HEALTH AND AMBULANCE SERVICES COMMITTEE

Members present:

Ms L Linard MP (Chair)
Ms RM Bates MP
Mr SL Dickson MP
Mr AD Harper MP
Mr JP Kelly MP
Dr CAC Rowan MP

Staff present:
Ms K Dalladay (Principal Research Officer)
Ms E Booth (Principal Research Officer)
Ms C Keyes (Executive Assistant)

PUBLIC HEARING—INQUIRY INTO THE PUBLIC HEALTH (CHILDCARE VACCINATION) AND OTHER LEGISLATION AMENDMENT BILL 2015

TRANSCRIPT OF PROCEEDINGS

THURSDAY, 10 SEPTEMBER 2015

Brisbane

THURSDAY, 10 SEPTEMBER 2015

_____

Committee met at 9.32 am

CHAIR: Welcome, ladies and gentlemen. Thank you for your attendance today. Before we start, I ask that all phones be switched off or put on silent. I now declare this public hearing of the Health and Ambulance Services Committee open. I would like to acknowledge the traditional owners of the land upon which we meet and pay my respects to elders past and present.

I am Leanne Linard, member for Nudgee and chair of the committee. The other committee members with me today are: Ms Ros Bates, deputy chair and member for Mudgeeraba; Mr Steve Dickson, member for Buderim; Mr Aaron Harper, member for Thuringowa; Mr Joe Kelly, member for Greenslopes; and Dr Christian Rowan, member for Moggill.

Today we are hearing evidence on the Public Health (Childcare Vaccination) and Other Legislation Amendment Bill 2015. The bill aims to increase immunisation rates by giving childcare centres the option to refuse, cancel or place a condition on the enrolment or attendance of a child who is not up to date with their immunisations. Childcare centres would not be required to exclude these children, but the centre would be protected from liability if they refused or cancelled a child's enrolment on the basis of their immunisation status. The bill also makes unrelated amendments to clarify the Health Ombudsman's information-gathering powers, to ensure the ombudsman can effectively undertake investigations into serious healthcare complaints.

Our inquiry into this bill commenced on 15 July and will conclude when we report back to the parliament by 2 October 2015. The committee has received 45 submissions which are published on the committee webpage.

I would like to advise you of a few procedural matters before we hear from our invited witnesses. The committee is a statutory committee of the Queensland parliament and as such represents the parliament. It is an all-party committee, which takes a non-partisan approach to inquiries. Committee proceedings are subject to the Legislative Assembly's standing rules and orders. People in the room not providing evidence are reminded that they are here to observe proceedings and may not interrupt. Anyone who disrupts proceedings may be removed at the discretion of the chair or by order of the committee. Hansard is making a transcript of proceedings which will become available as soon as practicable and the proceedings are also being broadcast live on the parliament's website.

I would now like to welcome our first witnesses from the Department of Health and the Department of Education and Training. I thank you all for your attendance today. I invite you to make an opening statement before I open it up to the committee to ask questions. If you are not able to answer a question, you may take it on notice. The secretariat will be in touch with you about timings for providing your responses after the briefing. Can you please introduce yourselves and then make an opening statement?

BROWN, Mr Scott, Acting Manager, Immunisation Program, Communicable Diseases Unit, Queensland Health

HARMER, Mr David, Director, Legislative Policy Unit, Queensland Health

McCOY, Ms Lisa, Acting Executive Director, Regulation, Assessment and Service Quality, Early Childhood Education and Care, Department of Education and Training

YOUNG, Dr Jeanette, Chief Health Officer and Deputy Director-General, Prevention Division, Queensland Health

ZGRAJEWSKI, Mr Mark, Manager, Legislative Policy Unit, Queensland Health

Dr Young: Thank you very much for this opportunity to brief the committee on the Public Health (Childcare Vaccination) and Other Legislation Amendment Bill 2015. I will provide a brief summary of the Public Health (Childcare Vaccination) and Other Legislation Amendment Bill, which amends two Health portfolio acts, before answering any questions committee members might have regarding this bill.

The primary purpose of the bill is to amend the Public Health Act 2005 to promote vaccination and protect children, their families and those who work with children against vaccine preventable disease. The bill will also make an urgent amendment to the Health Ombudsman Act 2013 to clarify the Health Ombudsman's information-gathering powers. First, I will deal with the childcare vaccination amendments to the Public Health Act 2005.

The bill clarifies the circumstances in which an approved service can refuse the enrolment or attendance or only allow conditional enrolment or attendance of a child on the basis of their immunisation status and be protected from liability for doing so. An approved service includes education and care services approved under the Education and Care Services National Law (Queensland) Act 2011 or the Education and Care Services Act 2013. This means that the bill will apply to family day care services, kindergarten services, long day care services, limited hours care services and outside school hours care services. The bill will not apply to unregulated services, as these services are often short-term, ad hoc arrangements. Schools are also excluded from the scope of the proposed bill.

In April 2015, the Prime Minister announced federal budget measures that would mean that parents who fail to immunise their children would no longer have access to family tax and childcare benefits. In keeping with these national changes, the bill does not exempt children whose parents object to immunisation on the grounds of conscientious objection. However, the bill makes allowances for children who are unable to be immunised for medical reasons or children who are on a recognised catch-up schedule.

The amendments to the Public Health Act 2005 will, subject to passing, commence on 1 January 2016. To support implementation of the legislation, a comprehensive implementation plan, including a communication strategy and marketing campaign, will be developed by the Department of Health in collaboration with the Department of Education and Training to inform all stakeholders of the consequences of the proposed changes and how they may be affected. A key feature of the implementation plan will be the development and distribution of communication materials to assist families and approved services to understand the changes to the Public Health Act 2005 and provide parents with accurate information on vaccination to help them to make an informed decision regarding their child's health and welfare.

The department has reviewed the 45 submissions made to the committee regarding the proposed childcare vaccination amendments and notes that the majority of 41 submissions that oppose the bill have been made by individual members of the public. I note that many of these submissions raise concerns about vaccine safety and vaccine efficacy. I wish to assure the committee that governments worldwide support and implement immunisation programs because immunisation is highly effective at preventing serious and life-threatening vaccine preventable diseases.

Worldwide it has been estimated that immunisation programs prevent approximately 2½ million deaths each year. Due to immunisation, diseases such as diphtheria, tetanus, haemophilus influenzae type B and poliomyelitis do not occur or are extremely rare in Australia. Recent media regarding a cluster of measles cases in Brisbane highlights for us all the vulnerability to serious disease faced by those who are unvaccinated. Measles is a global disease and is one of the leading causes of death amongst young children in the world. The World Health Organization reports that in 2013 there were 145,700 measles deaths globally and that measles vaccination resulted in a 75 per cent drop in measles deaths between 2000 and 2013 worldwide. Measles is a very serious but preventable disease which is why I strongly advocate for people to be vaccinated.

Immunisation has long been recognised as one of the most successful public health interventions introduced in Australia, enabling community health to be maintained and protected by reducing and eradicating vaccine preventable diseases. The majority of Queenslanders support immunisation and have their children vaccinated. This is validated by the high childhood immunisation rates in Queensland. While Queensland immunisation rates are consistently good—around 92 per cent—and often above national rates, they are below the desired 95 per cent target to achieve herd immunity for diseases such as measles. With groups of young children at various ages closely assembled in approved education and care services, it is important that most, if not all, children are up to date with their immunisations to best protect children and employees at the service from vaccine preventable diseases.

The amendments to the second act, the Health Ombudsman Act, apply to the information-gathering powers in the Health Ombudsman Act 2013. The proposed amendments have been developed in response to a recent decision of the Supreme Court that section 228 of the act is too ambiguous to support the issuing of a notice requiring a person to attend and answer questions. The proposed amendments address this by expressly providing that an authorised person may

require a person to attend at a stated reasonable time and place to answer questions or produce documents. The amendments will ensure that the Health Ombudsman has appropriate powers to carry out investigations into serious matters relating to the provision of healthcare services. I note that the department will be responding in writing to queries the committee has regarding these amendments.

CHAIR: Thank you, Dr Young, for your presentation. We will open it up now to the committee for questions. Dr Young, you mentioned that we have a fairly stable rate of immunisation at the moment in Queensland of 92 per cent. The target, of course, is 95 per cent. What appreciable difference will increasing the rate from 92 per cent to 95 per cent have on the Queensland population? Can you explain that a bit more?

Dr Young: Yes. There are some diseases that are so contagious—and measles is particularly one of them—that if there are people in the community who are not vaccinated those people will get the disease when exposed. We are seeing that today in the University of Queensland environment where we are seeing people get measles. You can then get outbreaks, and we have seen that over a number of years. That is why we aim for that 95 per cent coverage because we know that at that point it is far less likely that a disease can get hold in a community.

CHAIR: If we have a static rate of about 92 per cent, who makes up the eight per cent who are not vaccinating? Do you have a good understanding of what the issues are and why they are choosing not to vaccinate or who is represented in the eight per cent who are not vaccinating?

Dr Young: There are around 2.4 per cent who declare themselves under the current process as being conscientious objectors, so they have a firm belief that they do not want their children to be vaccinated. Then there is another group that find it a bit hard to get organised to get their children vaccinated, because it is quite a complicated schedule. That is why we are putting in place a number of processes to assist that group. Then there is another group who are sitting on the fence. They are not quite sure. We all know in life that sometimes it is easier to make no decision than to make a decision. Deciding to get your child vaccinated is a decision you need to make. For some people they just choose to leave it be. So we again believe that by putting in place various strategies we can assist that group to make an informed decision and progress with it.

CHAIR: On that basis, genuine medical grounds would be fairly rare or a small percentage?

Dr Young: Yes. We have also set up a clinic at the Lady Cilento Children's Hospital to assist parents who think their child has a medical contraindication so that they can see experts in this area and their children can be vaccinated in a highly supported environment, if the parents think there are concerns. That is one of the strategies to help that small group that may feel they have contraindications but they do not actually; they just need some more support—or, indeed, that group whose family members have potentially had problems. Again, there is no reason that that child might have a problem but the parents feel that they need more support. We are going through a lot of strategies at the moment to try to assist parents. We are not just putting this in as a single strategy. It is all about working together, and we think with all of these things working together we genuinely aim to get to a rate of 95 per cent.

Ms BATES: Dr Young, it is nice to see you again. You would recall that I was on the committee looking at the private member's bill, and I raised some issues and that was one of the reasons the bill did not proceed. There are children who have developed acquired immunity to things like measles and chicken pox that they would have come into contact with. My query back then was, 'What do parents do if their children have acquired immunity and how do they prove that so they can then be admitted into childcare facilities?' What do you do with babies who are too young to have gone through the vaccination protocol whose parents put them into a childcare facility?

Dr Young: Their GP can determine that they are immune through a blood test or having treated the child while they have had the disease. That then goes onto the database and they are regarded as up to date. We are not asking childcare centres to make medical decisions. They will just go to the information that is provided, and up the top there will be a statement 'up to date' or 'not up to date'. It is about being up to date with age-appropriate immunisation. Of course, children can enter child care from the age of six weeks, at which stage they will have had only their birth hepatitis B vaccination and they may have had their first two-month vaccination, because that can happen from six weeks of age, but that is all. So they would be regarded as up to date, but if the parent did not go ahead with the two-month, four-month, six-month and other vaccinations the child would no longer be up to date and would fall under that process that the childcare centre, or the other centres involved, can make a decision about the ongoing enrolment.

Ms BATES: I think back in 2014 Lawrence Springborg was quoted in the *Courier-Mail* talking about conscientious objection. He felt at the time that conscientious objections for vaccinations had been abused or misused and we were really dealing with people who were vaccine refusers. That is one aspect of it. The other you have spoken about before: the misconception about vaccines and educating parents that they may not have medical reasons to have their child exempt. Can you elaborate a little more on that? Conscientious objection is one of the areas that is ruled out in this bill.

Dr Young: Given that conscientious objection was a process that was put in place and managed by the Commonwealth—it is not a scientific term; it is a social term—and given that has now been removed, people who do not want their children to be vaccinated will just be deemed as people who do not want their children to be vaccinated. So there is not that status around it and that ability to be exempted. That is why it has not been included in this bill.

As to medical reasons to not be vaccinated, there are some. There are not many, but there are some genuine reasons people cannot be vaccinated. They are taken into consideration, a decision is made and they are deemed 'up to date' on that form, but there is a process to go through. The GP would work that one through. As I said, we now have a specialist clinic run at the Lady Cilento hospital to assist GPs with that.

Ms BATES: With the federal legislation 'no jab, no play' coming in, has that been considered in this bill? I do not think it had come into play when the private member's bill was originally brought forward?

Dr Young: No. The removal of the conscientious objection process has assisted us greatly because that was going to be in conflict. Now that has gone it makes it easier to manage this process. Immunisation is never about doing one thing; it is about doing a whole range of things. We believe this will greatly assist childcare centres when they make up their mind about what they are going to be doing.

Ms BATES: Thank you very much.

Mr KELLY: I am interested in the clinic that you mentioned at the Lady Cilento hospital. It is obviously based in the middle of Brisbane. I assume there are mechanisms in place for people from regional centres to access that service if they so desire?

Dr Young: Yes. As with all of our services, we do have superspecialist services in limited ranges because you need that high degree of expertise but, yes, any child anywhere in Queensland would be able to access that service. No doubt they will be looking at ways to simplify that for people. Using telehealth, which is now widely used across Queensland, would be one way. They might do outreach. That is up to them how they are best going to assist all children throughout Queensland with that process.

Mr KELLY: Some of the submissions we have received have indicated that the potential consequence of children not being enrolled amounts to coercion which would mean that families are not being given the opportunity of informed consent. How does that accord with your understanding of informed consent?

Dr Young: Ultimately this is a decision for every single parent to make. We have an obligation to provide the best information to them so they can make those decisions. We have the obligation to provide the best information to the directors of all childcare services, kindergartens and so forth so they can make the best decision for those children. We do believe it is very important that children are vaccinated so we will assist everyone to accomplish that aim.

Mr DICKSON: Dr Young, welcome back. My issue is probably a little complicated. I am a great believer in immunising the herd. I think we need to do that. We can see what is happening in the United States at the moment with black death. Something we thought had gone away is back. Here in Australia we have 15,000 children who are not immunised. What sort of communications strategy does the government have in place to educate mums and dads of the possible risk to their child's life and the possible risk of spreading something else throughout the community? We also have a lot of older people who are not getting reimmunised for whooping cough, for instance. My wife was one of those people who caught whooping cough at the age of 37. She did not know she had to get immunised again. Are we informing people, because they are going to be carriers?

Dr Young: There are a couple of issues there. With regard to the first one, we have started a process that will commence on 1 October to ring up the family of every single child who is not fully immunised who is under the age of five. That is starting on 1 October. It will be led by 13HEALTH. We are directly going to get in contact with people, provide them with information and refer them to their own GP to talk to their GP about being immunised. For the small number of people who do not

have GPs, we are going to work with GPs to set up clinics that we can refer people to. There are two parts to it: firstly, giving them information and, secondly, making it easier for them to get immunised. It is for that group that has struggled to get organised to get their children immunised. We have that process in place because it is so important to provide information to those people. I have forgotten your second question, sorry.

Mr DICKSON: It was relating to the 15,000 people, a gap of three per cent—

Dr Young: It was the adults, sorry, that you asked me about. The reason we are focusing on under-five-year-olds is for their own protection. We know that the deaths that occur as a result of whooping cough are in the youngest children so they are the group that has to be immunised. Although older people can get very sick from whooping cough, for instance, and from other diseases, they do not usually die. It is similarly so with measles. It is the younger ones who are the most vulnerable in our society. Particularly when we are gathering lots of children together, some who are too young to be immunised at all against some of the diseases—for instance, you cannot get immunised until 12 months against measles. Even in an epidemic we do not recommend it before nine months. That means you are vulnerable until that stage, and you are going to a childcare centre where you have a lot of other children, and children do rapidly pass diseases on from one to another.

That is why we are focusing on that under-five-year age group. We have done some other work with older communities about being vaccinated, and we have done our best to try to make it easier for adults to get vaccinated. At the moment we are trialling a program in pharmacies, for instance, which are vaccinating adults. That has been quite successful so we have been evaluating that. It is very important as well for adults to maintain their immunisation status. If they have any queries about that, they are best to speak to their own GP, who can organise that immunisation for them, but our focus at the moment is very much on under-fives.

Mr DICKSON: Please keep up the hard work.

Dr Young: Thank you very much.

Mr HARPER: Good morning, Dr Young, and your departmental representatives. Thank you very much for your contribution to what is a very important topic in the community. One of the submissions talked about the risk of childcare workers not being vaccinated. Do you think there could be a role for legislation that requires childcare workers to be vaccinated?

Dr Young: It is a very important issue, and it is one that we have struggled with for quite some time. You may have seen that we have brought in a compulsory process for ambulance workers to be fully vaccinated before they start work. We are working through Health at the moment to look at a similar process, looking at the issues and how to progress with it for other healthcare workers. Part of that will certainly look at other areas where you have vulnerable people, not only in childcare centres but also in aged-care centres. We have very vulnerable people there. Again, it would be advisable for workers in those centres to be vaccinated. At the moment it is very, very strongly encouraged. The National Health and Medical Research Council guidelines for immunisation, which are what we all work off, strongly encourage it but it is not mandated at this point.

Mr HARPER: As a former paramedic I think it is a great initiative to vaccinate childcare workers. Are there examples in other states and territories of laws such as this that have worked to increase vaccination, and how has that informed this legislation?

Dr Young: There are not as to what we are doing. Some other states have laws in place that before a child can start in a childcare centre or equivalent they must provide evidence of their vaccination status. It is not that they must be vaccinated but they must provide evidence whether they are or they are not. We have not gone down that route in Queensland to date because we can easily find out that information from the register. There is a requirement already under the accreditation standards that my colleague would be able to more fulsomely go through that childcare centres are meant to collect that information. We have not gone down that route. New South Wales definitely has, and I understand there is a submission from New South Wales about that. They may well have evidence as to whether that has improved outcomes in their state. From our look at the data, their vaccination rates look quite similar to ours so we do not think there is, but they will have their own data which would be more powerful as to whether that process has worked.

There is no other state that has done what we have done. Victoria's Premier made an announcement back in August that they were going to take legislation to their parliament to mandate what we are doing, but I do not know where they are up to with that. He did make an announcement that they would be taking that legislation to parliament before the end of the year and hoped to enact it on 1 January next year, but I am not aware of where they are up to in those stages.

Mr HARPER: Thank you very much.

Dr ROWAN: Thank you, Dr Young, and your colleagues for the important work you undertake in this vital area of public health. My first question relates to the current and future immunisation strategy that the department has in relation to immunisations and how this articulates with primary care, particularly general practitioners and the primary health networks.

Dr Young: Primary care is absolutely critical. They vaccinate well over 80 per cent of Queensland's children. If I can maybe clarify that: primary care through general practice vaccinates over 80 per cent. Then local government vaccinates a small number, and then our hospitals and health services. So it is absolutely vital that we continue to work very closely with general practice over this, and we do have a good working relationship with GPs. We provide the vaccines free of cost of course to GPs and then they deliver it to their patients, and we will continue that process.

We have engaged with GPs with our last initiative—when we are going to be ringing up every family with a child under the age of five who is not fully vaccinated. So we have been working for that very small group who do not have a GP, because we know they are a very small group but they are an important group. It is harder to work with that group. So GPs have come forward and are willing to assist us in providing clinics to assist that group.

Dr ROWAN: My next question relates to the data that the department collects in relation to exemptions for medical reasons. We have talked a little bit about those numbers across Australia—through my colleague the member for Buderim—but is there a breakdown across the state as to those numbers? Are there geographical variations, where there are more exemptions for medical reasons in some geographical areas as opposed to others? Is there a difference in the reasons for that in those particular areas?

Dr Young: I am sorry, I do not know the answer to that question. I do not know if Scott knows.

Mr Brown: No, sorry, I do not, because it is collected by the Commonwealth now.

Dr Young: We could ask the Commonwealth and see if we could get that information, because it actually would be very helpful for us in terms of the Lady Cilento clinic, so thank you for raising it.

Dr ROWAN: That would be great if you could take it on notice. My next question relates to the proposed amendments to the Health Ombudsman Act and compelling witnesses to appear in relation to health complaints investigations. Are there any additional natural justice provisions that need to be considered in your view, and should potential witnesses have legal representation with those?

Dr Young: I am very sorry, Dr Rowan, I cannot answer that question. It is not my area, but we can certainly take it on notice if the Chair is happy with that.

CHAIR: Thank you, Dr Young. Member for Moggill, we will send those questions to them because we do not have the right people here.

Dr Young: I apologise.

Dr ROWAN: Just coming back to immunisations, my final question relates to obligations on childcare providers retaining primary documentary evidence in relation to immunisation status. In your opinion, should that occur and, if it should, how would that process be implemented in a practical sense?

Dr Young: I believe they need to retain that for their benefit, but we always have that primary data ourselves and we can always access that very, very easily. Ms McCoy might have something further to say to that one.

Ms McCoy: There are two pieces of legislation, as Dr Young explained in her opening remarks. In terms of our legislation, they are required as part of the enrolment to keep information about immunisation status. That is already required under the current legislation, so this really just expands how they would satisfy the types of information they would be required to keep if they choose to use the provisions.

Dr ROWAN: Thank you.

CHAIR: Dr Young, I have two young children myself—aged two and four—and obviously vaccination is a very emotive issue. We have read all of the submissions that the committee has received and some of them take some very emotive views and concerned views about vaccinations. Certainly, I know in the case of my family that we made the decision in consultation with our GP and our paediatrician. Can you talk a bit about the efficacy and safety of vaccination, because that is a key concern?

Dr Young: Yes. Vaccines are very efficacious but they are not 100 per cent effective. That is one of the reasons we do aim for that 95 per cent coverage. The vast majority of people will develop immunity, but there is a very small group who do not. That is well known. The other issue is that although someone might have a breakthrough illness—so they might still get the disease after they have been vaccinated: it is rare, but it does happen—usually that is an attenuated form so they are much less sick. So there is still that protection. That is in terms of efficacy.

In terms of their safety, these vaccines are all trialled extensively and there is ongoing reporting about instances. Again, no pharmaceutical is 100 per cent safe. Every pharmaceutical will have side effects, and vaccines are no different. But the vast, vast majority of the side effects to vaccines are local ones—so they cause pain at the site of the injection, some redness, some swelling. Then far, far less commonly there are more serious effects, and that is one of the reasons that Lady Cilento clinic has been set up. It will assist people if they do have a more serious side effect and they need to have that vaccine again—because with a lot of vaccines you do need two or three doses for it to be efficacious or you need booster shots—so they can have that vaccine in a safe, protected environment.

I assure you that all vaccines are thoroughly tested. They have to go through the Therapeutic Goods Administration—it has a new name now, I apologise—and the Commonwealth for assessment before they are endorsed and are allowed to be used in Australia, and there is a very thorough process there. That process is well and truly tried and tested.

Ms BATES: I noticed before that one of my colleagues raised the matter of childcare workers being immunised. I am glad that we are looking at addressing that because I did raise that in the private member's bill last year. I also want to clarify again about the previous objections of the committee in the 2013 bill—at that stage it provided for objections, whether conscientious or medical, which has now been overturned due to the federal legislation. I think our stance at the time was because it was state legislation at the time and there was no federal legislation that overruled it, so I wanted to clarify that because I obviously spoke to you about that at the time.

Can you elaborate on some examples for the non-medical people in the room about what an approved medical reason for not being vaccinated would be? I raised this last time too. My daughter was a super allergy baby and she did have her vaccinations but every one of them was done in theatre or in the intensive care unit and I just waited for the code blue to be called. Can you give some examples of severe medical conditions that children could have that would make them exempt from this?

Dr Young: You have raised the main one, which is allergic reactions. That is again why that clinic has been set up—to provide those vaccines in a safe environment. That is the major one that we work through. As I said before, there are a lot of minor reactions that would not be regarded as reaching that threshold.

Ms BATES: Steve Dickson raised pertussis outbreaks. I think that is a really big issue because as you know there are a lot of adults wandering around with whooping cough who have no idea they have got whooping cough. Again, going back to my experience as a parent, my daughter was vaccinated three times in six years for pertussis and she still got pertussis. Is there any view on that?

Dr Young: Pertussis is not as efficacious a vaccine. The immunity does tend to wane in time, but the most important thing is to protect those babies under two months of age because they cannot get vaccinated until they are six weeks old and they are the ones who will die if they get it. It is an awful disease when adults get it, but they do not usually die from it, but little babies do. We have now rolled out a program that has been quite successful for pregnant women. In their third trimester, we are vaccinating them and that is passing on that immunity to their unborn babies so that baby is protected for the first six weeks. The UK did a similar program, which is why we followed. They had a whole run of deaths of little babies—I cannot remember now but I think it was about 10 deaths, and of course their population is so much bigger—and they put in the program and they only had one death after that in the evaluation period and that was in a mother who had not been immunised against pertussis during pregnancy. So it is a very effective program.

Ms BATES: I do remember something similar happening in Victoria in the early 1980s. I was working in the paediatric unit at the time and there was a child and it was a pretty big case in Victoria. I do not know exactly what the ratio is for the patients who are severely allergic to the pertussis vaccine, but a whole raft of babies—they were newborns who had effectively only just been out of hospital—were coming back in and we had really, really sick babies. We did not lose any but we had this whole rash just because there was one very highly publicised issue of a baby who had been vaccinated and had a reaction.

Dr ROWAN: I have one final question, Dr Young. If we were not to have the current range of vaccines that are available to be utilised, are you aware of any other treatment modalities which are evidence based which would lead to a reduction in infectious transmissible diseases?

Dr Young: Not one that is as effective as a vaccine. That is the most effective way of preventing vaccine preventable diseases.

CHAIR: Thank you very much, Dr Young, for the fulsomeness of your responses here today. There is one final minute if anyone else with you wanted to make any final statements or comments. I know the Department of Education and Training is here too—

Mr KELLY: I am happy for this question to be taken on notice. You mentioned that all medications have the potential for adverse outcomes. Would you be able to give us a percentage of adverse outcomes that might result from the various types of vaccinations—I know there are a range of them out there—versus the percentage of mortality rates in populations that were not vaccinated prior to the introduction of vaccinations?

Dr Young: We will do our best to address that. I think it is one best taken on notice because it is quite complicated in terms of the data. We are very happy to take that on notice.

CHAIR: Thank you. With that, our time has expired. Thank you so much for attending today and again for the fulsomeness of your responses. We very much appreciate it.

GILBERT, Mr James, Health and Safety Officer, Queensland Nurses Union

MOHLE, Ms Beth, State Secretary, Queensland Nurses Union

TODHUNTER, Dr Liz, Research and Policy Officer, Queensland Nurses Union

CHAIR: I welcome the Queensland Nurses' Union. Thank you very much for coming this morning. I invite you to take a moment to introduce yourself and make an opening statement, and then we will ask some questions.

Ms Mohle: The QNU thanks the Health and Ambulance Services Committee for providing time for us to present here today. I am Beth Mohle and the secretary to the Queensland Nurses' Union. With me today is James Gilbert, our health and safety officer, and Dr Liz Todhundter, our research and policy officer. We will take our submission as read, but we would like to make some opening remarks.

The QNU recognises the importance of immunisation as a public health initiative that saves lives. Immunisation not only protects individuals but also others in the community by reducing the spread of disease. Other than clean water, vaccinations had the most significant impact on public health during the 20th century and remains one of the most important activities involving health professionals. For these reasons, the QNU gives support to the bill.

In many ways immunisation programs have become the victims of their own success. In industrialised countries the vast majority of the population has never witnessed the diseases that vaccines protect against. Consequently, in recent times there has been a growing resistance to such interventions. However, we know that routine childhood immunisations protect babies and children from potentially serious diseases such as measles, polio, tetanus and whooping cough.

When high percentages of people are fully immunised, diseases such as whooping cough have less opportunity to spread because there are fewer people who can be infected. We recognise that there are parents or carers who choose not to vaccinate their children for various reasons that may be around vaccine safety or preference for natural immunity. Parents or carers who refuse vaccinations during infancy and early childhood may consent to vaccination after the child reaches school age. Unfortunately, children whose vaccinations are perpetually delayed or refused present a health risk to other children at school. Some parents with vaccination safety concerns may also express a strong distrust of government and vaccine manufacturers and, by extension, a distrust of conventional preventive medicine.

We know that giving childcare providers the option of excluding unvaccinated children from care may be confronting and contentious. Of course, children have an internationally recognised right to education. Also under article 22 of the Convention on the Rights of the Child, children have the right to good quality healthcare. We argue that these two rights are not mutually exclusive and work together to promote the best possible future for all children. Therefore, although we accept that parents have the right to make personal choices about immunisation, in choosing not to vaccinate they may place others at risk. For these reasons we support initiatives that will protect the public from any outbreak of a vaccine preventable disease.

We have not addressed the second part of the bill regarding the proposed changes to the Health Ombudsman Act. We understand that Labor has committed to a review of the Office of the Health Ombudsman and would like to hand up to the committee our original submission regarding the establishment of that office. It may assist in your deliberations. We have that submission here today.

CHAIR: Thank you for those opening comments. Just to touch on your submission and your comment, then, what options do you see as being the best ones to engage with parents who do have deeply held concerns about vaccinations?

Ms Mohle: I think it is really important that we do take a step back and give some careful thought to this, because I think people need to have their concerns heard. I think there are often competing interests and there are very deeply held views, as we know. I think we could look at strategies whereby we do establish mechanisms for parents to have their concerns heard and to feel that they have been heard. I think there certainly are issues in regard to, for example, new vaccine regimes that may not be the tried and tested ones and parents might have concerns about the efficacy of those. It does not do anybody any good to just stand back and say, 'We're not going to engage with you about that.' I think it is challenging, but we have to put our mind to how we provide avenues for engagement to occur, for concerns to be heard, for the evidence to be provided and for the evidence to be tested, if that is required. It is challenging; we absolutely do know that that is

challenging. We do support the initiative that Dr Young highlighted about the Lady Cilento hospital and what has been established there. I think there is a much greater need for community engagement and education about this.

Ms BATES: Earlier I raised with Dr Young the issue of childcare workers not being vaccinated. We all know that disease spreads in lots of different ways; it is not just from child to child or from health worker to child. You and I both know that health professionals can inadvertently spread nosocomial infections in hospitals. Does the QNU have a process to ensure that nursing staff have their vaccinations up to date as well? If we are going to do herd immunity with everybody and try to eradicate many of these diseases, we have to look at all different aspects.

Ms Mohle: Our policy committee gave some considerable attention to the whole issue of vaccinations the year before last. We have endorsed our federal body's policy in regard to vaccination, which I think we have provided as an attachment to our submission. It is an ongoing challenge and we certainly do promote it to our members to make sure that they keep their immunisations up to date. I might hand over to James. He can provide some background in terms of what happens at the hospital and health service level and how we engage with Queensland Health in relation to that.

Mr Gilbert: To date it has not really come to a head, so to speak. We are not in the business of telling people that they should be vaccinated. We advocate that they should be, but ultimately it is their decision. If the employer—say it was Queensland Health—said, 'In this area we believe there is a risk to not only yourself but to the people who are utilising the service and we would need to consider whether you can continue to work here unless you are vaccinated,' we would engage in looking at possible reasonable adjustment for those people to continue their employment. Ultimately it probably comes down to the employer's determination.

I do know there is a committee meeting at the moment in regard to health worker vaccination within Queensland Health. Currently, the only vaccination that is mandated in employment is hep B. I have the policy from the School of Nursing and Midwifery at University of Queensland. It follows suit. It essentially says that they recommend people be vaccinated for all of the vaccinations under the immunisation handbook for categories of workers, but the only one that it is mandated for is hep B.

Ms BATES: Are you aware of any screening programs for nursing staff who work in paediatrics or midwifery where they are likely to have to deal with these infections?

Mr Gilbert: We do not because we are not the employer.

Ms BATES: I know, but has there been any thought to it, because they are the ones most likely to be dealing with unvaccinated children or outbreaks of certain diseases.

Mr Gilbert: I am not au fait with what happens. You would probably have to ask Queensland Health. You would have to ask the private employers as well; they have paediatric wards as well. I am unsure. I would imagine that without it being mandated potentially people could say, 'I don't want it.'

Ms BATES: I guess where I am going with this is that you need to have protection—

Mr Gilbert: I understand where you are going. I have a health and safety background. The last time we did this committee, my view was that health and safety people look at things in terms in the hierarchy of control. Clearly, if you are going to rely on PPE that is not as effective a mechanism as vaccination. It is a much higher order of control in terms of managing it. That is where we are coming from, essentially. I am sure that is the way an employer would look at it, too. At the last committee I mentioned that I believe that childcare establishments have those obligations to the Work Health and Safety Act.

CHAIR: Beth, you talked about how important education is and, if I am correct in recalling, that more education would be better than mandating. I mentioned earlier to Queensland Health that I have a two- and a four-year-old and I have found that there was extensive information and education. It was mentioned by my GP, the hospital and the paediatrician. Is it your perception that there is not enough already?

Ms Mohle: It is not so much education; it is about engagement, about getting to the source of what the concerns are. It is a bit more nuanced than that; it is bit of a deeper dive, if you like. It is actually getting to the source of what the concerns are and trying to unpack those and see whether there are ways of dealing with that. I agree with you: there is a lot of information out there—basic public health education—about the importance of immunisation. I think it would really be beneficial to

take a bit of a deeper dive, if you like, and to engage with populations who express concern about that and try to get to the root cause of the concern and see whether it is possible at all to bridge the difference. It may not be possible. I think it is worth putting that effort into the engagement to do that.

CHAIR: Who do you feel is best placed to do that engagement?

Ms Mohle: I think Queensland Health has a role to play certainly in that regard, and the various hospital and health services, now that it is decentralised, could do that through their population health work and their general engagement with the community. It might be more of an issue at some hospital and health services than at others. We are aware that there are particular geographical areas where it is more pronounced. It might be a higher priority for those hospital and health services to look at engagement in relation to that and, as I said, to try to unpack the source of the concern to see whether there are strategies that could deal with that.

Mr KELLY: In relation to a range of public health strategies, there are always positive and negative approaches to getting compliance and you never get 100 per cent compliance. In something like cigarette smoking, drink-driving or the wearing of seatbelts, there is always an approach for public education matched with fines for people who do not comply with the education that is provided to them. Similarly, there have been some criticisms of this bill that it has some coercive issues. Your submission talks about the need for the government to allocate more resources for community engagement and education. Do you think that, as with other public health initiatives, we need to also encourage people to behave in a manner that is going to be of benefit to the entire population?

Ms Mohle: That is exactly our point—the fact that you cannot just rely on coercion; it really does need to be about engagement and, as I said, trying to get to the source of what the concern is. You get much more if you take the time to sit down and unpack the various interests that are at play here, because there are at times competing interests and that is hard work. It is not easy. We have had a lot of experience of doing that as a union. In our approach to industrial relations, for example, that is the approach that we prefer to take. It often takes a longer time to do it that way, but we find it generally leads to better outcomes because there is a better understanding of each other's perspective and people actually hear what the concerns are if we take the time. Coercion will only go so far and there will be a backlash with regard to a strictly coercive approach to anything. That has been our experience.

Mr DICKSON: I thank you and your colleagues for coming along today. By the sound of your opening statement, you are reasonably supportive of immunising the herd so that we do not become contagious and spread this throughout our community. The Nurses' Union is reasonably well heeled and they have a very good advertising campaign, which I have seen from both sides. Would the union be willing to assist in advertising and communicating to their members and also the general population about what a good idea it would be to immunise our young children? Have they done that in the past? Are there plans to do that in the future?

Ms Mohle: We certainly do promote that to our members and certainly through our health and safety yearbook. On an annual basis we provide to our members a health and safety yearbook. Each year we have a different theme for the health and safety yearbook. In the past we have covered off on immunisation. As I said, we will certainly look at continuing to do that. We do on a regular basis promote that, particularly in relation to our policies—and I highlighted the policies from the Australian Nursing and Midwifery Federation that we have endorsed with regard to vaccination. We certainly would be willing to promote that to our members. As to the extent of our responsibility to do that for the broader community, I would question it. Our focus is on our members and communicating to our members about what is important from their perspective. They would have a different perspective, as James highlighted, as an employee as well. More often than not, the main argument that we have about vaccination when they occur is about whether the employer is prepared to pay for it. That is a contentious issue. There is an expectation that workers pay for it rather than employers. I am more than happy to promote to our members and to do anything positive that we can through social media and the like to promote it more broadly as well.

Mr DICKSON: This is just a suggestion, and I know I say this tongue in cheek to a point, but what a great idea it would be if the union could use the same potential that there is in an election campaign to be out there promoting this issue. I think it would be a really great exercise and I would support it in a bipartisan way.

Ms Mohle: That is about what our priorities are from a policy perspective. There is only so much airspace out there and our objective is always to get our main point across in terms of what we are prosecuting in election campaigns. We certainly take the point that we have a role to engage with the community. We take that very seriously. Indeed, the Queensland Nurses' Union was the

organisation, along with the then Queensland Nursing Council, that formulated the social charter for nursing and midwifery in Queensland. That was very much about that engagement with the community and about forming a partnership with the community to improve the health and wellbeing of the whole community. We do take that obligation seriously.

Mr DICKSON: Thank you very much.

Mr HARPER: Good morning, Beth, and your fellow well-esteemed people in this area from QNU. It is good to have your contribution on this particular topic. I take your point about education in that more can be done in that space, but your submission called for robust independent evaluation of the evidence around vaccine efficacy and the ongoing process to enable proper consideration of the new evidence, and perhaps Dr Jeanette Young and the previous Department of Health people could answer this question. I am particularly interested in any thoughts that you have on the independent mechanism to evaluate the vaccine efficacy. As Dr Jeanette Young and the Queensland Health people did take the member for Greenslopes's question on notice, they will actually provide some good data around allergic reactions and all the rest of it. Can you expand on any of that before they are mandated?

Ms Mohle: I think that indeed the critical point here is the fact that we cannot necessarily rely on the fact that people necessarily understand that information about efficacy, and it is forever changing and more evidence is coming forward every day. So we have to have a strategy to update the evidence, if you like, and put that before the community and that is really critical, and I think that Dr Young's area has a really important role to play in that regard. It is particularly important when new vaccines come along as well. We really do need to make sure. We have very rigorous processes within Australia to ensure the safety and efficacy of vaccines, but I think that as a union we are very much evidence based so everything that we do should be founded on a very firm evidence base. Communicating that to the community can at times be a challenge, but we have to get better at communicating. As Mr Kelly said before, it is a really good way to actually look at it in terms of the evidence that he asked the Chief Health Officer to provide and it would be very useful to put that before the community in terms of the trade-off, if you like, in terms of the evidence. We have to get better at finding ways of engaging with the community on the evidence, but never taking for granted the fact that the evidence does not stand still. There is always new evidence that comes about and we need to look at how we continue to integrate that into our communications about public health issues.

Mr HARPER: In terms of the independent evaluation, would you accept the Department of Health's data?

Ms Mohle: The Department of Health can source data from a lot of different sources so, yes, absolutely, and from the federal government as well.

Mr HARPER: Thank you very much.

Dr ROWAN: Thanks very much to Beth and your colleagues for attending today. We know there are a number of rural and remote workforce challenges across Queensland and in some of our remote parts of Queensland we do have rural isolated practice endorsed registered nurses.

Ms Mohle: Yes, RIPERNs.

Dr ROWAN: Yes, RIPERNs, so my question is this: should those roles be upgraded to full nurse practitioner roles and immunisations be within the scope of independent nurse practitioners? If so, should those roles be funded across Queensland or in specific areas in your view?

Ms Mohle: Dr Rowan, they would not necessarily have to be at nurse practitioner level. We have argued for some time to successive governments that the RIPERNs are under-utilised as a role and that there should be a strategy to upgrade them to nurse practitioner level to service remote communities. But in relation to immunisation, there are other roles such as immunisation nurses in city areas that actually perform that function. So I think that there is a really great opportunity to look at the roles right now in terms of what is available, and we are coming up to our next enterprise bargaining negotiations where we will be looking at career and classification structures.

One new role that we have got under the current government is a nurse navigator role that is working across the continuum of care. They are not necessarily giving the immunisations as such, but part of that role could certainly be looking at issues like how we increase immunisation rates across the population. So I think that there is a great potential to look at new roles. I do not think it necessarily would necessitate an expansion of the scope of practice because I think it is currently within scope of practice. So I do not think you would necessarily have to go to nurse practitioner level

to do that, but I totally agree with you the RIPERNs are an under-utilised and very precious resource in rural and remote communities and we should be looking at ways to decrease the barriers to them utilising their full scope of practice.

Dr ROWAN: So is it the union's view as well that the nurse navigator role might sort of morph into more independent nurse practitioners in the hospital system?

Ms Mohle: No, and again that is not necessarily their role. A nurse practitioner may be a nurse navigator, but that is not necessarily the case. The way that we see the nurse navigator role is that they have a critical role to play in ensuring better coordination of care across the care continuum. We think that patient centred care really effectively in our current system is paid lip-service to. We talk about it, but we do not really do much to bring effect to it and we think all health professionals have a role to perform to ensure better coordination of care and to ensure that the patient is genuinely put at the centre of health and aged-care decision making. We think that the nurse navigator role is an important potential game-changer in that regard to work across the whole continuum—acute, primary health care and aged care.

We are really pleased that we have this initiative from the state government. We are keen to see it extended to the federal government to buy into that and we have actually made that submission to the federal government's review of primary health care. We think we need a game-changer—we absolutely do—because it is better for patients but it is also better for the sustainability of the healthcare system. So we absolutely welcome this initiative as a start, but we think much more can be done and we need to build upon that, which is why we will be lobbying for that in the upcoming federal election as well.

Dr ROWAN: My final question is should nurses in all Queensland public hospitals be required to be vaccinated to ensure patient safety and reduce infectious diseases in the community?

Ms Mohle: The position of the ANMF in the position statement that we attached was the fact that we believe that they should be immunised but with careful balancing, as James said, in terms of people who hold really deeply held conscientious objection. We need to work through that, but the broad policy position is that we believe that, yes, they should and we would work with members who do have concerns about that.

Dr ROWAN: Thank you.

CHAIR: Beth, James and Dr Todhunter, thank you very much for appearing this morning and thank you for your ongoing involvement in the inquiries of this committee.

Ms Mohle: Thanks and we will hand up this submission.

CHAIR: Yes, thank you.

LEASK, Associate Professor Julie, School of Public Health, University of Sydney (via teleconference)

CHAIR: I welcome Professor Leask via teleconference. Professor Leask, I am not sure if you have been watching proceedings this morning, but, just to inform you, we have witnesses in the room observing the proceedings and this morning we have heard from the Department of Health and department of education, the Queensland Nurses' Union and now obviously yourself. We will hear from other witnesses following you. I am Leanne Linard, the chair of the committee and the member for Nudgee. Other committee members present today are: Ms Ros Bates, the deputy chair and member for Mudgeeraba; Mr Steve Dickson, the member for Buderim; Mr Aaron Harper, the member for Thuringowa; Mr Joe Kelly, the member for Greenslopes; and Dr Christian Rowan, the member for Moggill. I thank you very much for speaking to us today. Thank you for your submission. I invite you to make any opening comments and then I will open it up to the committee for questions.

Prof. Leask: Yes, I have prepared an opening statement that goes for three or four minutes. Would that be not too long?

CHAIR: No, that is okay, thank you. We look forward to hearing that. If you would like to deliver that now, that would be lovely.

Prof. Leask: I am a social researcher who specialises in vaccine acceptance and I established the social research program at the National Centre for Immunisation Research and Surveillance and I have also advised global agencies, the US, Australian and state governments on matters relating to vaccine uptake and acceptance. I first want to say that vaccines are effective and the benefits continue to outweigh their risks and it is right to seek ways to improve coverage, but in summary this proposed amendment to give childcare providers discretionary power to exclude the unvaccinated rests on a false promise that such provisions will meaningfully reduce risk. It may also in fact intensify the risk of outbreaks. It misses the mark where the majority of the problems with transmission lie and is unethical I believe. I believe that amendments to this proposal would go much further in improving the protection of our most vulnerable, and in fact education and communication is a very important part of our programs but it is not enough and we do need regulation and we do need to hold services and parents accountable for their decisions. I will just expand on those points.

As this legislation is likely to be enforced in a heterogeneous way, the amendment promotes even further clustering of the unvaccinated by possibly leading to pop-up childcare arrangements of those who cannot access child care at the local centre because they refuse vaccination. It also by doing that intensifies the risks of outbreaks, as has been shown by some disease modelling that I detailed in my submission. It means that some children will also not be able to access child care because some of these parents will continue to refuse vaccination and thereby contravenes a national partnership agreement on universal access to early childcare education. It will not eliminate the risk of diseases in these centres because siblings, parents and staff can all have waned immunity and unwittingly spread diseases like measles and whooping cough and people like me who work in this very challenging area of improving vaccine acceptance believe that this sort of punitive approach will make our work so much harder.

I want to say that I applaud the government's target of 95 per cent vaccination coverage. I have heard that there is a plan to phone parents to remind them when their children's vaccines are due. I also noted when I was writing my submission that the immunisation strategy has been removed from the website which makes it hard to tell what other plans Queensland has in place. But for childcare provisions I recommend a new bill that is not actually that different from what is being proposed but it is more extensive. That bill would require retaining expanded provisions for the exclusion of the unvaccinated during an outbreak where there is that immediate risk. It would require childcare facilities to see documentation of age appropriate vaccination or a recognised catch-up schedule or a medical or vaccine objector exemption that has been signed by a doctor or immunisation provider.

No doubt you will hear today arguments against vaccination that will be wrapped up with the arguments against this amendment. Some people will make fairly radical claims with no basis or where the scientific issues are distorted or cherry picked. I want to make it clear that supporting vaccination does not have to be synonymous with supporting heavy sanctions and that in fact the most effective policies remind late parents and make it sufficiently difficult to obtain exemptions so that only the entrenched do so. We also need to ensure that departments are efficiently resourced to implement these requirements, to support parents and centres and to enforce them uniformly. That will mean a much more meaningful protection of communities and has evidence that it will improve vaccination rates, and New South Wales provides an example in this way.

It does not stop there. We cannot just focus on childcare facilities. We need reminder systems that are sustainable for the long term, home visiting for the home bound and support for Indigenous health workers. We need to make catch-up free for children born overseas and ensure that childcare workers, pregnant women and travellers are also up to date with their vaccinations. I welcome any questions.

CHAIR: Thank you very much, Professor Leask, for your opening statement. What factors do you feel have contributed to undervaccination? You have touched on some of those already, but how you do you feel they are best addressed? Perhaps in your answer you could go into the nature of that eight per cent in Queensland who are not vaccinating. Any comments you have on that would be lovely.

Prof. Leask: Sure. Queensland records show that two per cent of all children have parents who register a conscientious objection to vaccination. That is probably an underestimate. It may be closer to three per cent. But if your coverage is, say, 92 per cent then that leaves another proportion who are not up to date for other reasons, and those families need to be reminded. They need to be nudged and supported to get up to date. Those families are more likely to be disadvantaged, to be children in single-parent households, households with three or more children, to be living in poverty.

Also, we have slightly lower vaccination rates among Aboriginal and Torres Strait Islander families. That is largely not an objection; it is largely about access to culturally respectful health services and to managing the other demands in life such that the children get vaccinated on time. That group—what we call the group who lack opportunity to be fully vaccinated and up to date—is a bigger group than the group who lack what we call acceptance. With structures and regulations that nudge those families who lack the opportunity, or are not getting around to it on time, and make sure that the families who are on the margins of acceptance are tipped over the line and encouraged to get their kids up to date, that leaves a relatively small percentage who are just going to refuse, no matter what.

The work that I am doing at the moment with others is looking at how to minimise the proportion of parents who reject vaccination by dealing with this problem of vaccine hesitancy. That is where parents have a lot of questions and concerns such that they may delay some vaccines or reject them altogether. This is what we call a wicked problem. It is a very difficult one to address and we need a lot more evidence to know how to address it. Here I am not talking about trying to convince the entrenched refusers; I am talking about the fence-sitters. This proposal will make our work so much more difficult, because it chips away at the sustainable trust that we need to promote between hesitant parents and governments and the medical system.

CHAIR: Thank you, Professor Leask. The Queensland Nurses' Union spoke just before you—and I appreciate that you may not have heard the state secretary, Beth Mohle, speak. One of her comments was that she felt the important focus should be on engaging with those who are hesitant for any number of reasons. You have just touched on that again. How do you feel that engagement should best occur?

Prof. Leask: The studies tell us again and again that when parents are doubtful about vaccination they look to their health professionals, the family doctor in particular. We need to support the family doctor and immunisation nurse to be confident and knowledgeable in dealing with their concerns. We are working right now on a program of support and resources to assist hesitant parents in this way through a primary care communication package.

The other area is that parents often make their decision about vaccination, if indeed they make one, in the antenatal period, so it would be about targeting that period—making sure that antenatal educators and midwives who are influential then are also very supportive in encouraging them of vaccination. It is important that parents see health professionals whom they respect recommending vaccination, because that does make a difference to their willingness to vaccinate. We need to engage well not just with parents but also with midwives and other people who are influential in that decision-making process.

We have also found in our research that complementary alternative medicine providers are influential with parents who are on the margins of vaccine acceptance. For that reason we think it is important to better understand the range of attitudes that exist in those professions and to better engage with them and ensure their education includes evidence based education about vaccination.

The other area of engagement is at the community level. We know that vaccine refusers cluster in certain communities where it can be seen as a bit of a social norm, so we need to explore novel, positive and constructive ways of engaging with those communities so that the vaccine refusal is not socially normative—that, in fact, in most communities the majority still vaccinate and the families who

vaccinate are empowered to be peer advocates for vaccination, not in an argumentative way but in a constructive way. There are some exciting initiatives that grassroots groups are engaging in around Australia including, for example, the Northern Rivers Vaccination Supporters.

CHAIR: Thank you very much. I appreciate that.

Ms BATES: Thanks, Professor Leask, for your submission to the committee. I picked up on your comments about clustering of the unvaccinated, which can intensify the risk of an outbreak. How do you prevent this occurring? What amendment would you suggest in practical terms to the committee to implement this recommendation?

Prof. Leask: The clustering occurs such that—for example, I think the Sunshine Coast would be the most heavily clustered region in Queensland for active nonvaccinators and in some towns you will see vaccine objection reaching 20 per cent to 30 per cent. That is a problem, because you lose herd immunity in those communities and you risk seeding and sustaining an outbreak more readily. If you already have a clustering, that is a concern.

If you have a childcare centre in that community where, say, 70 per cent of children are fully vaccinated then that is not good. But if you have an arrangement where a childcare centre has no children who are vaccinated then if measles, for example, which is very contagious, comes into that centre it will spread like wildfire and then it could more readily get hold in the community in general. The clustering is a problem. It is something that needs to be addressed. We need to support the communities themselves—the parents, the immunisation providers, the local advocates, the GPs, the midwives in those communities—to be positive voices of support for vaccination. I think also, the most constructive way to keep those nonvaccinators at an absolute minimum is to hold them accountable, to encourage their engagement with the healthcare system by having this conscientious objection form signed by a doctor or a nurse and to minimise that group so that the late are reminded and the nonvaccinators are kept as small as possible.

Ms BATES: So that is something that you would like to see amended in this legislation?

Prof. Leask: My proposal, yes, is that you do have requirements for full vaccination upon child care entry but those requirements come with exemption for vaccine refusers or children who cannot be vaccinated medically. For the vaccine refusers, the exemption would be acquired only by going to a doctor or a nurse who would discuss the risks of their decision and sign that form. We also need to better support doctors and nurses who are asked to sign that form. It is a difficult process for them. Many of them find it difficult and they need greater support, which is something that we are also working on at the moment.

Ms BATES: I know years ago a lot of vaccines were egg based, but most of those do not contain egg anymore. Even the measles, mumps, rubella—the MMR vaccine—can be given safely to children with severe egg allergies, so those who have anaphylactic sensitivities. Do you still think there is some myth out there in the community from the old egg based vaccines and that people do not realise that they are not manufactured that way anymore and that could be a reason some people are refusing vaccinations?

Prof. Leask: That is a problem. It is a problem for parents who falsely believe that the vaccines are contraindicated in a child and it is a problem when immunisation providers falsely believe that a vaccine is contraindicated. That is why we need to support the continuing education of our immunisation providers including nurses, midwives and those who are giving immunisations.

I am not a medical doctor, but I know that the proportion of children who have a true medical exemption to vaccination is very, very small. There are, in fact, very few true medical exemptions, and an egg allergy needs to be reviewed by the doctor and then sometimes that vaccination can proceed. That is definitely something that parents and immunisation providers need to be aware of and up to date with. That is why a policy that mandates certificates forces that discussion, because the parents cannot put their children in child care unless they have obtained that medical exemption and then if upon review it appears that it is not a true medical exemption and they need to be vaccinated then they can get that up to date.

There are also immunisation specialist clinics in major teaching hospitals of the capital cities around Australia. Brisbane would have a clinic that sees children where there is a concern about that child being vaccinated or there has been an adverse event following immunisation, so those children can be reviewed and vaccinated under supervised circumstances by an expert.

Mr KELLY: Professor Leask, in your opening remarks you mentioned that you felt that the legislation was unethical. As a member of parliament currently on the government side of the House, I feel that we have an obligation to protect the broader community and it is broadly accepted among

the medical profession and the health profession generally that 95 per cent is the mark that we need to get to for herd immunity. How do you feel about our obligations in terms of doing what we can to get the population to that 95 per cent mark?

Prof. Leask: Like I said in my introduction, and it is very clear in my submission, getting to that 95 per cent is indeed important—in fact, higher if possible. We need to do that in ways that are proven by evidence to be effective and ethically sustainable. To me, this provision to allow childcare providers to exclude the unvaccinated at their own discretion strikes as a very mediocre attempt to address that very genuine need and very worthy target.

What I am proposing are much more effective and robust ways to get those immunisation rates higher, not just among children. It is also looking at adult vaccination rates and boosters to make sure they are also protecting our children. For example, we know that up to 50 per cent of babies who are hospitalised with whooping cough have acquired whooping cough from a parent, sibling or close family member. For that reason it is very important that family members are up to date with their vaccinations and why we need to pay attention to, for example, strategies to vaccinate pregnant women so that the babies receive that protection from whooping cough in utero.

I see that improving vaccination rates, reaching the 95 per cent coverage target, is very important. I would like to understand why the immunisation strategy has been removed from the website when I last looked and see what else Queensland has in plan, and I am very confident that the other measures that you are proposing are, in fact, going to be effective and more ethically sustainable than this one.

Mr DICKSON: Next time you refer to the Sunshine Coast just say the hinterland because that is the area that has the problem.

Prof. Leask: Thank you.

Mr DICKSON: Is there any better legislation anywhere that you know of on the planet? You have referred to our legislation that is looking to be put forward by the government and that is inadequate. Is there any better legislation anywhere that you know of on the planet that would be the sort of legislation we should align with? Secondly, what would be the two points that you would like to make, while you have the floor, to make this legislation better?

Prof. Leask: Just so I understand your questions, can I point to an example, model legislation? And the second question was?

Mr DICKSON: Just two points that you would like to make that would improve the current legislation that we have before the House.

Prof. Leask: New South Wales has implemented an effective and fair balance. It requires children to be up-to-date, age appropriately vaccinated and to present a certificate of that vaccination to a childcare facility prior to enrolment. If the parents are not able to provide that full vaccination certificate because of a medical exemption then they must register a medical exemption or if they have another objection to vaccination then they must register that objection form that is signed by a doctor or immunisation provider. So it is essentially a mandatory certificate policy that involves fines for childcare facilities that do not enforce the requirements and it continues to retain the right to exclude the unvaccinated child during an outbreak which reduces the immediate risk. It also has provisions, for example, for children who need to be enrolled in a childcare centre and are not up to date, but the parents plan to get them up to date. They can get a signed document to show that planned catch-up schedule. It covers all of the provisions that are needed and also has that outlet valve for the vaccine objectors who are just not going to get their children vaccinated no matter what.

Mr HARPER: Thank you very much for your contribution today. We know that you bring a lot to the table. In fact, I have been reading some of the passages from your 2013 book that you co-authored for the Department of Health of the Australian government: *Myths and Realities*. It certainly brings some good things to this particular bill. You just touched on the New South Wales model. Could I ask what evidence there is that the New South Wales model has led to improved rates of vaccination?

Prof. Leask: It is too early to tell directly from the New South Wales vaccination uptake what effect it has had on uptake. However, it is logical to assume that requiring families to get up to date before their children enter child care, and enforcing that requirement so that those facilities are really enforcing it themselves, will mean that there is more timeliness of vaccination. Very often it is the case that children are fully vaccinated eventually but they are not vaccinated on time and they end

up a statistic. We do not have any evidence yet because the figures are not in from New South Wales. The amendment to the Public Health Act was passed in July 2014, as I recall, so it is too early to tell from publicly available figures what has happened to the New South Wales coverage.

In addition, it is important to remember when looking at coverage figures now that the algorithm for assessing coverage has changed. It has become more strict. So if you just look at the coverage figures you may think that coverage has gone down. In fact, it has not, it is just that we have added another vaccine to that set of requirements for children to be up to date. I point to page 5 of my submission to the committee. I have a table of Australian and international evidence on things that actually do improve vaccine uptake. That table indicates that requirements for immunisation prior to school or child care entry come with evidence from overseas and other countries—from the US and other countries—that that can improve childhood vaccination rates. Essentially, what I am proposing has evidence that it will improve vaccination rates from overseas and what I am proposing also means that it will be done in a way that is fair for children and does not punish the children of vaccine refusers for the decisions that their parents are making by locking them out from child care.

Dr ROWAN: Thank you for your submission and contribution today which has been very valuable. Obviously access and availability of consistent, quality information related to vaccinations is critical. My question is should the Australian Commission on Safety and Quality in Health Care be developing a healthcare standard to guide health service providers on what information should be provided and in what format?

Prof. Leask: It is something I cannot answer off the top of my head. It is something I would have to look into to see exactly what that would mean. In essence, your question is about making sure that vaccination is provided in a way that meets high standards, that only the true contraindications are observed, that children are opportunistically vaccinated and that all health professionals are required to support vaccination and to recommend it and to encourage it or are certainly encouraged to do that, and I think that is very important. I think we do need to do more work with midwives who generally support vaccination, but do require more education and updates in relation to what is a very complex program nowadays. We also need to continue to support primary health networks to do that coal face work with primary care providers of immunisation so that their records, their ACIR records, are clean, that they are up to date, that they are dealing with recording error and that they are aware of the latest recommendations. Whether we should have some kind of quality framework that supports that is something I cannot really answer now without knowing more about what it means and what it would require.

Dr ROWAN: That is good. I was just trying to get to that point about the quality framework given there is so much information that exists out there and who should lead that process given that information can come via nurses and midwives and medical practitioners either in the hospital system or in general practice, but whether there is a role for a quality framework and if there is who should lead that process, whether that should be state based or whether it should be done at a national level.

Prof. Leask: We do have some pretty supportive national structures. We have the National Centre for Immunisation Research and Surveillance which in fact does provide regular updates on our vaccination program through the *Immunisation Handbook* and the updates associated with that. We have the federal Department of Health immunisation section which provides up-to-date information and the Australian Technical Advisory Group on Immunisation. Your question is really about how we make sure that our health professionals are consistently approaching vaccination recommendations with a strong evidence base and I think that is an important one. I will say that there will always be some health professionals who do not support vaccination. It is a minimal group. It is a very small group, like it is with parents, but they are very influential and we need to think about how we can constructively work with those professionals to increase their trust in a program that should enjoy great trust because it is such an important and safe program.

CHAIR: Professor Leask, thank you very much. Our time has expired. We very much appreciate you appearing before the committee today. Your information has been very valuable.

Prof. Leask: That is a pleasure. I wish you all the best today as you hear all the different information.

CHAIR: I call our next group of witnesses the National Vaccination-Skeptics Network and Rebecca Hansensmith to the table.

BEATTIE, Mr Greg, Past President, Australian Vaccination-Skeptics Network Inc.

DAVID, Ms Tasha, President, Australian Vaccination-Skeptics Network Inc.

HANSENSMITH, Ms Rebecca, Private Capacity

SMITH, Mr Brett, Member, Australian Vaccination-Skeptics Network Inc.

CHAIR: Welcome to you all. Rebecca, would you like to make a quick opening statement and then we will also give Tasha the opportunity to make an opening statement? We will then ask questions.

Ms Hansensmith: Good morning, Chairman, members of the committee and members of the public. Firstly, thank you for inviting me here to speak today. The standard objective of the current legislation, as set out in the explanatory notes, is to protect and promote the health of the Queensland public and one way in which this object will be achieved is by preventing, controlling and reducing risk to the public. I think that there are three key questions here: firstly, will this legislation be effective in preventing, controlling and reducing risk to the public; secondly, will it reach the right balance between the needs of individuals and the needs of groups; and, lastly, are there any unintended consequences of this legislation.

Will the legislation be effective? For this legislation to be effective the committee needs to consider if excluding unvaccinated and partially vaccinated children from child care will significantly prevent or control the risk of disease to the public. One of the concerns raised in the explanatory notes is the occurrence of pertussis, known commonly as whooping cough. The increasing incidence of whooping cough has been a concern of health authorities worldwide. Ways of addressing this have been at the forefront of discussions in this area. Interestingly, if we review the Queensland vaccination rates on the Australian Immunisation Register, we see that in the two-year-old group we actually have a 95 per cent vaccination rate for the DPT vaccine, which is diphtheria, pertussis and tetanus. The rate drops down slightly to 92 per cent by the time children reach school age. So, for children in the childcare age range we have reached a 95 per cent vaccination rate for pertussis as per the Australian Immunisation Register. In the explanatory notes we see that during 2010 and 2014 Queensland Health received 2,866 notifications for pertussis in the zero to four year age group. However, if we have reached the vaccination rate of 95 per cent for pertussis in the childcare age group, how will the measures in this legislation assist in increasing vaccination rates or preventing disease?

One of the issues to consider also with pertussis is that the newer acellular vaccine, whilst considered to cause less vaccine reactions, is not as effective at stopping the spread of whooping cough by vaccinated individuals. This has been highlighted by the Food and Drug Administration in the US, which oversees approvals of vaccines. It has been further noted by Associate Professor Julie Leask in her submission. She states that the efficiency of the acellular pertussis vaccine means that, while it prevents severe disease quite well, it is less effective in preventing milder or subclinical infections; hence it is still possible to spread, even in the vaccinated. Therefore, both vaccinated and unvaccinated children can spread whooping cough. It is then questionable that excluding unvaccinated children will achieve the stated objectives.

What about other disease transmissions? Currently we have a high level of vaccination of children in the zero to five age group. The current Queensland childhood vaccination rate is 92 per cent. However, children under the age of five make up only about seven per cent of the Australian population. If we have a variance of eight per cent in the unvaccinated or partially vaccinated, we are looking at only 0.5 per cent of the population. This legislation will address the vaccination issue only in this insignificant proportion of the population. In addition, we have seen that vaccinated individuals are able to contract and spread diseases that they have been previously vaccinated against, so the effectiveness of excluding children on their vaccination status will have little impact on the stated objectives. This is in the childcare environment. What is happening outside the childcare environment that impacts on this?

The explanatory notes state that when 95 per cent of the population is immunised, herd immunity protects the transmission of highly contagious conditions. What we have been discussing so far is childhood vaccination rates. We know that vaccine induced immunity wanes over time. Queensland Health has run media campaigns in recent months for adults to update their vaccines due to this issue.

CHAIR: Rebecca, are you making closing comments now? I am mindful of the time. I want to have an opportunity for the asking of questions, too.

Ms Hansensmith: I have a little more.

CHAIR: Do you want to make a final statement? Obviously you will get an opportunity to answer any questions that we ask, but I want to give Tasha an opportunity, too.

Ms Hansensmith: Certainly. I have a little more.

CHAIR: We have your submission, so is there anything different or in addition to the submission that you wanted to add?

Ms Hansensmith: I will go through some key unintended consequences of the legislation, if I may. Firstly, from a practical business point of view, childcare facilities will be under a lot of pressure to actually enforce this exclusion and that has problematic issues for children and their education. Another point that Ross raised is the fact that the legislation did not address the fact of natural immunity and I think that should be covered.

In summary, there are questions about the effectiveness of this bill to significantly address the stated objectives. We also face losing our individual rights for this benefit. As citizens we entrust elected members of parliament with the responsibility to make just legislation that manages the balance between the individual's needs and the group's needs. As public policy makers, I hope your review of the legislation will lead the way to making sure that parents and children are able to exercise their right to medical freedom. Thank you.

CHAIR: Thank you. For the purposes of the transcript, Rebecca, from my recollection of your submission you are appearing as a mother?

Ms Hansensmith: Yes and a private individual.

CHAIR: Thank you very much. Tasha, would you like to introduce yourself and your colleagues and then make a brief opening statement? Then we will open up to questions.

Ms David: Is it possible that we all do a little opening statement?

CHAIR: It would need to be 30 seconds. I am so sorry, but we are running out of time. We have a number of witnesses to follow you. Can you give an opening statement on behalf of the group?

Mr Beattie: We had a plan to say a few minutes each.

CHAIR: I think the secretariat advised each witness that you would have about three minutes as a group.

Mr Beattie: We were advised it would be 20 minutes, as a group.

CHAIR: That 20 minutes allows us questions as well.

Mr Beattie: Do you mind if I go first?

Ms David: That is fine.

CHAIR: I genuinely do not mind who gives the statement, so long as we keep it brief so that we can open up to questions from the committee.

Mr Beattie: Okay. Firstly, thanks for the opportunity to present here. I am a past president of what was then known as the Australian Vaccination Network and an author of two books on this issue. Today I am speaking mainly as someone who 20 years ago challenged a government run childcare centre that refused to accept my unvaccinated children. That is the very thing that this bill promises to protect childcare centres from. It cannot. That is the first point I would like to make and it is a very important one, so I will take a minute or so to explain it. It is not included in our submission, because I was not involved in authoring the submission.

It would be extremely unfortunate if this bill were to achieve the opposite of its intention and invite childcare centres to do something that exposed them to, rather than protected them from, liability. However, in my estimation and that of the New South Wales government, that is precisely what it will do. The New South Wales parliament debated an amendment identical to this bill in 2013. It did not pass because the government recognised that it would expose childcare centres to challenge and that that challenge would come via the Commonwealth Disability Discrimination Act, which is the same act that I used 20 years ago. Advice from their Attorney-General confirmed that such a move would indeed place childcare centres in breach of the act and that their state legislation was powerless to protect them from that.

I will quote selectively from the *Hansard* of that debate. The government parliamentary secretary stated that the government did not support the amendment. She said—

Allowing childcare facilities to adopt their own policies and refuse enrolment to unvaccinated children is not supported by the childcare industry peak bodies. Public health experts, including the National Centre for Immunisation Research and Surveillance, have strong objections to such an ad hoc approach.

…

... the proposed amendment would open childcare facilities ... to claims that the facility is in breach of the Commonwealth anti-discrimination law.

On the capacity of the New South Wales Public Health Act to protect childcare centres from that, she also stated—

Exemptions under a Commonwealth or State law apply only to actions taken in direct compliance with the prescribed law. The New South Wales Public Health Act is not a prescribed law under the Commonwealth Disability Discrimination Act.

In case you are wondering, I have checked and the Queensland Public Health Act also is not a prescribed law.

In a nutshell, this bill promises something that it cannot provide. It invites childcare centres to make a decision and promises to support them in that decision, but it cannot deliver on that promise. Childcare centres will get challenges. They will not come from me—my children have flown the coop—but there are thousands of others out there ready and waiting. If you want to meet some, come downtown on Sunday week. A rally against the proposed federal laws has been organised. The last one a couple of months ago was attended by several thousand. These are parents who are sick and tired of being pushed around and are prepared to act.

Do you want me to stop there and go on to the others, although I have other things to say?

CHAIR: We might move into questions. If there is something specific that you wanted to table, that could be done. I do not want to miss out on the opportunity for the committee to ask questions, which is the purpose of the hearing today. Thank you for your opening statements. Your submission opposes the immunisation amendments and argues that, if they are passed, exemptions on conscientious grounds should be retained. How would you see this working given the recent federal government changes that will remove the exemption for conscientious objection from 1 January 2016 in practice? Can you speak to that?

Mr Beattie: Those changes are not in place. They are not even a bill yet. All they are is a media talking point. There is nothing in place.

CHAIR: There will be, though. The government has said there will be.

Mr Beattie: There may be, sure, but there is nothing in writing yet.

CHAIR: My question is: given that the Commonwealth government has indicated that they will be put in place, how do you then see that working, given that it will remove an exemption of conscientious objection?

Mr Beattie: It is a good question and I do not think anyone can answer it yet. I do not know how they are going to do it.

Ms Hansensmith: The conscientious objection federal legislation is actually going to affect your ability to get a benefit for the child care. It does not actually stop you going to child care. If the Queensland legislation was to have conscientious objection in it, you would still be able to. You would be obliged to pay full fees, but you are still able to attend a Queensland childcare centre.

CHAIR: My question goes more to the fact that, if they remove the exemption for conscientious objection, the reality of reporting around that, keeping that reporting structure and the names of those, which is done by the Commonwealth, will no longer occur. We will not have access to that.

Ms Hansensmith: Are we actually removing that exemption or are we removing that exemption for the family tax benefit law—

CHAIR: It is a matter for the Commonwealth and not a matter before the committee.

Ms Hansensmith: My understanding is that it is removing it to receive a benefit, not necessarily removing it altogether.

Ms BATES: Rebecca, thanks for your submission. You were talking about childcare facilities and how an unintended consequence would be a cost to them around whether or not they decided to refuse entry et cetera. There are 28 private childcare centres in my electorate and I have spoken to quite a deal of them. I asked them if they thought particularly the federal 'no jab, no play' thing would affect them, because a lot of the legislation that childcare providers have to deal with is from a

federal level and not a state level. By and large, most of their comments were, 'It's another federal thing that we will have to deal with and we will deal with it.' I am giving you an example of what is happening in my electorate.

On natural immunity, you mentioned that that was an unintended consequence and that it had not been dealt with. I raised that in the debate on the private member's bill introduced by Jo-Ann Miller under the former government. I asked Dr Leask about that as well, because one of the sticking points for me with the previous legislation was that if your child has an acquired immunity, gone are the days when you send your kids off to play with the kids with measles and chickenpox so that they did get acquired immunity, because we have vaccines now to make sure that that does not occur. My understanding, and from my perspective I believe, that has been addressed. They will be able to do blood tests or, on actual diagnosis from a doctor, the doctor can then deal with that issue, so it will not be an unintended consequence.

Ms Hansensmith: Thank you, Ros.

Mr KELLY: Thank you for your submissions. The submission from the Australian Vaccination-skeptics Network notes that as one disease is allegedly reduced there is an equally dangerous emerging disease to replace it which inevitably requires yet another vaccine to be developed. Given this statement, what are your thoughts on developing new types of chemotherapy as we learn more about various cancers or developing further antibiotics if we discover a new type of bacteria?

Mr Beattie: I am sorry, but I do not see the relationship to this discussion. New types of chemotherapy?

Mr KELLY: Your submission states that as we allegedly vaccinate against one type of disease another disease emerges that we need to vaccinate against. It is suggesting to me that your thinking is that we should not be developing vaccines because there will always be another disease to cure. If we take a disease like cancer or other infectious diseases that we treat with antibiotics, should we simply give up on trying to treat those diseases if we discover new diseases or new things that need new cures?

Mr Smith: I think that is one of the issues that a lot of parents are concerned about. While some parents might feel the need to vaccinate against measles and polio, they do not particularly want to vaccinate on day one against hep B and rotavirus. If you actually look at how rotavirus got on the schedule in Australia and the Western World, it is a fine example of how a product like this should not be pseudo mandated. I do not know if anyone is really aware of rotavirus and how it became part of the schedule in the United States and then, de facto wise, in Australia, but it was developed and patented by Dr Paul Offit. He had the privilege of also sitting on the advisory board of the CDC to determine which vaccines would end up on the schedule. That vaccine ended up on the schedule in the United States and he made over $40 million, and it is now on our schedule. These are the concerns that parents have. No-one from this side of the fence is suggesting that we should not try to eradicate disease and create healthy populations, but there has to be some limit in terms of what parents are subjected to with regard to their children.

These are I think legitimate concerns. This book is a medical text that was released in July this year which proves that the aluminium hydroxide in vaccinations is linked to all autoimmune diseases on the planet today. I think that we need to step back and look at what we are doing. As I said, this legislation is going to affect parents. It takes away their choice of determining what vaccines they want to give their children. As I said before, we have created this division—on one side we have anti vaccine people and on the other side we have pro vaccine people. They are just the two opposite ends of the spectrum. There are a lot of people in between to whom these concerns have to be communicated. My understanding is that, no, bringing chemotherapy into the discussion in regard to vaccination is not overly helpful.

Mr KELLY: Your submission states that immunisation rates can be increased by positive policies. Is that suggesting that increased immunisation rates is a good objective that the Australian Vaccination-Skeptics Network supports?

Ms David: I am basically here to represent the human face of the people who are going to be most hurt by this legislation. I have children who have been vaccine injured and I also have children who are non-vaccinated who are extremely healthy, and we are not addressing that. We are not being heard. I heard Julie Leask and the Nurses' Union talk about engagement. We are not getting engagement. No-one is talking to us about why we choose to not vaccinate or why we have concerns. The only way to address this issue is to have an open forum, to have a discussion. The Australian Vaccination-Skeptics Network is not out there to say vaccinations are bad. We are out there to say

that we want everyone to be able to access the pros and cons of all of the information and make that crucial decision for themselves. I completely support anyone who wants to vaccinate their children. I have no problem with that whatsoever, but I do have a problem with parents being forced to vaccinate against their will.

In regard to the medical exemption that we are being left with, basically my children do not qualify because you have to have a severe and immediate reaction within seven days to qualify for a medical exemption. Even though my GP has said that my children have a genetic susceptibility to vaccine reactions, they do not qualify. I had a mother talk to me just recently whose son actually died after a vaccination. Her daughter also had a vaccine reaction but she was only able to get a medical exemption for six months. If you are leaving us with just this medical exemption, this is not protecting all children.

What we are asking for is to leave in the conscientious objection and leave parents to make these decisions, to respect the rights of all children. Otherwise we are disadvantaging some children in regard to getting vaccination rates up which even Julie Leask was saying is not necessarily possible through this legislation. I think in her terms she said that about a 0.3 per cent rise in vaccination rates would come through these kinds of punitive measures. The only way to really get together and to have a healthy population is for us all to talk and to engage and for you to listen to us because that is not happening right now.

No matter how much you force someone to do something, or you try to, they are not going to do it because you are asking us to do something that we believe is not necessarily in the best interests of our child. What parent would do that? Would you expect me, after I have had vaccine injured children, to go and vaccinate my two youngest who are healthy? Why would I do that when I have seen the harm? I have seen it. I have eight children. Six of them were vaccinated. I saw that harm with them. Once again, I ask that we can do that. That would be helpful.

Mr HARPER: Thank you very much for your contributions today. I just want to take up that last point. Associate Professor Leask also said in her opening statement that the benefits far outweigh the risks in terms of vaccination. I have a couple of questions that I would like to ask. Rebecca, you have indicated in your submission that, in effect, the legislation applies coercion to parents and therefore there is no informed consent. For many years the Queensland Ambulance Service staff have been required to be vaccinated for hepatitis B and other diseases. This is to protect the public from these diseases. If they do not get vaccinated without medical reason, they cannot be employed and would lose their income. Would you regard that as coercion?

Ms Hansensmith: Do you?

Mr HARPER: I am asking you the question.

Ms Hansensmith: Certainly. I thought that summed it up succinctly. When it cannot be predicted who will be harmed by a vaccine and it cannot be guaranteed that those who have been vaccinated will not get infected or transmit infection, the ethical principle of informed consent becomes a civil, human and parental right that must be safeguarded in law. The current legislation puts pressure on parents to accept a risk that may not outweigh the benefits for their individual child. I do feel that it is a level of coercion.

Mr HARPER: For the rest of the panel, in your submission you suggest that the expanding immunisation schedule provides a scientifically plausible explanation for the widespread and increasing incidents of immune system dysfunction. Are you aware of any research or evidence to support that claim?

Mr Smith: The book that I talked about just recently is a medical text from over 50 of the world's experts and doctors in autoimmunity. It is edited by Dr Yehuda Shoenfeld and it has many papers. That is the other thing. When liability was taken away from the vaccine manufacturer in 1986 for any damage the product caused, what moneys do you then expect to be spent on anything in regard to making that product as safe as possible from that point onwards? The vaccine manufacturer is not responsible for any damage. There are definitely two ingredients in vaccines that are problematic at the very least, and they are mercury and aluminium. I do not think there is any scientific doubt at this point about that. Those products should be removed immediately. We are looking at a science that is over 150 years old. We have been using mercury and aluminium in vaccines for over 100 years. To say at the end of 100 years that they are now a problem and should be removed, it has probably taken too long to get to that point.

I think if you came and said to anyone sitting over this side, 'There was a product that was going to eradicate infectious disease and there are no safety issues with it,' there would be no argument over here. When you have definite substances that are scientifically proven to be causing

serious problems in some people, they need to be removed. It is even the mechanism of why do some people respond to a vaccine and other people do not. To not even understand the mechanism behind why it works in an individual and why it does not work in an individual is problematic for me on its own. It is all very well to have the 95 per cent herd immunity goal in our heads, but the reason that people are resisting is that there are some reservations—and it is not always just about a lack of education. I have vaccinated my first two children. So I have been researching this topic for over 20 years. Sometimes the more you research a subject the more questions it raises. Definitely at this point I think that the science is starting to catch up with vaccination and it needs to be looked at. It is probably a discussion that is 50 years long overdue in this country.

Mr HARPER: Do I have time for one more question?

CHAIR: Yes. Can you keep it brief?

Mr HARPER: Yes. I will put it to the panel. If you have the right not to vaccinate your child, why do other parents not have the right to place their children in an environment that is supportive of vaccination? It is a moral question.

Ms David: Can you repeat that?

Mr HARPER: If you have the right to not vaccinate your child, why do other parents not have the right to place their children in an environment that is supportive of vaccination?

Ms David: They do have that right. Everyone has that right and that is what we are here to promote—choice. Every parent makes that choice for their child and they do the best they can. You cannot expect another parent to take a risk that you think is okay for you and then force it on to them. That is what it is about. It is about respecting choice, respecting parents and letting them do the best they can.

CHAIR: Member for Thuringowa, I am not sure that I understood your question. When you say 'supportive', do you mean essentially that parents should have the right to place their children in an environment where the children are fully immunised? Is that what you meant?

Mr HARPER: Yes. Sorry, I should have expanded on that.

Ms David: One thing that I did want to say is that I think that that is quite a dangerous precedent to set. Do we really want to be thinking about segregation, because this is basically what we are talking about right now? We are talking about segregating children. Segregation has never been a good thing for a society. That is something you really need to take on board. We do not want our children to be unvaccinated here and vaccinated there. We want our children to be children, to not have barriers, to be able to play and to be with each other without fear, without all of this ugliness and discrimination. These are the sorts of things that come with this kind of measure.

CHAIR: Thank you, Tasha. No-one would support segregation but, as a parent, we are talking about managing risk to our children.

Ms David: I know but in order to do that you are talking about segregation.

Ms Hansensmith: Am I able to address that very quickly?

CHAIR: Member for Thuringowa, has that been addressed?

Mr HARPER: Yes. That is fine.

Dr ROWAN: Thank you for attending today. In relation to your submission, I understand that you are wanting conscientious objector provisions to be in the legislation. In your opinion, who is best to certify that and should it be stored on a single database by Queensland jurisdictionally or nationally? Who should certify the conscientious objection and where should that be stored?

Mr Beattie: There was a survey done in *Australian Doctor Weekly* about two years ago where they asked doctors, 'Would you sign a conscientious objection form?' and 52 per cent of them said, 'No. I refuse to sign them.' So the current method of getting them signed is clearly ridiculous. We need to provide for conscientious objection. It needs to be available. Put in administrative hurdles if you must, but do not put in ideological hurdles—brick walls, not just hurdles. In my opinion, we need to make conscientious objection, as it always is, in the form of, say, a statutory declaration. You can say, 'Go to the doctor and be counselled,' but do not make their objection dependent on that doctor agreeing that they have made a good decision, because the doctor may be ideologically opposed to their decision. Where should it be stored? I am sorry but I do not know.

Dr ROWAN: In relation to government generally encouraging the uptake of vaccinations, do you see that there is a role for government in doing that at all or is there a view that it should not happen?

Mr Beattie: If I were to sit back and say I am not involved in the debate, governments take advice from various parties who have expertise and they devise policy based on that. I can see why governments would in general support vaccination, even though there are dissenting views out there. So I do understand that. There has to be room for those dissenting voices. I think the most important thing is engagement. It has been said many times here. Beth Mohle put it very well. The people who are not comfortable with vaccination need to be engaged. Those people who have views that are contrary to mainstream views need to be engaged. By hitting them with a big stick you are just going to galvanise them. You need to draw the carrot out and work out a nice way to use it, and that is to engage them. An organisation like ours has been booted around like you would not believe. But really we should be embraced. We should be engaged. The health department—Dr Jeanette Young, for example—should facilitate forums where we can raise our concerns and debate the competing viewpoints. That is what is going to bring harmony instead of this divisiveness.

Dr ROWAN: Just to clarify, it is your position that there is a place for childhood vaccinations, but your position is about choice as opposed to the role of vaccinations in preventing infectious diseases transmission.

Mr Beattie: Are you talking about my personal position or the AVN's position?

Dr ROWAN: The AVN's position.

Mr Beattie: The AVN, as strange as it might seem to you, does not actually have a position on vaccination. The AVN was set up to facilitate the sharing of information so that people could make their own informed decisions. It does advocate for people's rights but it does not advocate one way or the other for vaccination.

Dr ROWAN: Does it believe there is a place for childhood vaccinations?

Mr Beattie: It does not have a belief either way.

CHAIR: Deputy Chair, I believe you have a supplementary?

Ms BATES: It is more a summary, I guess, of your opening statement, Brett, particularly about rotavirus. You mentioned that the developer made sure he got financial benefit. Coming from a health, farming and biotech background, if nobody funded research there would be no drugs let alone any vaccines. I want to put on record that rotavirus is the most common cause of severe diarrhoea in infants. Before that vaccination was put on the market in the US, rotavirus A caused 2.7 million cases of gastro in children with 60,000 hospitalisations and around 37 deaths each year. Rotavirus A is the most common cause of outbreak of severe diarrhoea in children attending day care centres. From a personal perspective, before that vaccine came along I almost lost my six-month-old son to rotavirus from severe dehydration. I understand your comment about vaccinations and people benefiting from them, whether it is financially or otherwise, but I think the population in general benefits at a greater level.

Mr Smith: That is the beauty of choice. You made that decision and you have taken that choice, but there are a lot of parents who look at it and say, 'I don't particularly want to take the risk of having the rotavirus vaccine,' and I think those choices should be made available to parents. I think they should be able to look at the schedule and decide what communicable diseases they want to vaccinate their children against.

CHAIR: Greg, Tasha, Brett and Rebecca, thank you very much for your written submission and for appearing before the committee today.

CROSS, Ms Fleur, Team Leader, Consumer Education Health Program, Diabetes Queensland

CHAIR: Welcome. I am sorry that we are running a little late. You have been waiting patiently. Would you like to make a brief opening statement?

Ms Cross: Thank you. This is my first time appearing before a committee, so I am a little nervous. I am Fleur Cross. I am a credentialed diabetes educator and a registered nurse. I am the consumer education health program team leader at Diabetes Queensland. Thank you for the opportunity to provide supporting statements around our submission today. We are really here as the voice of people living with diabetes. Diabetes Queensland supports the bill and applauds the focus on preventative health. Increased vaccination rates can only improve the health outcome for children with and without diabetes.

Before I talk about the impact of vaccine preventable illnesses and the complications that can arise, I will draw attention to the important points made in my submission, and I will be very brief. Vaccination programs have provided one of the most successful prevention strategies for disease and have resulted in the near elimination of illnesses that have historically accounted for many deaths. Herd immunity is about 95 per cent, and in Queensland, as the Minister for Health stated in his second reading speech, childhood immunisation rates lie at about 92 per cent.

Diabetes can reduce the effectiveness of vaccination. We know this. Booster shots can resolve this. This supports the need for herd immunity to be met to provide the added protection from these vaccine preventable illnesses, as this limits exposure to unvaccinated children. There is evidence that there is an incidental benefit of vaccination as well. A Finnish study showed a causal link between the decrease in the incidence of mumps and a decreased rate of type 1 diabetes. Some research has gone further to draw a direct link between rotavirus infection and the induction of type 1 diabetes. Vaccination would impact on this in a positive way.

Our only concern relates to the possible use of the legislation beyond its intent as a possible method for excluding children on the basis of a medical condition such as diabetes. Our recommendation is that it is important that the guidance to centres is accompanied by strongly worded education that emphasises this relates solely to vaccination schedules.

Now I want to talk about the impact of illness on the person living with type 1 diabetes. A total of 1,400 children aged under 15 are living with type 1 diabetes in Queensland. Think of a nine-year-old boy who manages his diabetes. He checks his blood glucose levels by pricking his finger at least six times a day. He has to count his carbohydrate intake in grams at each meal and adjust his insulin accordingly. He is a mathematician. Getting the balance right when he is having growth spurts, playing cricket or doing exams is ongoing and relentless. The impact on his family, who have most likely been checking for overnight hypoglycaemia since diagnosis by getting up at 3 am, and the impact of regular health professional appointments to support management is huge.

Now imagine that boy contracting a vaccine preventable illness from a child without diabetes who is unvaccinated at after-school care. Aside from the risk of the effects of the disease, this nine-year-old boy is now needing to implement sick-day management because he is at a much higher risk of hypo- and hyperglycaemia, which can very quickly lead to medical emergencies. In fact, the national evidence based clinical care guidelines for type 1 diabetes in children, adolescents and adults revealed that if we are treating hypos we are looking at taking blood glucose levels every hour, we are looking at trying to drink a glucose-rich fluid, we are looking at reducing insulin. If that does not work, it is about seeking urgent medical advice and we know that hypos can lead to comas if untreated.

It also talks to hyperglycaemia and it talks, once again, about hourly blood glucose levels. It talks about testing for ketones hourly. It looks at consuming carbohydrate-free fluid so it does not impact on that elevated glucose level. Once again, if unable to reduce those glucose levels, they need to seek urgent medical advice and this can lead to diabetic ketoacidosis, which is a medical emergency.

The impact of missing school, of potential hospitalisation and of social isolation are all consequences of something that we see is preventable. Think of a three-year-old in a day care facility in the same situation and consider that impact on the family. These are the considerations when we talk about the impact of vaccine preventable illnesses on people living with type 1 diabetes.

Ms BATES: Thank you, Fleur. That was very interesting. I think it is tough enough for kids and parents with type 1 diabetes, let alone having to deal with the unintended consequences of the complications of diabetes. As you well know, even the best controlled diabetics sometimes end up with those consequences regardless of how well they look after each other.

Ms Cross: Yes.

Ms BATES: And it is more poignant for a little kid, too. You mentioned rotavirus and type 1 diabetes. I had not read that in your submission. That follows on quite nicely from what I asked in the previous session. Can you give me a bit more information on the effect of rotavirus on kids with diabetes?

Ms Cross: Yes. This is in our submission but I will read from it. It comes out of a study. Rotavirus can potentially accelerate the development of type 1 diabetes in children predisposed to the condition, so there is a susceptibility and rotavirus can be a trigger. By allowing rogue immune cells to attack the pancreas, some research has discovered that it is a precursor to the development of type 1 diabetes. Some research has gone further to draw a direct link between rotavirus infection and the induction of type 1 diabetes. From our stance, encouraging vaccination through measures such as those provided in the bill could then have that additional benefit in that causational factor.

Ms BATES: Just so I understand it: it is more like an autoimmune response to the rotavirus that can trigger people who have a propensity to develop diabetes?

Ms Cross: Absolutely. You can have a propensity to develop type 1 diabetes, and there has been a link showing that rotavirus has been the trigger to then lead to cell death in the pancreas and, therefore, type 1 diabetes.

Ms BATES: Thank you.

Ms Cross: We can provide that study.

Ms BATES: That would be terrific, thank you.

Mr KELLY: Your submission states that a person with type 1 diabetes is more susceptible to diseases. Is there any evidence regarding how much more susceptible they are to diseases that might be prevented by a vaccine such as chicken pox?

Ms Cross: I do not have the statistics. I have the studies which will reveal statistics, but I do not have the statistics with me.

Mr KELLY: You can take it on notice.

Ms Cross: Can I provide that to you?

Mr KELLY: Yes.

Mr HARPER: Is there any evidence or strong data to suggest that children with type 1 diabetes have a less effective immune response?

Ms Cross: Yes, there is. Once again, we have some evidence which we can provide as well. We know that children living with type 1 diabetes have less effective immunity response than people without diabetes. We have further evidence that we can provide to you on that.

Mr HARPER: Thank you.

CHAIR: Fleur, do children with type 1 diabetes still follow the schedule?

Ms Cross: Yes. Even though we know that it can reduce the effectiveness of the vaccination, there are recommendations around getting a booster vaccination. This really draws to the importance of herd immunity as protection as well. So they are able to get vaccinated. They may not have the immunity response that someone without diabetes might have. Therefore, that herd protects them but then they can go on and get a booster to increase that protection for themselves.

Ms BATES: To clarify, they do develop antibodies anyway?

Ms Cross: Yes. It is just not as effective as someone without diabetes.

CHAIR: Thank you very much for your opening statement, for your submission and for appearing on behalf of Diabetes Queensland. You have survived your first appearance before a committee. We thank you very much for the additional information that you can provide to our secretariat.

Ms Cross: Thank you.

PERRY, Dr Le-Anne, Executive Director, Queensland Catholic Education Commission

CHAIR: Welcome. Thank you for appearing before the committee. Would you like to make an opening statement?

Dr Perry: I am glad to follow Fleur. This is also my first appearance before a committee and I am six weeks into this job.

Ms BATES: We will be gentle.

Dr Perry: It is certainly my first time speaking around issues to do with early childhood care, having come from a different background. I thank the committee for the opportunity to provide a submission and to appear today. I appear today representing the 24 kindergarten services offered by our five delegated authorities. As you may be aware, the commission has responsibility for schools and so on, but I am here representing the interests of those who provide our kindergarten services across the state.

As our submission indicates, we strongly support vaccination as an important public health measure. Therefore, we strongly support this bill and the amendments proposed to the bill. It would be our view that vaccination is a critically important public health measure. It is supported by a very strong peer reviewed evidence base, and it is something that we support.

We support the bill in that it provides discretionary power to childcare providers and kindergartens in terms of flexibility with their enrolment practices. While it is the case that we would anticipate that our Catholic providers will require up-to-date vaccinations, we respect the right for people to have that discretion around making that choice of enrolment.

We also are very mindful of vulnerable children. Our providers currently and will continue to work very closely with parents if they present with their child who is not vaccinated or not up to date. Our current practice is that our providers do not just say, 'You're not vaccinated. Go away.' In fact, they work very closely. They help put the parents in touch with the relevant agencies and work them through and support that process to assist them—if that is the choice they wish to make in terms of vaccinations. As always, our providers take a very strong pastoral approach and work very closely with the providers. We obviously expect that that will continue to be the case.

We support the amendments. We support the discretionary power, but we would also anticipate that our providers will require children being enrolled to be up to date with their vaccinations unless they have the exemptions as provided for here. We would also strongly support that there be a very good communication process around this so that parents are very aware of what the changes are. We are also very supportive of the fact that, as we understand it, the bill will mean that people cannot be seen as being discriminatory if they choose not to enrol children who are not fully vaccinated. So we think that is a very important position to be in, particularly for staff, to protect them from being accused of being discriminatory, if that is the decision that the centre makes to do that. We would certainly also be looking that there be good resources provided around communicating it and giving our providers support as well.

CHAIR: Thank you very much for your opening statement. Dr Perry, you mentioned a vulnerable child. Could you just define, for the purposes of the committee, what constitutes a 'vulnerable' child?

Dr Perry: As has been provided in the information we were given—those who might come from an ESL background, a non-English speaking background, some from remote Indigenous communities, others who might not have engaged well in terms of having the requisite information either because of their educational background or their social circumstances. So those who may not have vaccinated their children through lack of information or lack of education or through some other personal circumstance. In other words, if someone presents, we do not just take the view, 'You haven't done this so therefore we're not even going to consider you.' Our response is to engage with the parent and to talk to them about it. If they indicate they wish to get their child vaccinated, we actually assist them to access the appropriate providers to do that.

CHAIR: Have there been discussions already about how you would consistently apply the assessment of what children might fall within that group so you would still let them come even though they might not be vaccinated? How would you ensure consistency across your different centres?

Dr Perry: I think that is something we would have to look at—what strategies we use there. There will always have to be a certain bit of individual flexibility there. My understanding is that the position of our providers would be that they would want all children in their centres to be vaccinated or to be on a catch-up schedule as described. From my understanding, it is unlikely that they would actually enrol a child where the parent says, 'We are not going to get the child vaccinated,' because

the preference of our providers is that all children are vaccinated unless they have the medical contraindications and so forth. So the position of our providers, as I am advised, is that they would want all the children in the centre vaccinated. I note that other centres may not choose to do that so parents will actually have a choice to go to other centres, not necessarily the Catholic ones.

Ms BATES: I want to ask a question that I asked the QNU and Queensland Health. Do you have a policy at all within the Catholic Education Commission about vaccinations of your childcare staff to prevent the spreading of disease from staff to a child and vice versa?

Dr Perry: I do not know the answer to that but I will find that out.

Ms BATES: You can take it on notice.

Mr KELLY: Thank you for your submission. In the submission, you note that the child's vaccination history is already part of your organisation's enrolment processes. Do you anticipate any further administrative burdens if this bill passes?

Dr Perry: I have not been advised that people anticipate there to be anything that is significant.

Mr HARPER: Could you please comment on how your organisation would operationalise the vaccination provisions if the bill is passed, with a particular focus on the use of discretionary powers in relation to the enrolment or attendance of unvaccinated children?

Dr Perry: Mr Harper, I probably cannot speak to the detail. Already, the processes require at enrolment for there to be a declaration around the vaccination schedule and I would anticipate that would continue. As I have indicated, I have been advised that out centres would be expecting every child to be vaccinated or to be on a catch-up schedule. My understanding is there would be the discussion at enrolment that that would be the expectation—that all children are vaccinated. So if people choose not to vaccinate their child, they would not meet the criteria for enrolment at the childcare centre unless there are the special circumstances that we have spoken about.

CHAIR: Have you received feedback from any of your centres or people you have spoken to who anticipate there could be some kind of conflict or concern about having to tell parents that your policy is their child will not be admitted?

Dr Perry: My understanding is that that has been the practice now, so they are not anticipating great concern. The feedback we received—which was very supportive of the fact that they will be protected from being described as discriminatory—suggests to me that that has been an issue, where if it has been indicated to parents that 'You really need to have your child vaccinated' there could be those who make accusations that you are being discriminatory in your practice. So if this bill provides support to ensure they are quite clearly protected from being called discriminatory, that will be a very positive thing.

CHAIR: So essentially you are saying that this bill gives the protection really for Catholic education to continue with the policy they already have in place?

Dr Perry: That is correct. So that is why there has been very positive feedback from our providers around this bill.

CHAIR: Thank you. I think you have also survived your first appearance before the committee unscathed. We thank you very much for your appearance and for your submission.

Dr Perry: Thank you, and I hopefully helped you catch up some time.

KIDD, Dr Richard, Board and Council Member, Australian Medical Association (Queensland)

CHAIR: I welcome Dr Kidd from the Australian Medical Association Queensland branch. Thank you very much for your written submission on behalf of AMA Queensland. Would you like to make an opening statement?

Dr Kidd: Yes. I will try to be brief. I am sure you want to get to your lunch.

CHAIR: We have made up time. Thank you.

Dr Kidd: Thank you for the opportunity to speak today. AMA Queensland is the state's peak medical advocacy group for some 6,000 medical practitioners who are our members and a lot of others who are our unfinancial members. We represent medical practitioners across Queensland and throughout all levels of the health system. We have previously advocated publicly on issues of public health and vaccination, and AMA Queensland and our members take a very strong interest in these issues. To quote from the current *Australian Immunisation Handbook*—

For more than 200 years, since Edward Jenner first demonstrated that vaccination offered protection against smallpox, the use of vaccines has continued to reduce the burden of many infectious diseases. Vaccination has been demonstrated to be one of the most effective and cost-effective public health interventions. Worldwide, it has been estimated that immunisation programs prevent approximately 2.5 million deaths each year. The declaration of the global eradication of smallpox in 1980, near elimination of poliomyelitis and global reduction in other vaccine-preventable diseases, are model examples of disease control through immunisation.

Vaccination not only protects individuals, but also protects others in the community by increasing the overall level of immunity in the population and thus minimising the spread of infection. This concept is known as 'herd immunity'. It is vital that healthcare professionals take every available opportunity to vaccinate children and adults. Australia has one of the most comprehensive publicly funded immunisation programs in the world. As a result of successful vaccination programs in Australia, many diseases, for example, tetanus, diphtheria, *Haemophilus influenzae* type b and poliomyelitis, do not occur now or are extremely rare in Australia.

In our AMAQ submission, we noted that we understand that this bill protects childcare centres from liability if a child's enrolment or attendance is refused or cancelled on the basis of their immunisation status. If the centre reasonably believes the child is a vulnerable child and refusing enrolment or attendance would not be in the best interests of the child, the Queensland bill allows childcare centres to choose to enrol or accept their attendance despite the child's immunisation status not being up to date. AMA Queensland believes this approach strikes the right balance between protecting public health and ensuring that vulnerable children are not excluded from interaction with their peers.

We commend the bill for promoting increased vaccination by creating a provision which ensures that, if a child has fallen behind on their immunisation, the child may still be admitted through an agreement between the childcare centre and the parent to bring the child's immunisation status up to date. By empowering childcare providers to make decisions on who they allow into their care, the bill promotes public health and increases herd immunity through constructive, rather than simply punitive, measures. It is a sensible provision and we support this amendment to the Public Health Act 2005.

This amendment to the public health bill is timely and enables national activity addressing communities becoming vulnerable through inadequate herd immunity. Right now we are dealing with a measles outbreak in Brisbane. Not long ago, a baby died from pertussis. There was a decline in the acceptance of pertussis vaccine in Britain in the mid-1970s, and between 1977 and 1979 there was an epidemic of 102,500 cases of pertussis during which 27 children died from the direct consequences of pertussis and 17 developed permanent neurological damage. Acceptance of pertussis vaccine has now improved to about 93 per cent, and pertussis has declined. Similar large epidemics occurred in Japan and Sweden at about the same time due to low acceptance of the pertussis vaccine. There have been two major epidemics of poliomyelitis in Holland in 1984 and 1991 occurring in a religious group who refused vaccination. There was no spread to the rest of the population whose uptake of polio vaccine was very high.

In the national environment, health minister Ley noted that at least 166,000 children were recorded as being more than two months overdue for their vaccinations last year. This figure is in addition to Australia's 39,000 conscientious objectors. She acknowledged the stresses busy parents face every day and that many missed immunisations are unintentional, which is why they are providing incentives and support to help keep children up to date with their vaccinations. Ms Ley said—

But there are parents intent on refusing to immunise their child and our 'no jab, no play, no pay' measure ensures they understand there is a significant price attached to their actions.

Immunisations don't just protect your child, but others as well—it's known in medical terms as 'herd immunity'. Vaccination is therefore one area of life where it pays to be part of the crowd.

That is probably the main things I wanted to say. AMA Queensland very much commends your amendment to the bill, thank you.

CHAIR: Thank you. Dr Kidd, could you speak to the comment that we had earlier and some questions around herd immunity? Should we be maintaining immunisations throughout life as well, rather than just focusing obviously on kids?

Dr Kidd: Certainly for some diseases it is very important we maintain herd immunity throughout life. Pertussis is a good example. One of the most vulnerable groups for pertussis is newborn babies and young babies before they have been able to complete perhaps the first 12 months of the immunisation program. The baby who died highlights that. I think in the most recent case it was one of the adults who acquired pertussis and we are certainly seeing a recrudescence of pertussis amongst older people over the age of 50, so it does make sense to have whole-of-life herd immunity for some conditions such as pertussis.

CHAIR: I have young children—a two-year-old and a four-year-old—so I had my booster when I had them. What about measles, rubella and mumps? When you go through the schedule realistically, you do not have them anymore. I certainly have not had any boosters for those sorts of things. Can you speak to that? Is that necessary? Is that a consideration?

Dr Kidd: You may have forgotten or they might have checked your immune status when you were pregnant. We do like to give people MMR preferably before they become pregnant but you can do it during pregnancy. So certainly young adult women are still getting MMR boosters. Throughout life, we are routinely giving people boosters for tetanus in particular and attached to that is diphtheria. Maybe we should have the pertussis attached to that as well.

CHAIR: Thank you. So your answer is yes and it is being done in many respects now.

Dr Kidd: Yes.

Ms BATES: You are a GP, so from GP land can I ask you how many children in your many years of experience have you dealt with who for true medical reasons could not ever be vaccinated?

Dr Kidd: A very, very, very small number—practically none. There is the very occasional one that might have an anaphylactic reaction to eggs, which has been a problem in the past. It is practically none.

Ms BATES: Just following on from the chair's comment about pertussis and whether or not you should be vaccinated, do you think we should be having a bit of an education campaign for adults about the symptoms of adult pertussis? Obviously it is not the cough, the red eyes, the teariness and the whoop that the babies get. I think a lot of adults are walking around with pertussis but not realising it actually is that.

Dr Kidd: Absolutely and I think AMA Queensland would love to partner in a campaign to raise awareness around that.

Mr KELLY: Thank you for the work that your association does. Many of the submissions today have indicated that infectious diseases declined not because of vaccination but because of improvements in hygiene and nutrition. Could you comment on that, please?

Dr Kidd: Certainly. I can direct you to the immunisation health website, the Australian government website. They have a booklet there called *Myths and Realities,* fifth edition 2013. It goes very much to addressing those concerns in detail and dismissing them. Is there anything in particular?

Mr KELLY: No, thank you. I will go and look at that book. There have been a number of statements today that I seem to recall people have made that one of the arguments against vaccinations is that we do not exactly know the mechanism of how they work. There is another drug, which I am sure you are familiar with, which in America they call acetaminophen. It relieves pain, as you know. Do we know how it relieves pain?

Dr Kidd: Probably not in great detail. I think the person sitting to your immediate right could give a better answer than me. It is an area of speciality.

Mr KELLY: Unfortunately I cannot interview him, Dr Kidd. For the benefit of the transcript, that drug is known—

Dr Kidd: In the case of many medicines that we use, we might think we understand how they work and sometimes we find they work in a different way or have some other part to them. Sometimes we find that things we are developing for one thing work much better for something else. Zyban, which was the first antismoking drug, was developed as an antidepressant. It did not work very well as an

antidepressant, but someone noticed that a lot of the people who had it stopped smoking. With a lot of really good medications that we use we do not fully understand how they work, but we do extensive clinical studies to determine that they are safe. That is the main thing.

Mr KELLY: We know that acetaminophen is effective in most cases against pain. It is also effective against fever. We also know that it is safe; is that correct?

Dr Kidd: Yes.

Mr KELLY: We also know that in Australia it is called paracetamol; is that correct?

Dr Kidd: Yes.

Dr ROWAN: Thanks very much for your submission today on behalf of AMA Queensland. We know that there are a range of incentives in primary care to encourage people to uptake immunisations on behalf of their children. Are there any additional measures which you believe could be implemented in Queensland in primary care to further enhance the uptake of the vaccination program amongst vulnerable childhood populations?

Dr Kidd: Again, with the introduction of this amendment to the bill, a campaign—and AMA Queensland I am sure would be very keen to partner in a campaign to raise awareness. We would be very interested in doing that. I have to declare a bias there. I think the best place for it is with the family doctor for a number of reasons. We have excellent record systems. We do ensure that when immunisations are given it gets to the national register. More importantly, if children cannot have the vaccination on a particular day—and school based vaccine programs have this issue as children may be sick or absent on the day—it is very difficult in those programs to do follow-up, whereas general practice has excellent recall systems. We can follow these children up and we do. My practice, for example, has a 96 per cent immunisation rate and many other general practices around Queensland do. Having said that, there are some pockets, particularly in North Brisbane and a few other places in Queensland, that have been identified as being at risk in terms of herd immunity.

Dr ROWAN: What would be the view of AMA Queensland in relation to all healthcare workers including doctors in our Queensland hospital system being required to show evidence of immunity or vaccinations prior to commencing work in hospitals and continuing their employment in hospitals?

Dr Kidd: Excuse my ignorance: I thought they already did. I get student nurses and others coming in and having to have their hep B and other immunisations done. If it is not actually policy, I think it would be really good policy.

Dr ROWAN: Finally, we heard some evidence today in relation to potential immune system dysfunction or illness as a consequence of receiving a vaccination—and I am happy for you to take this question on notice. Is AMA Queensland aware of any research or evidence to support that proposition in relation to immunisations and that people can develop immune or other related illnesses?

Dr Kidd: There have been a couple of studies but they have been flawed. At the end of the day, the real evidence is that immunisation activates the immune system in terms of developing meaningful immunity against diseases that in many cases kill 10 people out of every hundred who get them. That is the really important take-home message: for children who get meningitis, pneumococcus, pertussis, diphtheria, the mortality rate is about 10 per cent. Then you have the terrible disability—the kids who get meningococcus and end up losing limbs or having brain damage or heart damage. It goes on and on. At the end of the day, there is plenty of evidence that vaccination activates the immune system in a very useful way. I do not think there is any real evidence that it does anything to harm the immune system.

Mr HARPER: It is great to see the AMA, the peak body, supporting immunisation and vaccination in this state and, in particular, this legislation. Parents who are seeking an exemption to vaccination requirements must be counselled by a GP on the benefits and risks of vaccination in order to be granted that exemption. How do you see the role of GPs changing if conscientious objection exemptions are removed?

Dr Kidd: I do not think it is going to change greatly because with conscientious objection now GPs like me will spend a significant amount of time trying to do genuine consultation and trying to educate people. Sadly, from that personal experience, the people who do nominate themselves to be conscientious objectors at the moment seem to be very fixed and not very open. Whether that will change when there are financial and other implications for their chosen status remains to be seen. I suspect that the actual discussion around the science and the benefits and looking at the actual risks and benefits of the diseases versus the immunisation probably will not change greatly.

CHAIR: Thank you, Dr Kidd. I have more of a final comment. I just wanted to make the comment that when I had my young children—and you read or hear many frightening or concerning things before you do your own research—my GP was instrumental in us making our decision to vaccinate and provided me with empirical articles and was willing to go as far as he needed to in order to make sure I was confident with the information provided. I wanted to make the point that our GPs are so important in doing exactly what we have heard here from a number of witnesses and that is to engage with people. They are the credible source of information to be able to do so and to allay any concerns. I thank you for your appearance here today on behalf of the AMA Queensland and for your submission. Thank you.

Dr Kidd: Thank you for the lovely feedback on general practice, which I love.

CHAIR: With that, I will thank all the witnesses for attending today, and to those who have made written submissions I thank you for assisting us in our examination of this bill. The secretariat will be in touch in relation to providing any answers to questions taken on notice. A transcript of the proceedings will be available on the committee's parliamentary webpage as soon as practicable. Our final report will also be made available on our webpage after it has been tabled in the parliament by 2 October 2015. I would like to thank the committee secretariat for their invaluable support and Hansard for their attendance today. I declare the meeting closed.

Committee adjourned at 12.23 pm