Submission to the Health and Community Services Committee Queensland Parliament

Re: Public Health (Exclusion of Unvaccinated Children from Child Care) Amendment Bill 2013

Submitted by:
Greg Beattie (President)
on behalf of the Australian Vaccination Network Inc.

Summary
The Australian Vaccination Network opposes the Bill for the following reasons:

1. There is no necessity for the Bill
   1.1 Vaccines do not warrant coercion
      1.1.1 Claims of saving lives lack evidence
      1.1.2 Eradication of illness by vaccines is disputed
      1.1.3 Unvaccinated children are not a demonstrated danger to others
      1.1.4 Vaccines carry risk
      1.1.5 Vaccination rates are already high

2. The Bill is arbitrarily selective
   2.1 Does not propose exclusion of those unvaccinated for age or medical reasons
   2.2 Does not propose exclusion of those vaccinated but not 'protected'

3. The Bill introduces coercion, and uncertainty about who is responsible for consequences

4. Effect on consumers

Submission

The Australian Vaccination Network Inc. (AVN) would like to thank the Committee for inviting us to make a submission regarding this Bill. We wish to be invited to appear as a witness at the public hearing.

We oppose the Bill on the grounds that it unnecessarily introduces coercion and confusion in an area which is the subject of ongoing debate. The AVN believes vaccination should be an opt-in procedure and that consumers should retain their freedom to choose without fear or favour. Specifically, we oppose the Bill for the following reasons:

1. There is no necessity for the Bill.

1.1 Vaccines do not warrant coercion.

They are commercial products and should be left to sell themselves. The rationale for introducing a Bill is based on several claims which are politically popular though lacking sufficient evidence to warrant a legislative approach, viz:

1.1.1 Claims of saving lives lack 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. Readers will immediately see that if a role was played in the transition it was small in comparison to other factors.

The vast majority of the declines 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.

1.1.2 Eradication of illness by vaccines is disputed.

a) 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 in the previous point (1.1.1) 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.

b) Polio
The claim that polio is being eradicated by vaccination is disputed by many researchers who point out that the definition of polio has evolved over the years and is now much more restrictive than before the vaccine was available en masse. 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. In short, polio – the microbe – appears to be undergoing eradication. Polio – the illness – on the other hand, appears to be unaffected.

Although polio, as currently defined, is rare today, the World Health Organisation (WHO) still records, each year, in excess of 100,000 cases of an acute paralytic illness which is clinically indistinguishable from polio. Prior to the advent of mass vaccination, and the change in definition, these cases would have been recorded as polio. They are now named Acute Flaccid Paralysis (AFP) and are currently recorded by the WHO at a global rate of 6 per 100,000 children. This is roughly similar to the rates recorded in the pre-polio-vaccine era, when AFP did not exist as a statistical entity and the cases were recorded as polio.

Whether the vaccine caused a reduction in actual illness is a matter for speculation.

1.1.3 Unvaccinated children are not a demonstrated danger to others.
We are unaware of any evidence which supports the claim that unvaccinated children pose a threat to others. This claim is informed by opinion rather than empirical evidence, and is based on an assumption that unvaccinated children are more likely to develop an illness and subsequently pass it to another. There are weaknesses in this argument:

a) 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

b) Logic
If an unvaccinated child poses a threat to a vaccinated child, there must surely be little faith in the protective efficacy of the vaccine, otherwise the vaccinated child would be assumed protected. Indeed, if they are not protected, they should face the same exclusion policy an unvaccinated child would, for the very same reason.

1.1.4 Vaccine rates are already high.
Vaccination rates are currently the highest they have ever been. The Australian Childhood Immunisation Register reports that all states have rates of fully vaccinated children at around 90% or greater.
http://www.medicareaustralia.gov.au/provider/patients/acir/statistics.jsp

This can be contrasted with the 1990s when rates were in the 70-80% range.
http://www.health.gov.au/internet/main/publishing.nsf/content/cda-cdi3302c.htm

If the impetus for this Bill is, in part, to respond to perceived low vaccination rates we believe that perception to be poorly informed.

2. The Bill is arbitrarily selective

Presumably this Bill is considered necessary to protect the health of those in the facility who are not already protected. But if the logic inherent in the proposal is sound, those who are 'not already protected' should face the same exclusion policy.

2.1 Does not allow exclusion of those unvaccinated for age or medical reasons

For example, there are children who cannot be vaccinated for one reason or another, including those too young or medically unfit to be vaccinated. Shouldn't these children face the same exclusion policy, for the same reason unvaccinated children do?

2.2 Does not allow exclusion of those vaccinated but not 'protected'

There are also those who are vaccinated but who don't produce the required biological response. This is generally thought to be 5 to 15% of all vaccine recipients although some studies suggest the proportion is much higher than this. Again, shouldn't these children be identified and face the same exclusion policy?

3. The Bill introduces coercion, and uncertainty about responsibility for consequences

3.1 Vaccines carry risk

Post marketing surveillance of vaccine safety is critically flawed. No one knows exactly what proportion of adverse events following vaccination are actually reported to the system, however, it is generally conceded that this proportion is very low. Many serious injuries and even deaths escape evaluation simply because they are not reported to the system. The AVN has documented more than 1200 such cases. Clearly, safety profiles which are informed by such a system are untrustworthy. This has raised significant concerns in the community.

Controlled vaccine trials reported in the literature are met with varying amounts of scepticism. Almost all of these have compared reaction rates in vaccine recipients with controls who received either another vaccine, or a "placebo" containing worrying ingredients such as the aluminium-based adjuvants which are used in vaccines and thought to be responsible for many safety issues/concerns. Again, this has raised significant scepticism in the community regarding safety.

We saw recently (in 2009) in Western Australia a vaccine which had been licensed for use had not been adequately tested prior to being used on thousands of children. More than 250 were admitted to hospital and at least one child was left permanently disabled.

Parents have valid concerns about the safety of these medical procedures and are rightly critical of official efforts to downplay potential risks. It is widely acknowledged that

Australian health authorities do not independently test vaccines – neither individually nor in the combinations in which they are administered.

The Australian Immunisation Handbook (published by the Australian government) states:

> "For consent to be legally valid, the following elements must be present:
>
> 1. It must be given by a person with legal capacity, and of sufficient intellectual capacity to understand the implications of being vaccinated.
>
> 2. It must be given voluntarily in the absence of undue pressure, coercion or manipulation.
>
> 3. It must cover the specific procedure that is to be performed.
>
> 4. It can only be given after the potential risks and benefits of the relevant vaccine, risks of not having it and any alternative options have been explained to the individual."
> http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/handbook10-2-1

It is our belief that the proposed legislation violates this policy in regard to a parent's ability to give their consent freely, without loss of, or threat to, other entitlements or freedoms.

3.2 Responsibility
Under the proposal a child care service operator will be placed in an extremely difficult position. When confronted with the decision to include or exclude an unvaccinated child, the operator must consider the following possible consequences:

a) Exclusion
According to legal advice recently presented to the Parliament of New South Wales an operator who chooses to exclude an unvaccinated child, without offering a conscientious objection option, may be in breach of the Federal Disability Discrimination Act.

b) Inclusion
Other parents with children at the facility, being aware that this Bill provides for exclusion, may hold an operator responsible for their child developing an illness if that operator did not exclude a child from the facility who was not vaccinated for the illness.

For discussion of the two points above, please see the Parliament of New South Wales Hansard.
http://www.parliament.nsw.gov.au/prod/parlment/hansart.nsf/V3Key/LC20130620006?open&refNavID=undefined

4. Effect on consumers
A parent who avoids or delays administration of one or more of the recommended

vaccines will be disadvantaged in that their access to child care and early education facilities will be more restricted than for parents who accept and follow the schedule.

Such disadvantage may be severe in cases where a parent is unable to find practical alternatives, and is faced with loss of employment and/or personal development opportunities. Children may be faced with decreased social and educational opportunities in the important early years of their life.

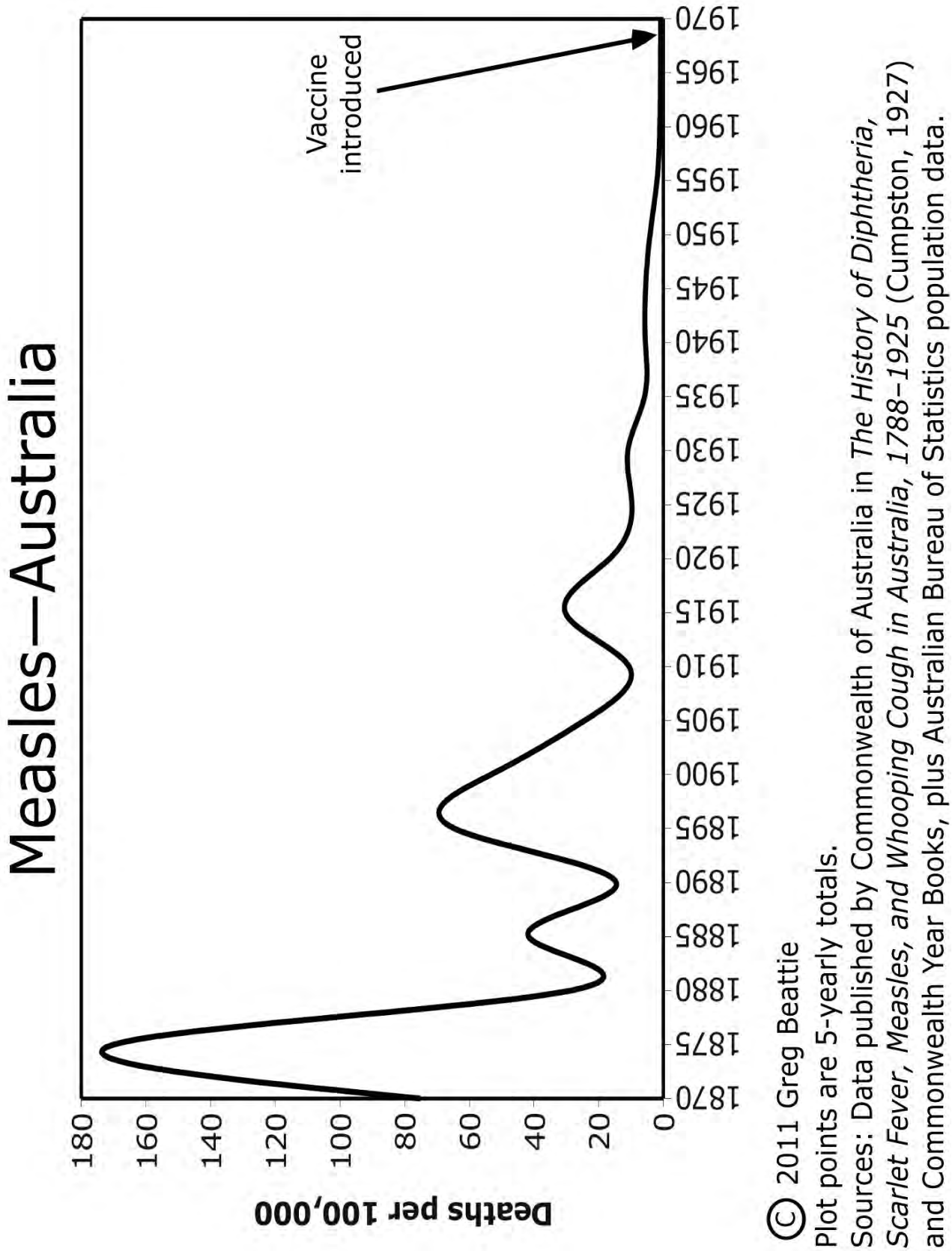
A parent may elect to vaccinate a child solely to avoid these disadvantages, and that vaccination may result in an adverse outcome. In such circumstances the question of liability may be problematic for the child care facility operator.

Finally, we feel this Bill is likely to create division and foster an 'us and them' attitude in our communities. We feel this is undesirable.

Yours sincerely

Greg Beattie
President
Australian Vaccination Network Inc.
(On behalf of Committee)

Appendix 1.


Measles—Australia
Vaccine introduced
Deaths per 100,000
0
20
40
60
80
100
120
140
160
180
1870
1875
1880
1885
1890
1895
1900
1905
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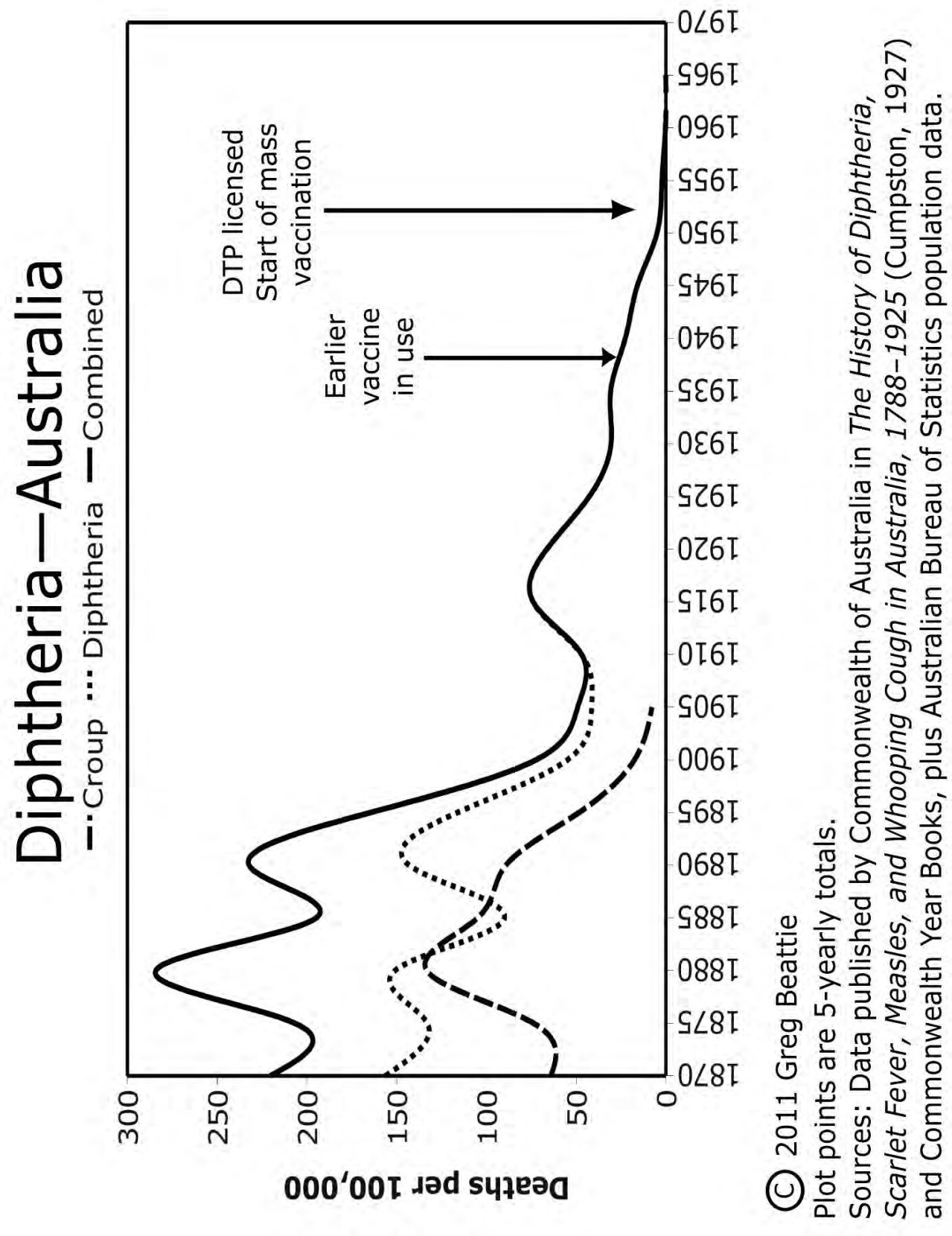
1915
1920
1925
1930
1935
1940
1945
1950
1955
1960
1965
1970
© 2011 Greg Beattie
Plot points are 5-yearly totals.
Sources: Data published by Commonwealth of Australia in *The History of Diphtheria, Scarlet Fever, Measles, and Whooping Cough in Australia, 1788–1925* (Cumpston, 1927) and Commonwealth Year Books, plus Australian Bureau of Statistics population data.

Appendix 2.


Diphtheria—Australia
Croup
Diphtheria
Combined
DTP licensed
Start of mass
vaccination
Earlier
vaccine
in use
Deaths per 100,000
300
250
200
150
100
50
0
1870
1875
1880
1885
1890
1895
1900
1905
1910
1915
1920
1925
1930
1935
1940
1945
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1960
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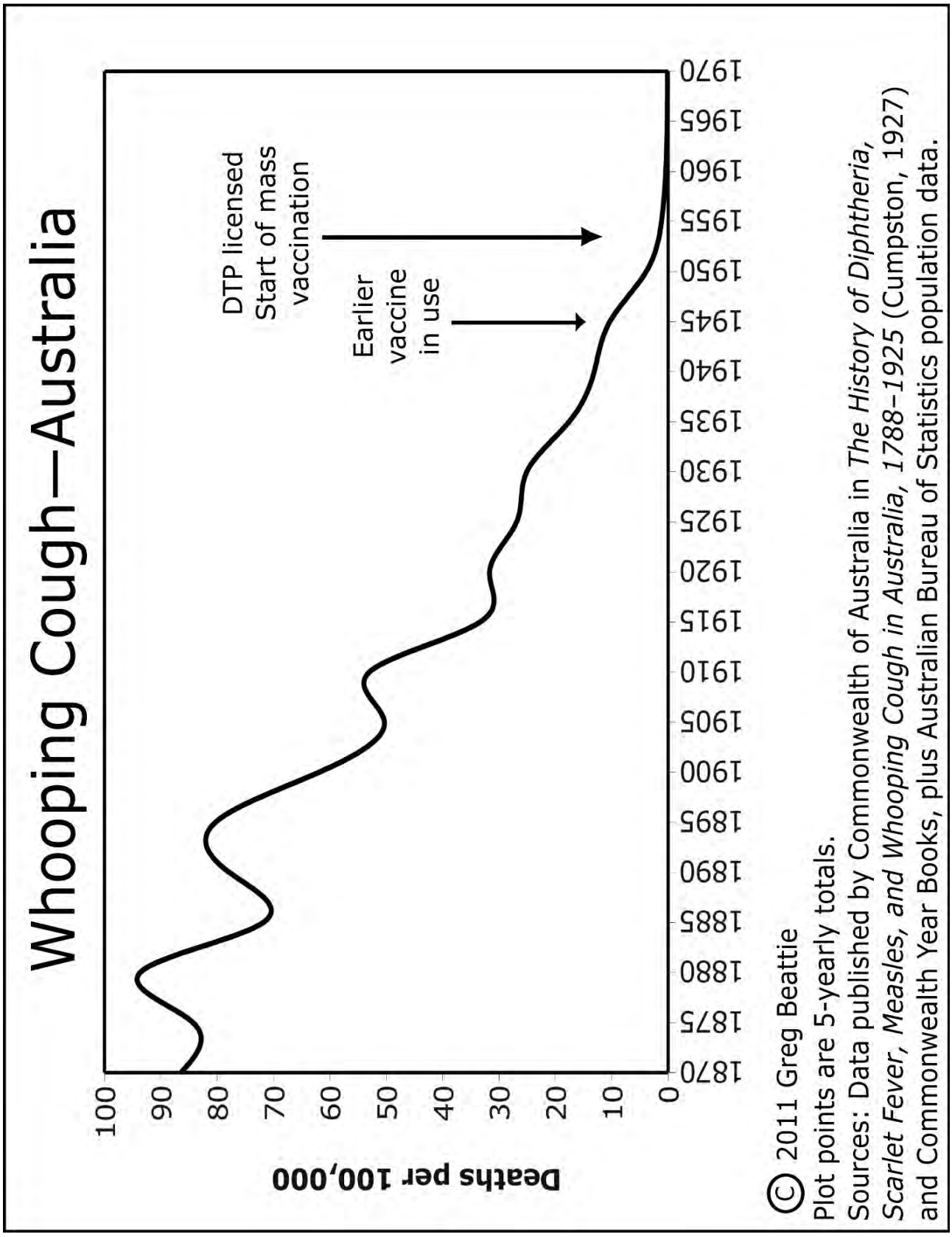
Appendix 3.


Whooping Cough—Australia
DTP licensed
Start of mass
vaccination
Earlier
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Deaths per 100,000
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50
40
30
20
10
0
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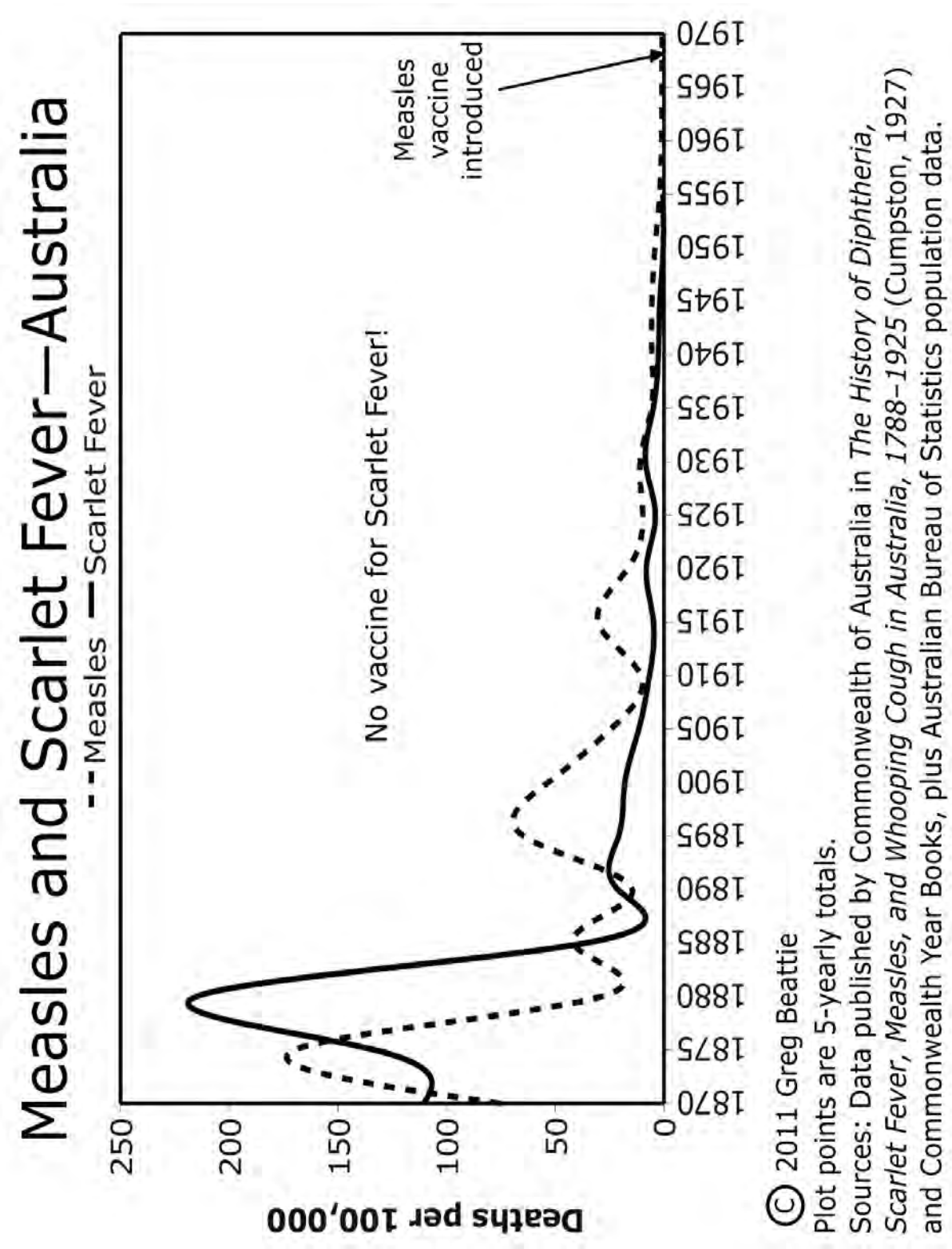
Appendix 4.


Measles and Scarlet Fever—Australia
Measles
Scarlet Fever
No vaccine for Scarlet Fever!
Measles vaccine introduced
Deaths per 100,000
250
200
150
100
50
0
1870
1875
1880
1885
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1895
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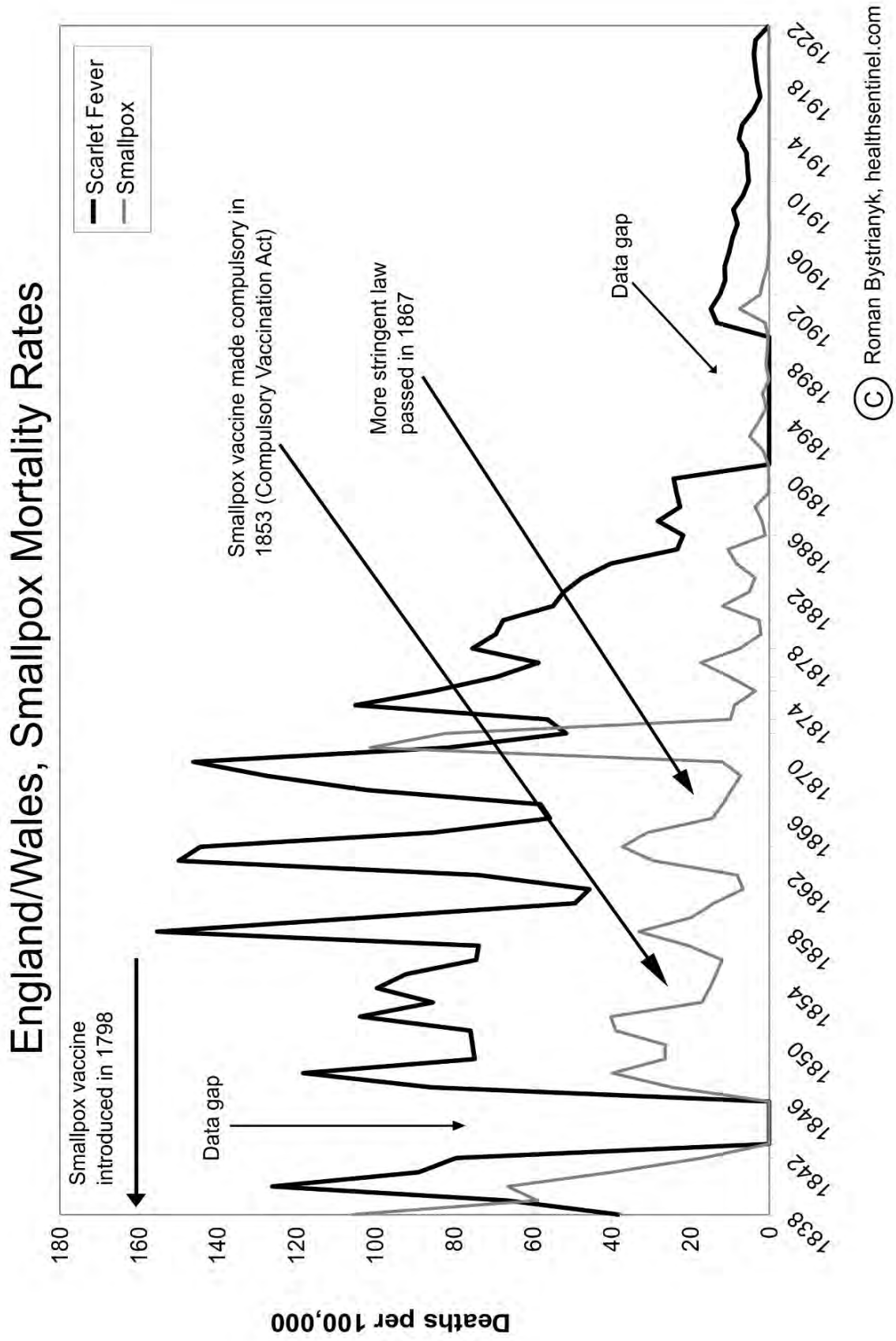
Appendix 5.


England/Wales, Smallpox Mortality Rates
Scarlet Fever
Smallpox
Smallpox vaccine introduced in 1798
Data gap
Smallpox vaccine made compulsory in 1853 (Compulsory Vaccination Act)
More stringent law passed in 1867
Data gap
Deaths per 100,000
180
160
140
120
100
80
60
40
20
0
1838
1842
1846
1850
1854
1858
1862
1866
1870
1874
1878
1882
1886
1890
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1898
1902
1906
1910
1914
1918
1922
© Roman Bystrianyk, healthsentinel.com
References: Record of mortality in England and Wales for 95 years as provided by the Office of National Statistics - Published 1997;
Report to The Honourable Sir George Cornewall Lewis, Bart, MP, Her Majesty's Principal Secretary of State for the Home Department,
June 30, 1860, p. a4, 205; Written answer by Lord E. Percy to Parliamentary question addressed by Mr. March, M.P., to the Minister to Health
on July 16th, 1923; Essay on Vaccination by Dr. Charles T. Pearce, M.D Member of the Royal College of Surgeons of England

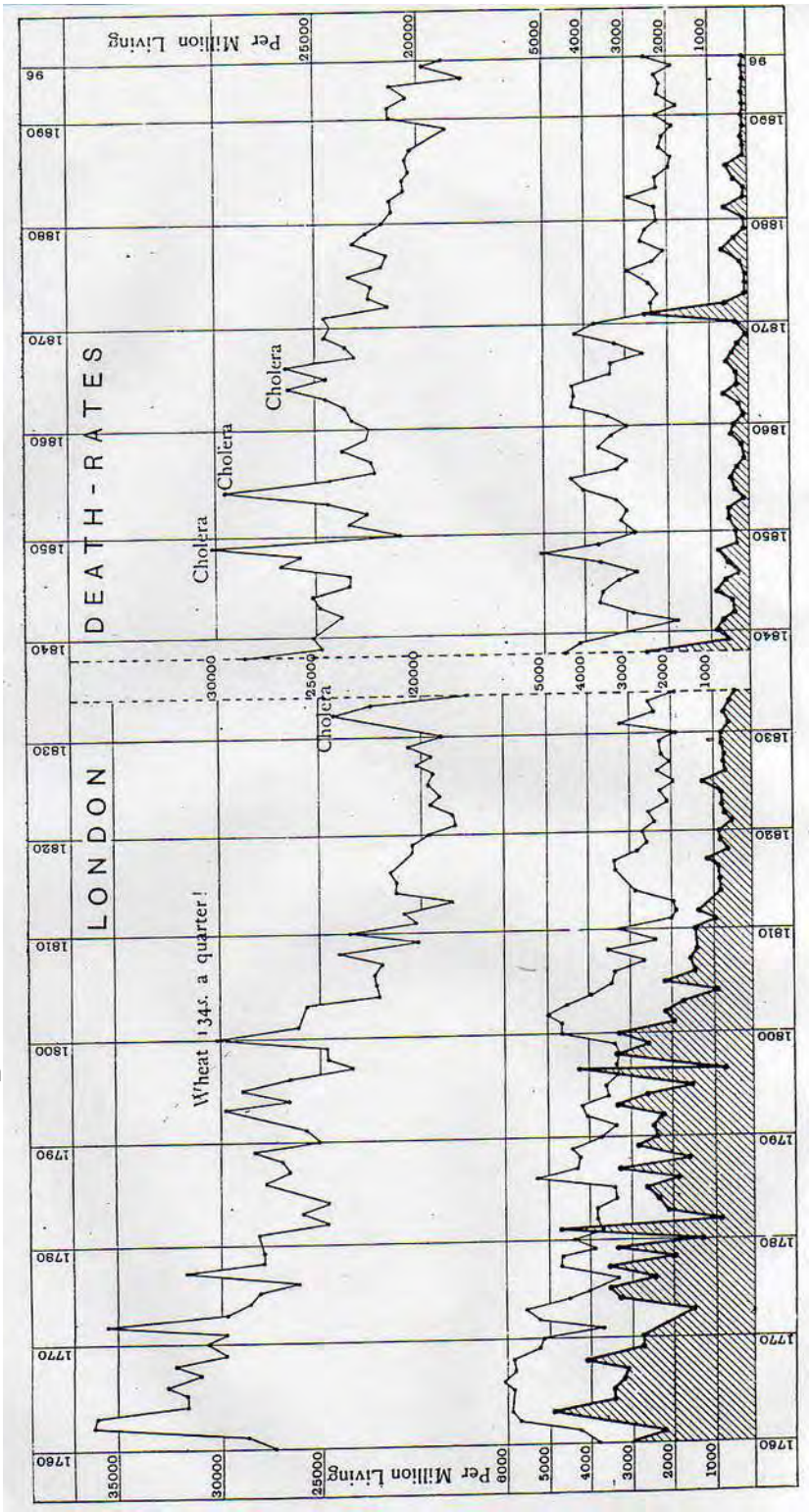
Appendix 6.

This is a copy of a graph hand-plotted by Alfred Russel Wallace, showing death rates in London for the period 1760-1896. It is available in his book* online.

Wallace was co-founder of the theory of evolution, and has been described as one of the most important scientists of the past 200 years.

Smallpox (the lower, shaded area) is compared with all zymotic illnesses (middle line) including measles, fevers, whooping cough and diphtheria, as well as deaths from all causes (upper line). There is a "break" in data toward the end of the 1830s. This reflects a change in data source. The earlier figures are from the old Bills of Mortality (considered less accurate). The latter figures are from the General Register, established in 1836.

The vaccine was introduced in 1798 and slowly gained acceptance over the first 40 years of the century, after which the British government provided it free of charge. The graph (explained more completely in the book) demonstrates that the trends in the three separate lines were the same. All death rates rose and fell together, even though smallpox was the only one with a vaccine.



* Wallace AR. Vaccination, a delusion: its penal enforcement a crime; 1898
http://www.whale.to/vaccine/wallace/comp.html