeficiency diseases are serious, potentially life threatening conditions that are increasing in number and complexity.
6) Autoimmune diseases affect 5% of Australians and are more common than cancer or heart disease.

(Allergy and Immune Diseases in Australia (ADIA) Report 2013, Australasian Society of Clinical Immunology and Allergy Inc., p 2)

http://www.allergy.org.au/images/stories/reports/ASCIA_AIDA_Report_2013.pdf

We are of the informed view that the dramatically expanding immunisation schedule provides a scientifically plausible explanation for the widespread, and increasing incidence of immune system dysfunction in the population. Increases of this magnitude cannot be explained by genetics and immunisation stimulates the immune system in an abnormal way.

A recent published review echoes our concerns in relation to autoimmune conditions. It states:

> *"vaccines are able to elicit the immune system towards an autoimmune reaction, and "there is evidence of vaccine-induced autoimmunity and adjuvant-induced autoimmunity in both experimental models as well as human patients".*

(Guimaraes et al., 2015, Vaccines, adjuvants and autoimmunity, Pharmacological Research)

http://www.sciencedirect.com/science/article/pii/S1043661815001711

The relative contribution vaccines make to immune system mediated chronic disease is potentially medical science's dirtiest and best-kept secret and should not be permitted to continue. We would welcome the opportunity for an AVN representative to brief the committee further about our extensive research findings in this area, which has been conducted over many years.

5.7 Conflicts of Interest are ubiquitous in Medical Science and don't always involve money

Financial conflicts of interest are common in medical science, so the general public should have every right to remain sceptical of recommendations of experts.

> *"Conflicts of interest in medical research are extremely common – one recent study† found that 52% of the experts involved in developing clinical practice guidelines for the management of diabetes in the United States and Canada had a financial conflict of interest."*

Conflicts of interest don't always involve money. It has been suggested that intellectual conflicts of interest are almost ubiquitous and often overlooked as a source of bias.

> *"According to Gordon Guyatt, a Professor in the Faculty of Medicine at McMaster University, 'intellectual conflicts of interest are completely ubiquitous' and have generally been ignored.*
>
> *Intellectual conflicts occur when clinicians or researchers may be too deeply embedded in their own area of expertise to objectively look at a research question "with an open mind". Guyatt argues that 'even when money is not involved … we [scientists] get very attached to our ideas.' This is compounded by university culture, which rewards researchers if their work is highly referenced by others and is perceived to be influential. This environment creates an incentive for those participating in guideline development to highlight their own research in clinical practice guidelines."*

(Laupacis & Born, 2012, Conflicts of interest don't always involve money, KevinMD)

http://www.kevinmd.com/blog/2012/02/conflicts-interest-involve-money.html

† *Barbiturates and fractures.*
The BMJ (formerly the British Medical Journal)
http://www.bmj.com/content/2/6087/640.1

6.0 Whooping Cough (Pertussis) – conscientious objectors are not to blame for outbreaks

Australia is in the grip of an unprecedented, fear-based media campaign to mislead and convince an unwitting general public of the dire risk conscientious objectors to immunisation pose to the public health, particularly in relation to Whooping Cough. As a result, we felt obliged to address the issue separately here. Some segments (not all) of the medical and scientific community have been complicit in this fear-mongering, by failing to correct blatant falsehoods perpetuated by tabloid journalists and shock-jocks, as well as actively propagating misinformation themselves.

For example, following the well-publicised of death of Riley Hughes from Whooping Cough earlier this year, Dr Bridie O'Donnell, who was described as a medical expert in an interview on 'The Project', claimed that if everyone had been vaccinated that he would still be alive. This is a blatant lie.

(2015, Whooping cough boosters needed for adults, Blake)

https://www.youtube.com/watch?v=GTUTvkY9T-s

Riley Hughes was too young to be vaccinated, and it has been reported that his mother was vaccinated only three years prior and that close family contacts were also up-to-date with boosters. If the vaccine his mother received three years ago had been effective, then some level of passive immunity should have been conferred via trans-placental transfer. Clearly this was not the case.

6.1 Death rate for Whooping Cough is low and stable

While the death of any baby is regrettable, the number of deaths from Whooping Cough is stable and this is unlikely to change while the current vaccine is used. It is offensive in the extreme to promote a conclusion that conscientious objectors are to blame for Whooping Cough deaths.

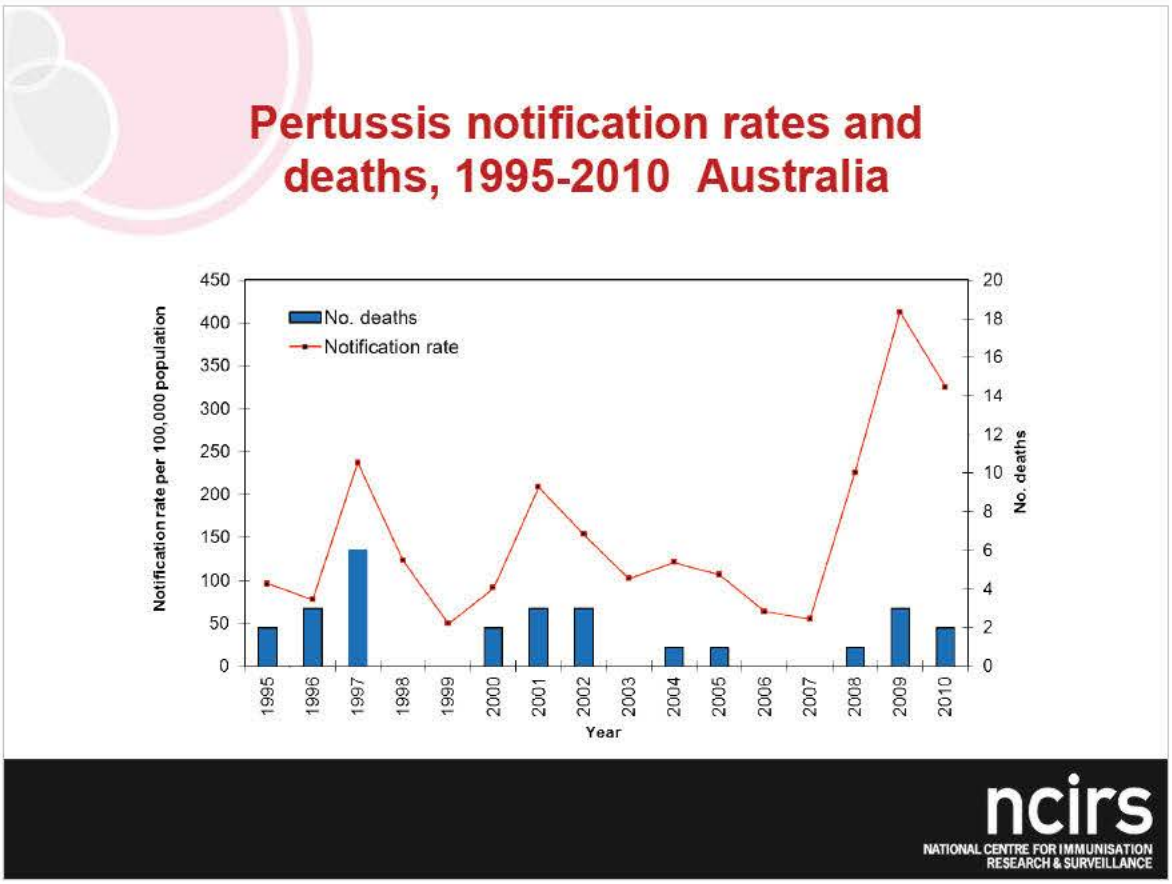
Professor Peter McIntyre stated this exact view back in 2012.

> *"What's certain is that whooping cough will not go away and, tragically, deaths in very young babies will still occur without better ways to protect them before they themselves can be protected by immunization."*

(McIntyre, 2012, Does whooping cough vaccine for parents protect newborns (and who should pay for it)?, The Conversation)

https://theconversation.com/does-whooping-cough-vaccine-for-parents-protect-newborns-and-who-should-pay-for-it-6980

The following graph details deaths from Whooping Cough in Australia between 1995 and 2010.



http://www.ncirs.edu.au/news/past-news-events/Day%201/McIntyre-Is-Australia-world-capital-PertussisWS-25_26Aug11.pdf

Death rates were stable between 1995 and 2010, yet immunisation rates increased significantly in the same period, lending weight to the argument that increasing immunisation rates against Whooping Cough will not reduce the small number of deaths from the disease.

Between 2006 and 2012 there were 11 deaths from Whooping Cough, 10 of whom were too young to be immunised, and between 2009 and 2015, 12 babies have died from Whooping Cough. This equates to 2 deaths per year, the same number as in 1995.

(Pertussis Vaccines for Australian: Information for Immunisation Providers, 2015, NCIRS)

http://www.ncirs.edu.au/immunisation/fact-sheets/pertussis-fact-sheet.pdf

6.2 Whooping Cough is not a vaccine-preventable disease

Whooping Cough is a toxin mediated disease, endemic to Australia, with cyclical epidemics, and contrary to popular claims, this hasn't changed in the 60 years that the vaccine has been used in mass immunisation programmes. Despite the claims of the medical and scientific communities that the earlier whole-cell Pertussis vaccine was more effective than the one used today, there have always been outbreaks of Whooping Cough in highly vaccinated populations and speculation about a resurgence of the disease.

(Christie et al, The 1993 epidemic of pertussis in Cincinnati. Resurgence of disease in a highly immunized population of children, New England Journal of Medicine)

http://www.ncbi.nlm.nih.gov/pubmed/8202096

As can be seen in the table on the following four pages, there have been many revisions to scheduled boosters over the years. For example, in 1985, when the earlier vaccine was used, a booster was added to the schedule for 18mth olds in response to increased outbreaks in fully vaccinated 4-5 year olds. It would seem some things never change.

(NCIRS, 2015, Significant events in diphtheria, tetanus and pertussis vaccination practice in Australia)

The table on the following four pages can also be referenced using this hyperlink:

http://ncirs.edu.au/immunisation/history/Diphtheria-tetanus-pertussis-history-July-2015.pdf

Significant events in diphtheria, tetanus and pertussis vaccination practice in Australia

Year	Month	Intervention
1892		Antitoxin first used to treat diphtheria
1920		CSL began manufacturing diphtheria and tetanus antitoxins (for treatment of cases) and whole-cell pertussis vaccine Limited use of pertussis vaccine
1921–1928		Limited introduction of diphtheria toxin–antitoxin vaccine
1929		Diphtheria toxoid vaccine introduced for vaccinating case contacts
1932		School-based diphtheria vaccination programs commenced
1939		Tetanus toxoid vaccine introduced – used mainly to vaccinate the Armed Forces
1940		D phtheria vaccination programs introduced for infants at welfare centres
1942		Pertussis vaccination programs started in most states/territories using whole-cell pertussis vaccine (Pw)
1953		Diphtheria-tetanus-whole-cell pertussis vaccine (DTPw) introduced Infant-based schedule involving 3 doses of DTPw vaccine introduced (in addition to school-based programs); schedule varied by state/territory
1975		First national vacc nation schedule recommended and funded 3 DTPw doses for infants at 3, 4 and 5 months of age 4th dose of DTPw recommended and fu ded for infants aged 15–18 months Booster doses with combined diphtheria-tetanus (DT) vaccine recommended and funded for 5–6 year olds or prior to school entry Booster doses of tetanus toxoid recommended every 5 years
1978		4th dose of DTPw removed from schedule
1982		National schedule changed to DTPw at 2, 4 and 6 months of age, with DT at 18 months of age and at 5–6-years of age or prior to school entry A booster dose of adult diphtheria-tetanus vaccine (dT) recommended at age 15 years or prior to leaving school Booster doses of tetanus toxoid recommended every 10 years
1984		Use of dT in place of tetanus toxoid recommended for adult booster vaccinations at 10-year intervals Alumi ium adjuvant added to DTPw vacci e to improve potency
⋆ 1985		4th dose of DTPw re-introduced and funded at 18 months of age due to an increased number of pertussis cases in 4–5-year olds
1991		3 doses of monovalent pertussis vaccine recommended for children aged <4 years who had rece ved primary immunisation with DT
1994	July	5th dose of DTPw at 4–5 years of age recommended and funded on the vaccination schedule (replacing DT) dT school vaccination programs commenced in some states for 15–19 year olds
1996		First diphtheria-tetanus-acellular pertussis (DTPa) vaccine registered for primary immunisation in infants aged 2–12 months and as a booster in children aged 15 months–6 years

 Last updated July 2015

(NCIRS, 2015, Significant events in diphtheria, tetanus and pertussis vaccination practice in Australia)
http://ncirs.edu.au/immunisation/history/Diphtheria-tetanus-pertussis-history-July-2015.pdf

⋆ In 1985, when the earlier vaccine was used, a booster was added to the schedule for 18mth olds in response to increased outbreaks in fully vaccinated 4-5 year olds. It would seem some things never change.

Year	Month	Intervention
1997	February	DTPa recommended for 4th and 5th doses of DTP vaccination at 18 months and 4–5 years of age
	February	Monovalent pertussis vaccine no longer available
	August	DTPa funded for all 5 childhood DTP doses in NT and SA
	September	DTPa nationally funded for 4th and 5th doses of DTP vaccination at 18 months and 4–5 years of age (QLD did not commence funding until December)
1998	April	Second diphtheria-tetanus-acellular pertussis (DTPa) vaccine registered for primary immunisation in infants aged 2–12 months and as a booster in children aged 15 months–8 years
1999	February	DTPa nationally recommended and funded for all 5 childhood DTP doses (QLD did not commence funding until April)
	February	Combined DTPa-hepB vaccine registered for primary immunisation and as a booster in children
2000	March	2nd booster dose of DTPa scheduled at 4 years of age instead of 4–5 years
	March	A single dT booster dose recommended at 50 years of age (unless a dT dose has been documented within the last 10 years), replacing the recommendation for dT booster doses every 10 years
	March	DTPa-hepB vaccine used at 2, 4 and 6 months of age (in ACT, NSW, NT, QLD and SA)
	June	First adult/adolescent formulation dTpa (reduced antigen content) vaccine registered for use in individuals aged ≥10 years
2001	April	Combined DTPa-hepB-IPV and DTPa-hepB-IPV-Hib vaccines registered for primary immunisation in infants aged ≥6 weeks and as a booster in children aged 18 months
2002	April	First combined DTPa-IPV vaccine registered for primary immunisation in infants aged ≥6 weeks and as a booster in children aged 15 months–6 years
	August	Second combined DTPa-IPV vaccine registered for primary immunisation in infants aged 2–12 months and as a booster in children aged 15 months–6 years
	October	Combined DTPa-IPV-Hib vaccine registered for primary immunisation in infants aged 2–12 months and as a booster in children aged 15–20 months
2003	September	Booster dose of DTPa at 18 months of age removed from schedule
	September	Adolescent dTpa booster recommended at 15–17 years of age, replacing dT
	September	Single dose of dTpa recommended for healthcare workers and infant close contacts
2004	January	dTpa funded for adolescents; the eligible age group varied in different jurisdictions
	June	First combined dTpa-IPV vaccine registered for use in individuals aged ≥4 years
2005	October	Second dTpa vaccine registered for use in individuals aged ≥10 years
	November	Combined DTPa vaccines funded for use at 2 4 and 6 months of age Combined DTPa-hepB-IPV Hib vaccine used in ACT, NSW, TAS and WA (for non-Indigenous children); DTPa-IPV vaccine used in other jurisdictions and in Aboriginal and Torres Strait Is ander infants in WA
	November	DTPa-IPV funded for use as a booster in children aged 4 years
2006	March	Second combined dTpa-IPV vaccine registered for use in individuals aged ≥4 years
2008	March	Combined DTPa-hepB-IPV Hib vaccine used in QLD, SA and VIC
	October	dTpa funded by NT for mothers of newborn infants under cocoon strategy

Last updated July 2015

(NCIRS, 2015, Significant events in diphtheria, tetanus and pertussis vaccination practice in Australia)

http://ncirs.edu.au/immunisation/history/Diphtheria-tetanus-pertussis-history-July-2015.pdf

Year	Month	Intervention
2009	February	Combined DTPa-hepB-IPV-Hib vaccine used in Aboriginal and Torres Strait Islander infants in WA
	March	dTpa funded by NSW for parents, grandparents and carers of infants aged <12 months under cocoon strategy
	March	Advice provided in NSW that 1st dose of DTPa-hepB-IPV-Hib vaccine could be given as early as 6 weeks of age
	April	dTpa funded by ACT for parents and grandparents of infants aged <12 months under cocoon strategy
	May	dTpa funded by NT for parents and carers of infants aged <7 months living in the same household under cocoon strategy
	June	dTpa funded by VIC for parents of infants aged <6 months under cocoon strategy
	June	Adolescent booster dose of dTpa scheduled at 11 years instead of 15–17 years of age
	August	dTpa funded by QLD for parents of infants aged <6 months under cocoon strategy
	October	Pre-school booster dose of DTPa-IPV scheduled at 3.5–4 years instead of 4 years of age
	October	Combined DTPa-hepB-IPV-Hib vaccine used in NT
2010	March	dTpa funded by TAS for parents and grandparents of infants aged <6 months under cocoon strategy
	June	TAS ceased funding of dTpa under cocoon strategy
	October	dTpa funded by SA for parents and grandparents of infants aged <6 months, who hold a health care or pensioner concession card under cocoon strategy
	December	SA ceased funding of dTpa under cocoon strategy
2011	January	dTpa funded by WA for parents, grandparents and carers of infants aged <7 months under cocoon strategy
	February	Recommendation nationally that 1st dose of DTPa-hepB-IPV-Hib vaccine could be given as early as 6 weeks of age
	March	dTpa funded by QLD for parents and carers of infants aged <6 months under cocoon strategy
	December	ACT ceased funding of dTpa under cocoon strategy
2012	June	QLD and VIC ceased funding of dTpa under cocoon strategy
	July	dTpa funding by NSW restricted to new mothers in maternity units (or GP within 2 weeks of giving birth) under cocoon strategy
	December	WA ceased funding of dTpa under cocoon strategy
2013	March	A dose of dTpa recommended for adults aged ≥65 years, if 10 years or more since the last dose
	March	A single dT booster dose recommended for overseas travellers if 10 years or more since the last dose (5 years or more if travel is high risk) (dTpa recommended if not previously received)
	March	A booster dose of dTpa recommended for healthcare workers and infant close contacts if 10 years or more since the last dose
	March	dTpa recommended for women, either during pre pregnancy planning, during the third trimester or as soon as possible after delivery (preferably before hospital discharge). A booster dose of dTpa recommended if 5 years or more between a previous dose and the expected delivery date for a subsequent pregnancy.

Last updated July 2015

(NCIRS, 2015, Significant events in diphtheria, tetanus and pertussis vaccination practice in Australia)

http://ncirs.edu.au/immunisation/history/Diphtheria-tetanus-pertussis-history-July-2015.pdf

Year	Month	Intervention
2013 cont'd	July	dTpa funding by NSW restricted to new mothers in maternity units of public hospitals only under cocoon strategy
	September	dTpa funded by NT for women during the third trimester of pregnancy and for parents until the infant is 7 months of age
2014	July	dTpa funded by QLD for women during the third trimester of pregnancy
	September	Second combined DTPa-hepB IPV-Hib vaccine registered for use in infants aged ≥6 weeks
2015	March	Booster dose of DTPa recommended at 18 months of age
	March	dTpa recommended for women as a single dose during the third trimester of each pregnancy (or as soon as possible post partum for any pregnancy where antenatal vaccination does not occur)
	March	dTpa funded by NSW, SA and WA for women during the third trimester of pregnancy
	April	dTpa funded by ACT for women during the third trimester of pregnancy
	June	dTpa funded by VIC for women during the third trimester of pregnancy and for parents until the infant is 6 months of age
	June	dTpa funded by TAS fo women during the third trimeste of pregnancy

Last updated July 2015

(NCIRS, 2015, Significant events in diphtheria, tetanus and pertussis vaccination practice in Australia)

http://ncirs.edu.au/immunisation/history/Diphtheria-tetanus-pertussis-history-July-2015.pdf

The current vaccine is an acellular, toxoid vaccine. As an acellular vaccine, it's not even theoretically possible for the vaccine to prevent the colonisation and transmission of the bacteria alleged to be responsible for Whooping Cough. The vaccine largely targets the toxins produced by the Pertussis bacteria, but does not prevent the colonisation or transmission of the bacteria to either immunnised or unimmunised people, including babies who are too young to be vaccinated. The vaccine is, at most, only theoretically capable of reducing the severity of the disease, not the incidence of the disease. Whooping Cough would be more accurately described as a potenitally vaccine-modifiable disease.

(Jason, 2013, Acellular pertussis vaccines protect against disease but fail to prevent infection and transmission in a nonhuman primate model, Proceedings of the National Academy of Sciences of the United States of America)

http://www.pnas.org/content/early/2013/11/20/1314688110

What this means is that even if every single person was immunised against Pertussis, the disease could not be eradicated, was not close to being eradicated, and a small number of babies will still die from the disease. A healthy unimmunised child is no more likely to transmit the disease to a vulnerable baby than a fully immunised one.

6.3 The significant increase in Whooping Cough notifications has been misrepresented to mislead the public

One of the key ways the general public is being misled by the media and some (not all) public health experts is through the misuse and misrepresentation of Whooping Cough notifications. They are using the dramatic increase in notifications in recent years to cultivate the belief there's been a dramatic resurgence of the disease, when there are any number of alternative explanations for the rise. While we acknowledge a real rise in notifications, this doesn't necessarily mean there's been an increase in incidence of the disease, although we acknowledge that possibility. It needs to be remembered that notifications and incidence are not the same thing. If the real incidence of Whooping Cough had increased as dramatically as notifications, then deaths should have dramatically increased as well, but this is not what has been observed. Secondly, even if there had been a real increase in incidence, that would be a poor indictment of the vaccine, given vaccination rates have increased significantly since the 1980s.

Scientists have proposed various reasons for the increase in Whooping Cough notifications. These include, changes to diagnostic criteria, more sensitive laboratory procedures such as PCR, a shift in strain dominance as well as increased awareness, vigilance, and a willingness of medical doctors to diagnose and seek laboratory confirmation of Whooping Cough, particularly in fully vaccinated children and adults.

When the vaccine was believed to be highly effective, doctors were unlikely to consider the possibility of Whooping Cough in the fully vaccinated, and as such were unlikely to seek laboratory diagnosis for the presence of the bacteria in these patients. This is known in scientific circles as a pro-treatment or diagnosis bias. As evidence about the ineffectiveness of the vaccine began to be accepted, doctors began to consider Whooping Cough in their differential diagnosis of fully vaccinated children presenting with persistent cough.

Between 2006 and 2012, an increasing proportion of notifications had PCR (a more sensitive laboratory test), were recorded as the method of diagnosis, increasing from 6.9% in 2006 to 58.7% in 2012.

(2014, Australian vaccine preventable disease epidemiological review series: pertussis, 2006–2012, Department of Health)

http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-cdi3803b.htm

Similarly, a study published in 2011 found that *"an increase in pertussis testing following recognition of early epidemic cases may have led to identification of previously undetected infections, resulting in a further increase in notified disease and awareness among GPs"* and that *"the changing likelihood of being tested may also be due to expanding availability and use of PCR testing in Australia."*

(Kaczmarek et al, 2013, Sevenfold rise in likelihood of pertussis test requests in a stable set of Australian general practice encounters, 2000–2011)

https://www.mja.com.au/journal/2013/198/11/sevenfold-rise-likelihood-pertussis-test-requests-stable-set-australian-general

It was reported in 2012 that a vaccine-resistant strain had emerged and was increasingly being identified in diagnosed cases.

> *"The strain was responsible for 31% of cases in the 10 years before the epidemic, but has accounted for 84% since – a nearly three-fold increase, indicating it has gained a selective advantage under the current vaccination regime."*

(Norrie, 2012, Vaccine-resistant whooping cough takes epidemic to new level, The Conversation)

https://theconversation.com/vaccine-resistant-whooping-cough-takes-epidemic-to-new-level-5959

A study published in 2012 found a temporal association between increased media coverage of outbreaks of Influenza and an increase in notifications, by increasing demand for diagnostic tests.

(Olowokure et al, 2012, Volume of print media coverage and diagnostic testing for influenza A(H1N1)pdm09 virus during the early phase of the 2009 pandemic, Journal of Clinical Virology)

http://www.ncbi.nlm.nih.gov/pubmed/22710009

Further, a very recent published study, suggests that a resurgence in Whooping Cough can be explained by asymptomatic transmission of the bacteria by the fully immunised.

(Althouse et al, 2015, Asymptomatic transmission and the resurgence of Bordetella pertussis, BMC Medicine)

http://www.biomedcentral.com/1741-7015/13/146

6.4 Recently reported Whooping Cough outbreaks in fully vaccinated children

The following three articles report on outbreaks of Whooping Cough in fully immunised children in schools. The first one reports that 19 children from the same school were diagnosed with the disease despite being fully immunised.

http://fox13now.com/2015/03/27/19-kids-in-summit-co-diagnosed-with-whooping-cough-despite-being-up-to-date-on-vaccinations/

The second reports on four diagnosed cases in the same school all of whom were fully immunised, with the school having a 99.5% immunisation rate.

http://www.ksbw.com/news/pertussis-outbreak-at-monterey-park-school/31881324

The third reports on 70 cases of Whooping Cough all of whom were immunised against the disease

http://webcache.googleusercontent.com/search?q=cache:k5WAA8DYS6UJ:www.kwch.com/news/local-news/70-diagnosed-with-whooping-cough-in-reno-county/34378784+&cd=1&hl=en&ct=clnk&gl=au

There are endless examples of Whooping Cough outbreaks in the fully immunised.

Earlier this year, there was a Whooping Cough outbreak at a Kilcoy school, and 19 children were diagnosed, however the immunisation status of these children has not been reported. We have been unable to obtain this information from Queensland Health and will need to apply for this information through the Right to Information process, and there's no guarantee it will be provided even then. We call on the government to provide this information to the committee in the interests of transparency.

http://www.caboolturenews.com.au/news/whooping-cough-outbreak-kilcoy/2595513/

7.0 We oppose the Bill unequivocally

We are stridently opposed to the Bill. The proposed immunisation requirement represents an unnecessary, unjustified and insidious intrusion by the state into decisions about the health and welfare of children, decisions which rightly reside with parents.

We have grave concerns about the negative effects an immunisation requirement will have on social cohesion and believe it would cultivate and legitimise bigotry.

We concur with the claim in the Explanatory Note to the effect vaccination is extremely popular which is the very reason an immunisation requirement is unnecessary and unjustified.

Providing for exemptions to an immunisation requirement would go some way to alleviating our most potent concerns with the Bill.

8.0 International Human Rights instruments protect the right to freedom of thought, conscience or religion

Articles 18 of the Universal Declaration of Human Rights (UDHR) and International Covenant on Civil and Political Rights (ICCPR) protect the right to freedom of thought, conscience and religion. This would suggest that a belief – whether informed by religious doctrine, conscience or something different altogether – is to be protected under Australian law.

http://www.un.org/en/documents/udhr/index.shtml#a18

http://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx

9.0 The definition of religion is broad and predicts the emergence of new religions based on beliefs against vaccination in response to totalitarian vaccination laws

The High Court of Australia has adopted a broader definition of religion than is popularly accepted. *(High Court of Australia, Church of the New Faith v. Commissioner of Pay-Roll Tax (Vict.) [1983] HCA 40; 1983 154 CLR 120)*

http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/cth/HCA/1983/40.html

In his judgement that Scientology was a religion, Justice Murphy stated:

> *"The truth or falsity of religions is not the business of officials or the courts. If each purported religion had to show that its doctrines were true, then all might fail. Administrators and judges must resist the temptation to hold that groups or institutions are not religious because claimed religious beliefs or practices seem absurd, fraudulent, evil or novel; or because the group or institution is new, the number of adherents small, the leaders hypocrites, or because they seek to obtain the financial and other privileges which come with religious status. In the eyes of the law, religions are equal. There is no religious club with a monopoly of State privileges for its members."*

He subsequently suggested conditions which may be sufficient, but not necessary, to show the existence of a religion:

> *"On this approach, any body which claims to be religious, whose beliefs or practices are a revival of, or resemble earlier cults, is religious. Any body which claims to be religious and to believe in a supernatural Being or Beings, whether physical and visible, such as the sun or the stars, or a physical invisible God or spirit, or an abstract God or entity, is religious. For example, if a few followers of astrology were to found an institution based on the belief that their destinies were influenced or controlled by the stars, and that astrologers can, by reading the stars, divine these destinies, and if it claimed to be religious, it would be a religious institution. Any body which claims to be religious, and offers a way to find meaning and purpose in life, is religious. The Aboriginal religion of Australia and of other countries must be included. The list is not exhaustive; the categories of religion are not closed."*

It is our view, that under such a definition, it would not be at all surprising to see the emergence of one or more new religions which have at the core of their doctrine, a deep and abiding belief against vaccination, (or even just against certain vaccines), in addition to a belief that pharmaceutical based medicine should only be used as a last resort, or in the case of an emergency or trauma, instead of being central to therapeutic and preventative health goals. In the context of draconian laws such as proposed by this Bill, as well as LNP No Jab No Pay laws at the federal level, we would argue this prospect is almost guaranteed.

Certainly, some of our more dogmatic critics have described us as a tin-foil hat wearing religious cult on more than one occasion, and opposition to vaccination, as a belief, has been around since Jenner's Smallpox vaccine was first unleashed on an unwitting public. It would also be fair to say, that some of our members would only submit to vaccination "over my dead body" or by force.

10.0 Historical legislative precedent for immunisation exemptions in Australia in the context of low immunisation rates

We note the longstanding and bipartisan legislative support for exemptions to an immunisation requirement since at least 1997, when such a requirement was first enacted in Commonwealth legislation.

(Child Care Payments Act 1997 (Cth), section 8)

https://www.comlaw.gov.au/Details/C2004A05289/Html/Text#param10

It's important to consider that in 1997, immunisation rates were significantly lower than today, with less than 75% of children aged 12 months fully immunised in accordance with the schedule, yet the Commonwealth parliament still elected to provide for exemptions in that context.

http://www.health.gov.au/internet/main/publishing.nsf/Content/cdi3701m

This compares with the approximately 91% of 12-15 month olds fully vaccinated at the end of 2014, an increase of more than 20% from baseline over that period.

(2015, ACIR – Annual Coverage Historical Data)

http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/acir-ann-cov-hist-data.htm

Far from contributing to a fall in immunisation rates, immunisation rates have actually increased significantly since the right to object to immunisation was first protected by legislation. In other words, the significant increase in immunisation rates has occurred within a legislative framework which accommodates freedom of choice and without a need for coercion or punishment by the state.

In addition to broad support for exemptions, both the ALP and LNP – when in federal government – have given specific legislative force to religious exemptions under section 7 of A New Tax System (Family Assistance) Act 1999 (Cth) for the purpose of eligibility to Child Care Benefits and/or Family Tax Benefits.

Section 7 of the Act provides that the Minister may make determinations, by legislative instrument, to exempt a specified class of children from an immunisation requirement (sub-section 1), or that a specified class of children meets the immunisation requirement in the circumstances described in the determination (sub-section 2).

(A New Tax System (Family Assistance) Act 1999 (Cth))

https://www.comlaw.gov.au/Details/C2014C00170/Html/Text#_Toc386550790

As recently as 2013, the federal ALP government determined, by legislative instrument, a religious exemption from the immunisation requirement for the purpose of eligibility to Child Care Benefits.

(Child Care Benefit (Immunisation Requirements) (DEEWR) Determination 2013)

https://www.comlaw.gov.au/Details/F2013L01056

The federal LNP government has made similar determinations in the past.

(Family Assistance (Exemption from Immunisation Requirements) Determination 2003)

https://www.comlaw.gov.au/Details/F2007B00271

While the only determinations that have been made historically under section 7 have been in relation to a religious organisation, there is no requirement in the wording of the provision for the determination to be in relation to a religion specifically. In other words, it is a broad discretionary power.

It is also important to consider that a more general religious exemption has been available under section 6, sub-sections 3 and 4, using the definition of conscientious objection in section 5 of the same Act since 1999 when it repealed the Child Care Payments Act.

> *"An individual has a **conscientious objection** to a child being immunised if the individual's objection is based on a personal, philosophical, religious or medical belief involving a conviction that vaccination under the latest edition of the standard vaccination schedule should not take place."*

https://www.comlaw.gov.au/Details/C2014C00170/Html/Text#_Toc386550788

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11.0 Recent bipartisan policy support for religious exemptions

We acknowledge current ALP and LNP policy to pursue measures which aim to increase immunisation rates, but note, both parties have recently expressed in-principle support for religious exemptions in relation to an immunisation requirement in Commonwealth laws.

ALP Leader Bill Shorten stated his support for exempting the children of parents who have a deeply-held religious view against immunisation from such a requirement under Commonwealth legislation.

(Shorten, 2015, Labor will work with government to increase immunisation rates)

http://billshorten.com.au/labor-will-work-with-government-to-increase-immunisation-rates

Similarly, federal LNP Social Services Minister, in announcing the so-called No Jab No Pay laws, expressed his in-principle support for religious exemptions, by stating that existing exemptions on religious grounds will continue.

(Morrison, 2015, No jab – no play and no pay for child care)

http://scottmorrison.dss.gov.au/media-releases/no-jab-no-play-and-no-pay-for-child-care

While the Minister has since revised his position on religious exemptions to the effect he will not be approving any further exemptions and will be cancelling the one existing exemption because the church concerned no longer has an objection to immunisation, that position was informed on the basis there is currently no other religions in Australia with a registered objection to immunisation. His position also failed to give due consideration to a broader definition of religion, and as such, did not provide for the possibility of emerging religions which have an objection to immunisation.

(Morrison, 2015, Government ends religious 'No Jab No Pay'of benefits exemption)

http://scottmorrison.dss.gov.au/media-releases/government-ends-religious-no-jab-no-pay-of-benefits-exemption

12.0 An Immunisation Requirement is Unnecessary

12.1 Australia has high and stable rates of immunisation and low rates of conscientious objection

Australia already has high and stable rates of immunisation, the highest ever, and the small increase in the rate of recorded conscientious objections to immunisation does not represent a real increase, but rather reflects an increased awareness of the need to register in order to receive entitlements.

(Leask, 2013, With vaccination rates stable, 'no jab, no play' rules are beside the point, The Conversation)

https://theconversation.com/with-vaccination-rates-stable-no-jab-no-play-rules-are-beside-the-point-14522

Following the introduction of No Jab No Plays in New South Wales in 2014, which provides for, and requires registration for conscientious objection, it would be expected registered rates to have increased as a consequence, but this is not the same as a real increase.

For as long as vaccines have existed, there have been people opposed to the practice, but the numbers have always been small. There's no evidence to suggest the rate of conscientious objectors is rising from its historically very small base, even though registered rates may have.

Australia has gone from very low rates of immunisation in the 1980s to very high rates currently, and this has been achieved without the need to resort to draconian measures such as that proposed. Immunisation rates increased from a low of 53% in 1986 to 92.08% in 2014.

(ABS, 2001, Vaccination Coverage in Australian Children – ABS Statistics and the Australian Childhood Immunisation Register (ACIR))

http://www.abs.gov.au/ausstats/abs@.nsf/mf/4813.0.55.001#4.%20RESULTS%20-%20VACCINATION%20COVERAGE

(Department of Health, 2015 ACIR – Annual Coverage Historical Data)

http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/acir-ann-cov-hist-data.htm

The 'carrot' approach has worked very well to increase vaccination rates; there is no policy imperative for a 'stick' approach.

12.2 An immunisation requirement and amendments to the Public Health Regulations are not necessary to protect the public health

While we accept that individual rights may be subject to limitation by the state for the purpose of protecting the public health, there is absolutely no empirical evidence that healthy, unvaccinated children are more likely to be vectors of disease, whether vaccine-preventable or not, or that excluding unvaccinated children from child care centres or schools serves to enhance the protection of other students or the public health in general. While this may be a popular belief, there's simply no evidence to support it. Indeed, there are numerous examples in the medical literature and media reports of disease outbreaks in highly vaccinated populations.

It is commonly accepted among jurists – and we concur with that consensus – that the state needs to satisfy a very high burden of proof when pursuing any derogation of individual human rights. It is not sufficient for the government to merely claim it is necessary, it needs to show that it is necessary by the highest standards of evidence. We don't believe the government has satisfied, or could satisfy this burden of proof.

Given every human being carries billions of microbes – many of which are claimed to be potentially pathogenic – it's simply impossible to quantify the risk posed by an individual based on vaccination status alone. We consider that very idea to be ridiculous. There is no evidence the overall quantum of pathogenic microbes is reduced in those vaccinated relative to those who remain unvaccinated.

> *"[...] It seems to me that any human can be described as a "potential infective hazard"; and one could not reasonably demand of Dr Whitby that he quantify precisely the increased risk, if any, posed by L; but the evidence is so imprecise that even if I disregarded Dr Vance's views (which I am not in the least inclined to do), I would not be able to reach a conclusion that suspension was reasonably necessary to protect public health. [...]."*

(L v Minister for Education [1996] QADT 2 (18 January 1996))

http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/qld/QADT/1996/2.html

It is claimed in the Explanatory Note to the Bill, that there were over 6,500 notifications of vaccine-preventable diseases in child-care aged children between 2010 and 2014, but the relative percentages of notifications attributable to vaccinated versus unvaccinated children has not been provided. Just because there have been vaccine-preventable diseases notified does not necessarily mean the source of these were exclusively or even mostly, from unvaccinated children, and it would be misleading to suggest otherwise.

> *"It is assumed that unvaccinated children are the primary reservoirs of disease. This assumption is challenged by the recent release of Australian data showing that, of all notified cases of whooping cough in 1-4-year-olds, roughly 75% had been previously fully vaccinated."*

http://vaccinationdilemma.com/whooping-cough-australian-children-how-many-were-vaccinated

(Beattie, 2013, ibid. p 3)

We would suggest that most of those 6,500 notifications represent vaccine failure in fully vaccinated children and in the interests of transparency call on the government to release the percentages attributable to unvaccinated, partly, and fully vaccinated children. The secrecy surrounding this type of information is a source of constant frustration – it is in the public interest that this information be readily accessible. It most certainly shouldn't require a Right to Information appplication in order to access it. If the information is collected it should be available as a matter of course.

As has been described in the Whooping Cough section, there is sufficient empirical evidence that vaccinated children may serve as asymtomatic carriers of Whooping Cough. In a study published in 2000, it was found that 60% of the children at a child care centre who tested positive to the bacteria remained asymptomatic, and this was in relation to the earlier whole cell vaccine which has been claimed to be more effective than the one used currently. In other words, vaccinated children can act as a reservoir for infection.

(Srugo et al. 2000, Pertussis Infection in Fully Vaccinated Children in Day-Care Centers, Israel)

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2627963/pdf/10998384.pdf

In 1999, a fully immunised Sydney health care worker was noted to have transmitted Pertussis to four neonates.

(Peterson et al, 2010, Nosocomial pertussis infection of infants: still a risk in 2009)

http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-cdi3404e.htm

In the case of Mumps, as recently as last month, a large outbreak of Mumps was reported in Western Australia. Of 49 confirmed cases, all had been fully vaccinated with two doses of the vaccine.

(Broome North Primary School, 2015, Kimberley Mumps Outbreak)

http://broomenorthps.wa.edu.au/2015/07/kimberley-mumps-outbreak/

We are able to provide many other examples.

The Public Health Act already confers sufficient powers to exclude unvaccinated children from schools and child care in the event of a Measles outbreak, or suspected outbreak. There is absolutely no evidenced need to extend these powers to the exclusion of healthy, non-immunised children on the basis of some poorly defined risk of a future, potential outbreak being caused by these children.

We note the existing guidelines for the management of case contacts in the event of outbreaks and would argue that any amendment to the Public Health Regulations should be in accordance with current practice which only requires the exclusion of case contacts in relation to outbreaks of Measles.

(2014, Time Out, Department of Health Queensland)

https://www.health.qld.gov.au/ph/documents/cdb/timeout_poster.pdf

These existing powers are more than sufficient, and strike the right balance between the rights of the individual, and the rights of the general public.

12.3 A 95% vaccination rate in not necessary – vaccine-induced herd immunity is disputed

We reject the claim in the Explanatory Note to the effect that a vaccination rate of 95% is required to achieve a herd immunity effect, and note the source of that claim was not provided. We would suggest that 95% figure is merely a spurious invention, and one which has been the subject of frequent upward revisions over the years every time a vaccine failure has been identified.

Even if we were to accept there is a herd immunity effect arising from vaccination, it would be impossible to quantify in such discrete numerical terms, would obviously vary by disease. It would also need to consider vaccination coverage rates in adults as well as children over six years of age. Reported vaccination coverage rates only pertain to children under six years of age, and it is now widely accepted that vaccines do not confer lifelong immunity as was once believed. That estimates of herd immunity allegedly conferred by vaccination only consider vaccination coverage rates in children under six years of age, and not older children or adults, who serve as significant reservoirs of disease, provides the necessary context in which vaccine-induced herd immunity theory can be rightly dismissed as a pseudo-science.

In addition, many of the vaccines on the current vaccination schedule are not even theoretically capable of producing a herd immunity effect anyway; this much at least, is uncontroversial.

A US-based Immunologist, recently published an open letter to legislators, wherein she identifies vaccines that are not theoretically capable of producing a herd immunity effect and are only capable of offering protection to individual vaccine recipients.

These include Inactivated Polio Vaccine (IPV), Tetanus, Diphtheria, Whooping Cough, HIB (via a shift in strain dominance under pressure from the vaccine), and Hepatitis B.

(Obukhanych, 2015, An Open Letter to Legislators Currently Considering Vaccine Legislation)

http://thinkingmomsrevolution.com/an-open-letter-to-legislators-currently-considering-vaccine-legislation-from-tetyana-obukhanych-phd-in-immunology/

Vaccine-induced herd immunity has also been questioned in relation to Measles.

A 2014 paper reported on a case of Measles in a person previously vaccinated with two doses of the vaccine and which resulted in four secondary cases that were also confirmed to have received either two doses of measles-containing vaccine or a past positive measles IgG antibody.

(Rosen et al., 2014 Outbreak of Measles Among Persons With Prior Evidence of Immunity, New York City, 2011, Clinical Infectious Diseases)

http://cid.oxfordjournals.org/content/58/9/1205

We would also like to remind the committee that the Queensland government withdrew funding for the Whooping Cough 'cocooning strategy', a micro version of herd immunity theory, in 2012, due to concerns it was ineffective and therefore a waste of taxpayer funds.

Whether or not the other vaccines have the capability to produce a herd immunity effect is the subject of an ongoing scientific dispute. The question has certainly not been answered to the standard necessary to introduce an effective vaccine mandate.

13.0 The immunisation requirement is arbitrarily selective

The Bill's effect to exclude unvaccinated children exclusively, and not other unprotected children, defeats its stated purpose of being necessary to protect the public health. If unvaccinated children are claimed to pose a risk to the public health, then by necessity, similarly unprotected children must also pose the same risk, and as such should be the subject of exclusion as well. These include:

a) those who can't be vaccinated for medical reasons; and

b) those who are too young to have been vaccinated; and

c) those who have been vaccinated, but who are not protected due to not producing the required biological response claimed to confer immunity; and

d) those who were not vaccinated in utero; and

e) child care centre employees.

In addition, we would argue that children recently vaccinated with live, attenuated viruses pose a risk to the public health so should also be the subject of exclusion in the post-vaccine period. That vaccine recipients are capable of transmitting vaccine-strains diseases is shown in the following four papers, two pertaining to Chicken Pox, and two to Measles

(Kluthe et al, 2012, Neonatal vaccine-strain varicella-zoster virus infection 22 days after maternal postpartum vaccination, Paediatric Infectious Disease Journal)

http://www.ncbi.nlm.nih.gov/pubmed/22572750

(Gan et al, 2011, Transmission of varicella vaccine virus to a non-family member in China, Vaccine)

http://www.ncbi.nlm.nih.gov/pubmed/21134454

(Kaic et al, 2010 Spotlight on measles 2010: excretion of vaccine strain measles virus in urine and pharyngeal secretions of a child with vaccine associated febrile rash illness, Croatia, March 2010, Euro Surveillance)

http://www.ncbi.nlm.nih.gov/pubmed/20822734

(Jenkin et al, 1999, What is the cause of a rash after measles-mumps-rubella vaccination?, Medical Journal of Australia)

http://www.ncbi.nlm.nih.gov/pubmed/10494235

14.0 The Bill's immunisation requirement exceeds the power of the parliament to make such a law

We acknowledge the parliament's power to make laws in relation to public health matters generally and disease outbreaks more specifically, but it is our strong view, that power doesn't extend to applying effective quarantine measures to otherwise healthy, but unvaccinated children in ***non-outbreak conditions***, a power which is usually reserved for public health emergencies, and usually not even then.

The proposed exclusion measures are analogous to applying wartime powers during times of peace. We feel certain the general public would have been rightly outraged if the Australian government had continued to exercise its wartime powers of detention of citizens of German descent after the end of World War II, yet this is the type of power that is being proposed in this Bill. It's one thing to exclude unvaccinated children in the event of an outbreak of Measles, quite another to exclude them in non-outbreak conditions.

15.0 The Bill conflicts with the Disability Discrimination Act 1992 (Cth) (DDA) and seeks to limit its operation

The Bill's immunisation requirement violates sections 5 and 6 of the DDA and seeks to limit its operation by protecting child care centre owners and directors from liability for acts of discrimination which would be otherwise unlawful.

For the purposes of the DDA, an unvaccinated child has a disability so is protected from discrimination on that basis.

Disability is defined in the DDA as:

c) the presence in the body of organisms causing disease or illness; or

d) the presence in the body of organisms capable of causing disease or illness; and includes a disability that:

j) may exist in the future (including because of a genetic predisposition to that disability).

While section 48 provides that discrimination is not unlawful if it is reasonably necessary to meet the public health, we believe that it would be impossible for a child care centre to satisfy such a condition for the reasons outlined elsewhere in our submission.

16.0 The Bill's immunisation requirement without exemptions amounts to an effective mandate or 'practical compulsion'

The Bill's immunisation requirement amounts to an effective mandate or 'practical compulsion' for those who rely on access to child care services in order to participate in the workforce or self-development activities such as study. The concept of 'practical compulsion' was defined by Justice Webb in British Medical Association v The Commonwealth.

([1949] HCA 44; (1949) 79 CLR 201)

> *"To require a person to do something which he may lawfully decline to do but only at the sacrifice of the whole or a substantial part of the means of his livelihood would, I think, be to subject him to practical compulsion. [...] If Parliament cannot lawfully do this directly by legal means it cannot lawfully do it indirectly by creating a situation, as distinct from merely taking advantage of one, in which the individual is left no real choice but compliance."*

http://www.austlii.edu.au/au/cases/cth/HCA/1949/44.html

The above definition skilfully exposes the element of compulsion when the whole or substantial part of one's livelihood is at risk. It is dishonest in the extreme to argue that parents will still have a choice about whether to immunise their children if the Bill is passed without provision for exemptions. A choice between immunising one's children and forfeiting one's place in the workforce is no choice at all for those parents with a deeply-held belief against immunisation; they will have to leave their jobs (or study) if they rely on access to child care services. This is simply unacceptable.

17.0 Vaccine Injury Compensation Scheme – without one there should be no element of compulsion

Unlike many industrialised countries, Australia does not have a statutory vaccine injury compensation scheme, and while we are not lobbying for such a scheme, would argue that the parliament should not pursue legislation with any level of coercion or compulsion, and for those reliant on child care services, the proposed legislation, amounts to an effective mandate or practical compulsion.

In 1997, former Australian Greens Senator, Dee Margetts, during a Senate discussion about the Child Care Payments Bill, argued there was a *"reciprocal obligation on any government which actually requires compulsion for a particular activity—in this particular case child immunisation—which is seen to be for the public good"* so that *"if the vaccination harms the child, there is an obligation on the Commonwealth government to make sure that adequate compensation is available".* (p. 8687)

http://www.aph.gov.au/binaries/hansard/senate/dailys/ds111197.pdf

It is widely accepted among Australia's legal profession that vaccine injury victims face extremely poor prospects of obtaining legal redress without a statutory compensation scheme, through either product liability or actions in negligence.

The family of Western Australian father-of-five Ben Hammond, who was left quadriplegic by a TDaP he received as an adult, has learned first-hand the difficulties of obtaining compensation for his vaccine injury and have been campaigning for such a compensation scheme ever since.

https://www.youtube.com/watch?v=xvcMo_-RM78

For some perspective, the US Vaccine Injury Compensation Program (VICP) has paid out $3.2 billion compensation since its inception.

18.0 Consent to immunisation is not legally valid in the presence of coercion

Australian law generally protects an individual's right to refuse medical treatments for themselves or on behalf of their children, except in the limited circumstances of a medical emergency or parental neglect, and that includes a right to refuse immunisation. Consent to vaccination is a matter between a medical professional and their patient without intrusion or coercion by the state.

Immunisation, like all medical procedures, carries with it the risk of death, disability and chronic disease. The tragic examples of Saba Button, Lachlan Neylan, Izzy Olesen and Ashley Epapara are cases in point. Both Saba Button and Lachlan Neylan suffered major brain injuries resulting in severe and permanent disability from the immunisations they received. Izzy Olesen suffered Stevens Johnson Syndrome resulting in blindness and major skin scarring, and regrettably, Ashley Epapara died. You can read their stories at the following links.

http://www.perthnow.com.au/news/western-australia/saba-button-the-girl-who-is-never-alone/story-e6frg13u-1226035296706

http://www.themercury.com.au/news/national/toddler-who-was-given-an-adult-flu-shot-is-left-severely-brain-damaged-and-unable-to-walk-or-talk/story-fnj3ty2c-1226756398505

http://www.vaccinationinformationnetwork.com/izzys-story/

http://www.abc.net.au/news/2010-09-10/flu-vaccine-cant-be-ruled-out-in-toddlers-death/2256142

Importantly, unlike a medical procedure performed on a sick or injured person for therapeutic goals, immunisation is a medical procedure performed on healthy people for a potential future benefit. For this reason, the standard of informed consent to the procedure should be arguably higher than that for a therapeutic purpose, and most definitely should only be given freely, without coercion.

The Bill proposes that the immunisation requirement be in accordance with the Australian Immunisation Handbook, which defines valid consent as requiring it to have been given voluntarily, in the absence of undue pressure, coercion or manipulation.

http://www.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home~handbook10part2~handbook10-2-1#2-1-3

Making entry to child care contingent upon immunisation interferes with the ability to give valid consent at law, particularly for those with a deeply-held belief against immunisation, and who are reliant on child care services in order to work or study. These people will not be able to comply with the immunisation requirement because they will be unable to give consent freely. In any case, doctors are prohibited from accepting consent under such circumstances. Professor Raina Macintyre recently expressed this concern in relation to similar amendments to Commonwealth laws.

(The Australian, 2015, Questioning vaccination policy is not synonymous with anti-vaccination)

> *"In addition, doctors must obtain valid consent to vaccinate children, and consent is not valid in the presence of any form of coercion."*

http://www.theaustralian.com.au/opinion/letters/questioning-vaccination-policy-is-not-synonymous-with-anti-vaccination/story-fn558imw-1227312423699

This obviously raises questions about the legal validity of the Bill particularly in the absence of immunisation exemptions.

19.0 The Bill's immunisation requirement is poorly targeted – conscientious objectors represent only a tiny percentage of unimmunised children and are unlikely to capitulate

According to the Australian Child Immunisation Register (ACIR), the rate of registered conscientious objectors was only 1.77% at the end of 2014.

(Department of Health, 2015, ACIR – National Vaccine Objection (Conscientious Objection) Data)

http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/acir-cons-object-hist.htm

With an overall immunisation rate at 92.08% it is clear that the vast majority of unimmunised children (6.22%) are unimmunised for reasons other than their parents are conscientious objectors.

A/Professor Leask estimated that the impact of the Commonwealth No Jab No Pay laws on immunisation rates may be as little as 0.3%. In other words, all pain and grief for conscientious objectors to immunisation, but negligible gain for immunisation rates.

(Leask, 2015, Will stopping vaccine objectors from accessing payments have its desired impact?)

https://julieleask.wordpress.com/2015/04/11/will-stopping-vaccine-objectors-from-accessing-payments-have-its-desired-impact/

In this context, it's important to note that these 6.22% of children are extremely unlikely to be attending child care anyway, because if they were, they would already be registered as conscientious objectors which is currently required to access Commonwealth Child Care Rebates.

Professor Raina Macintyre argues there has been a lot of research into the beliefs of conscientious objectors, which has found it is extremely hard to change their views.

(Edwards, 2015, Vaccination: Expert says 'draconian' threats to withhold welfare payments unlikely to get parents to vaccinate kids)

http://www.abc.net.au/news/2015-04-13/no-benefits-for-anti-vaccination-parents/6387914

Consequently, even if an entire half of conscientious objectors capitulate – and the empirical research suggests this is overly optimistic – then the immunisation rate would only be increased by 0.85% at most, and more importantly, will leave the other 6.22% of unimmunised children unaffected by this amendment.

These figures put into clear perspective the absurdity of applying such a punitive policy lever to the small percentage of conscientious objectors to immunisation, and exposes it as nothing more than ideologically or politically motivated.

A recently published Australian study found that most children who were not up-to-date with immunisations had parents who were in favour of vaccination, and that socioeconomic disadvantage and chronic medical conditions were the key reasons for them not being up-to-date.

(Bourne, 2015, Children not immunised due to socioeconomic barriers, Medical Xpress)

http://medicalxpress.com/news/2015-08-children-immunised-due-socioeconomic-barriers.html

20.0 The immunisation requirement violates principles of equity and the right to work under international human rights instruments

There will be a disproportionate, negative impact on women, including single mothers, by reducing their workforce participation or opportunities for self-development, their ability to provide essentials and luxuries for their children, and the immunisation requirement violates Article 23 (1) of the Universal Declaration of Human Rights, which protects the right to work and the right to protection against unemployment.

21.0 The immunisation requirement will punish children by denying them access to an essential service which their parents help fund through their taxes

That child care and early education services are an essential service, vital to the economic prosperity of Australia, is reflected in the bipartisan, taxpayer subsidisation of these services over a long period. The effect of the Bill will be to deny some children access to early education and socialisation opportunities.

All taxpayers contribute to the cost of subsidising essential services like child care, not just those who immunise their children, and no child should be denied access to early education services.

22.0 Public Health experts oppose coercive vaccine policies

Public health experts, including Professor Raina Macintyre, A/Professor Julie Leask, and A/Professor Kristine Macartney, have publicly questioned the merits of effective vaccine mandates without exemptions for various reasons.

(Macintyre & Salmon, 2015, Want to boost vaccination? Don't punish parents, build their trust)

https://newsroom.unsw.edu.au/news/health/want-boost-vaccination-don%E2%80%99t-punish-parents-build-their-trust

(Leask, 2013 With vaccination rates stable, 'no jab, no play' rules are beside the point)

http://sydney.edu.au/news/84.html?newsstoryid=11610

(Macartney, 2015, Forget 'no jab, no pay' schemes, there are better ways to boost vaccination)

https://ama.com.au/ausmed/forget-%E2%80%98no-jab-no-pay%E2%80%99-schemes-there-are-better-ways-boost-vaccination

23.0 Coercive vaccination policies are polarising and have unintended consequences

Public Health experts have also argued that coercive vaccination policies, may backfire, by polarising immunisation-hesitant parents, or parents who selectively immunise, and convert them to immunisation objectors.

> *"Parents who feel they are being unduly coerced or punished to vaccinate their children are likely to become anti-vaccination. This coercion may push the hesitant parent in the exact opposite direction to what it is intended to achieve. Other members of the public may also feel sympathy for these parents."*

They claim access, education, awareness, and affordability are the key determinants of immunisation uptake with GP incentives also playing a role.

(Macintyre & Salmon, 2015, ibid)

For example, a child of a parent who is generally in favour of immunisation but who has an objection to only one particular immunisation will be punished to the same extent as one that is totally unimmunised. Similarly, many parents who generally support immunisation, also value civil liberties and the right to choose, free from coercion by the state. The policy, as proposed does not provide for such nuanced and diverse beliefs, and may act to erode public trust in immunisation.

24.0 Immunisation rates can be increased by positive policies without the need to resort to coercive policies

Immunisation acceptance/hesitancy and risk communication are A/Professor Leask's special areas of interest and expertise. She strongly favours positive policies to remove structural barriers to vaccination up-take, tailored communication strategies, and professional development and engagement of vaccination providers.

(Leask, 2011, Target the fence-sitters, Nature)

http://ses.library.usyd.edu.au/bitstream/2123/8960/2/Leask_Nature_accepted.pdf

25.0 Industry opposed the Commonwealth No Jab No Pay Laws that would achieve the same effect as the Queensland Bill

Contrary to the claim in the Explanatory Note to the Bill to the effect there is industry support for the measures, in February of this year, a representative of peak body, Early Childhood Australia, espoused its opposition to proposed exclusionary Commonwealth laws so we are puzzled as to why that position would have shifted in such a short time period.

> *"Samantha Page from Early Childhood Australia said she "wasn't convinced" that the measure will work. "We don't want children excluded," Page told Guardian Australia. "It will further ostracise these kids. I don't think exclusion and punishment is going to change anything … We need to engage and persuade parents rather than force them [to vaccinate]."*"

Another peak body was also reported to be opposed to exclusionary measures, but we note was not mentioned in the Explanatory Note.

> *"Gwynn Bridge from the Australian Childcare Alliance said the decision to immunise should be made by parents"*

http://www.theguardian.com/australia-news/2015/feb/22/backlash-against-calls-to-link-vaccination-to-childcare-benefits

26.0 The Australian Medical Association (AMA) is playing politics with children's lives

Prior to the announcement of the Commonwealth No Jab No Pay No Play laws, the Head of the AMA publicly stated its opposition to exclusionary measures, which will punish children, but performed a monumental back-flip once the policy was formally announced.

> *"Head of the Australian Medical Association (AMA), Dr Brian Owler, agrees. The AMA has stepped back from calls to cut off subsidies for parents who do not immunise their children.*
>
> *"We don't want to punish particular children," Owler told Guardian Australia. "We want to make sure that those people who have genuine concerns about vaccinations go to see their GP."*

http://www.theguardian.com/australia-news/2015/feb/22/backlash-against-calls-to-link-vaccination-to-childcare-benefits

The AMA is a professional body (union) representing its member's interests and political agendas and for this reason their position should carry no greater weight than any other citizen, when it comes to controversial policy matters such as this.

27.0 Many doctors support choice

The AMA does not represent the views of all doctors. Many doctors support a pro-choice position, but are afraid to speak publicly about their position out of concern they will be accused of being anti-vaccination and struck off the medical register. Dr Mark Donohoe GP, who spoke at a No Jab No Pay march in June, espoused this pro-choice view, describing the proposed abolition of exemptions in Commonwealth legislation as effective compulsion.

(2015, Dr Mark Donohue speech at No Jab No Pay No Way Sydney Protest June 21st, Freedom of Choice Events)

https://www.youtube.com/watch?v=mXXTKSMJUY8

Some of our members report that their doctors support a pro-choice position, particularly member doctors of the Australasian College of Nutritional and Environmental Medicine (ACNEM). While ACNEM has a policy in support of vaccination, they don't have a particular position in relation to vaccine mandates, but on the basis of reports from our members, we would argue that most of their members would support freedom of choice.

28.0 Immunisation exemptions – signed statement by parents should be sufficient

In the event an immunisation requirement is enacted with exemptions, we submit that a signed statement from the parents to the effect they have a conscientious objection to vaccination for philosophical or religious reasons be deemed sufficient to satisfy compliance. A form signed by a doctor to register an objection should only apply to objections on medical grounds.

This position is informed by the significant difficulties our members have faced over the years in finding doctors who are willing to sign off on exemptions, which is currently required for eligibility to Family Tax Benefit A supplement and Child Care Rebate.

Many doctors have demonstrated they are prepared to circumvent the intent of the legislature by refusing to sign the forms on the basis they have a conscientious objection to immunisation exemptions, even though the signing of the forms does not constitute an endorsement of conscientious objection to vaccination, but rather certifies that they have counselled a parent on the benefits and risks of vaccination. This has been particularly problematic for people living outside capital cities.

Whether or not doctors are legally required to sign the forms has been the subject of debate. We are of the view that doctors are legally obliged to sign the forms under the current Commonwealth Act, and this view accords with the view of a medico-legal expert who wrote about this issue a few years ago.

(2012, Dorey, Do doctors have to sign Conscientious Objector forms? Australian Vaccination-skeptics Network)

http://avn.org.au/2012/04/do-doctors-have-to-sign-conscientious-objector-forms/

However, a 2013 article argues that doctors are not required to sign the forms.

(Shepherd, 2013, How to handle non-vaccinators, Australian Doctor)

http://www.australiandoctor.com.au/smart-practice/work-wise/how-to-handle-non-vaccinators

Given a significant percentage of doctors do not want to sign these forms in the first place and have demonstrated their willingness to circumvent the intent of the Commonwealth legislature in the past, we would suggest not enacting a requirement for them to do so in relation to the Queensland Bill, and instead adopt our suggestion. This would eliminate any ambiguity and legal conflict about the issue.

End of submission

avn.org.au

building responsibility into vaccination

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