Submission in respect to Public Health (Childcare Vaccination and other legislation) Amendment Bill 2015

Background

In 2013, the Public Health (Exclusion of Unvaccinated Children from Childcare) amendment bill was not passed in favour of an education campaign. This campaign resulted in an increase in childhood vaccination rates. This significantly contrasts with the results achieved from the New South Wales (NSW) introduction of legislation where an overall decline in vaccination rates was experienced. (Source: ACIR)

Recently, the Health and Ambulance Services Committee has undertaken targeted consultations with 'key industry stakeholders'. These stakeholders, which included representatives from lead approved education and care services, generally supported the amendments. However public health experts were not consulted for this amendment to the Public Health Act.

Lack of consultation with public health experts

The Committee has failed to undertake consultation with public health organisations such as the National Centre for Immunisation Research and Surveillance (NCIRS) This demonstrates a need for wider consultations that include public health experts, to determine evidence-based ways to increase vaccination rates.

A/Professor Leask, an outspoken critic of punitive, coercive vaccination policies has claimed that these policies are counter-productive. Her areas of interest and expertise are in immunisation acceptance/hesitancy and risk communication; consequently she strongly favours positive policies to remove structural barriers to vaccination up-take. These include tailored communication strategies and professional development and engagement of vaccination providers.
http://ses.library.usyd.edu.au/bitstream/2123/8960/2/Leask_Nature_accepted.pdf

Professor Raina MacIntyre argued that coercive vaccination policies, may backfire, by polarising immunisation-hesitant parents, or parents who selectively immunise, and convert them to immunisation objectors.
https://theconversation.com/want-to-boost-vaccination-dont-punish-parents-build-their-trust-40094

A punitive rather than persuasive environment can have implications in the wider community. A child of a parent who is generally in favour of immunisation but who has an objection a particular vaccine will be punished to the same extent as one that is totally unimmunised. Similarly, many parents who generally support immunisation, also desire civil liberties and the right to choose in a medical treatment, free from coercion. The bill does not provide for distinctions such as selective or delayed immunisation and may act to erode public trust in immunisation more generally.

Administrative hurdles, such as the current requirement to be counselled by a medical doctor on the benefits and risks of vaccination in order to be granted an exemption, should be preferred to measures which penalise children for their parent's actions.

Medical procedures

At present there is no legislation under any Health Act that compels a person to accept the administration of a vaccine in Australia. The government website presenting information on immunisation also carries the disclaimer that

> *"The Commonwealth of Australia does not warrant or represent that the information contained on this site is accurate, current or complete. Users should exercise their own independent skill or judgement or seek professional advice before relying on it. The Commonwealth of Australia does not accept any legal liability or responsibility for any injury, loss or damage incurred by the use of, or reliance on, or interpretation of, the information contained on this site."*

Immunisation, like all medical procedures, carries with it the risk of death, disability and chronic disease. Importantly, unlike a therapeutic medical procedure performed on a sick or injured person, immunisation is a medical procedure performed on healthy people for a potential future benefit. As such the standard for informed consent to immunisation should be higher than that of therapeutic procedures. For consent to be 'valid', the Australian Immunisation Handbook requires 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

As a consequence of the government and the childcare industry driven immunisation policies - doctors are sidelined and left in a precarious position. Whilst doctors are generally supportive of immunisation, there is scepticism about the quality of scientific evidence purporting to support the safety and efficacy of certain vaccines. Professional standards surrounding valid consent (in the absence of coercion) and professional opinions surrounding a customised approach (based on individual needs and vulnerabilities) will become compromised. Medical issues may not be able to be addressed by the Medical Contraindication to Immunisation form (IMMU12) as this exemption primarily deals with previous adverse reactions to a vaccine or vaccine ingredient, not an inherent vulnerability.

Purpose and outcomes

The purpose of the bill is to improve public health by increasing childhood vaccination rates; however these two actions may not have a direct relationship with one another.

Australia has had steadily increasing childhood immunisation rates for the last twenty years. For the 2 year old age group, vaccination rates have increased dramatically from an estimated 35% in 1995 to over 90% in 2004. (Sources: ABS and ACIR). Since 2004 the increase has been somewhat slower to about 92% in 2014. In spite of these high childhood vaccination rates, disease outbreaks still occur, particularly in relation to whooping cough.

Immunisation is being promoted as a community responsibility; however this responsibility is brought upon a small percentage of the population, that is, children under 5 years. Those who do not capitulate, either in full or in part to the current childhood immunisation schedule, make up 0.32% of the Queensland population (i.e. 15 000 children under 5 year in Queensland population of

4.691 mil). Efforts to address outbreaks of disease are disproportionately being concentrated on this small segment of the population

Whooping cough

Whooping cough is a toxin mediated disease with cyclical epidemics. In Queensland, between 1991 and 2008 cyclical peaks reached about 60 cases / 100 000 population after which the notification rates soared to 200 cases / 100 000 population in 2011. (Source: National Notifiable Diseases Surveillance System). ' Cocooning' was a strategy used between 2009 and 2012, with the aim of protecting babies from catching diseases from the people around them.
http://www.news.com.au/breaking-news/states-ending-free-parent-whooping-vaccine/story-e6frfku0-1226350174856

The problem lies not with vaccination rates which are at an historical high, but with the vaccine which targets the toxins produced by the Pertussis bacteria. The pertussis bacteria itself is not targeted by the vaccine. The acellular pertussis vaccine does not prevent the colonisation or transmission of the bacteria to either immunised or unimmunised people, including babies who are too young to be vaccinated. It is a personal vaccine to reduce the severity of the disease and asymptomatic carriers they are liable to spread the disease unknowingly. A healthy unimmunised child is no more likely to transmit the disease to a vulnerable infant than a fully immunised one. For the reasons given above, the current pertussis vaccine is unable to offer herd protection.
http://www.pnas.org/content/111/2/787.abstract
http://www.ncirs.edu.au/news/past-news-events/Day%201/McIntyre-Is-Australia-world-capital-PertussisWS-25_26Aug11.pdf

Measles

The herd immunity threshold for measles has been used as a benchmark for the entire vaccination schedule. Due to vaccine efficacy waning over time, we do not have vaccine acquired herd immunity for measles in the population. Instead any vaccine acquired immunity hitchhikes on top of the permanently immune majority of adults who acquired their immunity naturally in the pre-vaccination era. According to US immunologist Tetyana Obukhanych PhD:

> *the problem is the proportion of vaccinated but non-immune young adults is now growing, while the proportion of the older immune population is diminishing due to age. Thus, over time mass vaccination makes us lose rather than gain cumulative immunity in the adult population*.
> http://vaccinechoicecanada.com/about-vaccines/general-issues/herd-immunity/herd-immunity-can-mass-vaccination-achieve-it/

Measles outbreaks also occur in fully vaccinated populations , for example:
Measles outbreak in a vaccinated school population: epidemiology, chains of transmission and the role of vaccine failures
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1646939/
Measles Outbreak in a Fully Immunized Secondary School Population
http://www.ncbi.nlm.nih.gov/pubmed/3821823

The childhood immunisation schedule also includes numerous diseases (and vaccines) which do not respond to herd immunity theory. These include: tetanus, hepatitis A, hepatitis B. It is unreasonable to legislate for compliance to the Childhood Immunisation Schedule on the basis of a responsibility to the community, when some of the diseases included do not easily circulate in the community.

The US-based Immunologist, Tetyana Obukhanych PhD, also recently published an open letter to legislators, in which she identifies vaccines that are not 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.
http://thinkingmomsrevolution.com/an-open-letter-to-legislators-currently-considering-vaccine-legislation-from-tetyana-obukhanych-phd-in-immunology/

Adverse Reactions

Vaccines contain small amounts of modified viruses or bacteria (foreign protein), *and* chemical preservatives, additives and antibiotics, that are injected into the tissues of humans. Some of the chemicals in vaccines include neurotoxins and allergens e.g. aluminium, mercury, sodium borate, formaldehyde and antibiotics. Mercury is still found in some vaccines that are given to pregnant women and children and in particular multi-dose vials of vaccines such as influenza. These substances carry a potential risk. However even though vaccines contain many environmental toxins there have been no studies that investigate vaccines as a possible cause of the increase in chronic illness in children.

Many parents have concerns about the combined effects of the vaccine schedule in the developing body, starting from birth with the hepatitis B vaccine. This combined schedule of vaccines has never been tested for safety .

It cannot be predicted who will be harmed by a vaccine and adverse reactions are a reality. Adverse reactions to vaccines are considered ‘rare’, ‘unlikely’ and ‘1 in a million’, however as adverse reactions are routinely denied and consistently underreported - their true occurrence is unknown . Tragic examples include Saba Button, Lachlan Neylan, Izzy Olesen and Ashley Epapara. 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, Ashley Epapara died. Do these children have any greater or lesser value than a child such as Riley Hughes who tragically died from whooping cough?

Worldwide there has been billions of dollars paid in compensation for vaccine damage. In many countries, for example France and Japan, there is much debate about the lack of safety and efficacy of vaccines, and many doctors are questioning their use and safety.

Australia does not have a vaccine compensation scheme in place for vaccine damage. It is unreasonable to coerce a medical procedure which carries with it a risk of disability or death, when there is no reciprocal obligation on the government to make sure that adequate compensation is available. The full effect of any decision will be borne by the parents.

In 2015 the Human Rights Commissioner, Tim Wilson, informed the public that human rights can be infringed by governments if it is for a legitimate public health purpose, proportionate to the risk and done by law. This bill to 'encourage' parents to comply with the immunisation schedule cannot be considered a legitimate public health purpose for the aforementioned reasons and when the results cannot be predicted.

In addition, as the immunisation schedule continues to expand, what it takes to be considered 'fully vaccinated' is not static and is constantly changes as new vaccines and additional doses are included. It is particularly troubling when coercive legislation is introduced to schedule without limitations.

I would to conclude by asking that any public hearing that is held by the committee on this matter that I and Lica Bienholz would be able to further address in person the committee. Thank you for taking the time to read my submission.

Yours Sincerely

Jason Woodforth
Former Member for Nudgee