HEALTH AND COMMUNITY SERVICES COMMITTEE

Members present:

Mr TJ Ruthenberg MP (Chair)
Mrs JR Miller MP (Deputy Chair)
Ms RM Bates MP
Dr AR Douglas MP
Mr JD Hathaway MP
Mr JM Krause MP
Mr DE Shuttleworth MP

Staff present:

Ms S Cawcutt (Research Director)
Mr K Holden (Principal Research Officer)

PUBLIC HEARING—INQUIRY INTO THE PUBLIC HEALTH (EXCLUSION OF UNVACCINATED CHILDREN FROM CHILD CARE) AMENDMENT BILL 2013

TRANSCRIPT OF PROCEEDINGS

MONDAY, 19 AUGUST 2013

Brisbane

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Committee met at 9.00 am.

BEATTIE, Mr Greg, President, Australian Vaccination Network Inc.

BROER, Mr Michael, Private capacity

HAINES, Mrs Merilyn, Private capacity

HANSENSMITH, Ms Rebecca, Private capacity

CHAIR: Good morning and welcome. I declare this public hearing of the Health and Community Services Committee open. My name is Trevor Ruthenberg and I am the member for Kallangur and chair of the committee. Mrs Jo-Ann Miller MP, the member for Bundamba is the deputy chair. The other committee members are Ms Ros Bates, the member for Mudgeeraba; Dr Alex Douglas, the member for Gaven; Mr John Hathaway, the member for Townsville; Mr Jon Krause, the member for Beaudesert; and Mr Dale Shuttleworth, the member for Ferny Grove.

This hearing is part of the committee's inquiry into the Public Health (Exclusion of Unvaccinated Children from Child Care) Amendment Bill 2013. The bill is a private member's bill introduced by Mrs Miller. Witnesses are not required to give evidence under oath, but I remind witnesses that intentionally misleading the committee is a serious offence. I remind those present that these proceedings are similar to parliament and are subject to the Legislative Assembly's standing rules and orders. Under the standing orders, members of the public may be admitted to or excluded from the hearings at the discretion of the committee. Mobile phones or other electronic devices should now be turned to off or switched to silent, please. Hansard is making a transcript of the proceedings. The committee intends to publish the transcript of today's proceedings, unless there is good reason not to.

I welcome first up Mr Greg Beattie, the President of the Australian Vaccination Network Inc; Mrs Merilyn Haines; Ms Rebecca Hansensmith; and Mr Michael Broer. Starting with Mr Beattie, I invite witnesses to make a five-minute statement, if you would like to.

Mr Beattie: Thank you very much, Mr Chairman, and the rest of the committee for the opportunity to outline our concerns. I would like to make a special appreciative note of the amount of consultation that has gone on here in stark contrast to what has happened in a more southern state recently with similar legislation. We appreciate that.

The Australian Vaccination Network was formed to assist people in their search for information on this issue and to protect their right to make choices freely. We support debate, because we recognise that it is through discussion that the truth is permitted to bubble to the surface. Vaccination is a controversial issue. Some support it and some reject it. The rest fall on a spectrum between. A recent SBS survey estimated that 53 per cent of Australians have concerns about the procedure. The issue has been debated for more than 200 years and both sides have always had support from all levels of the scientific hierarchy. However, when coercion raises its head, the debate becomes hostile and the issue divisive. History is littered with examples of this. In England, more than 20,000 people gathered to burn a copy of the Vaccination Act in the 1880s. In Brazil, open revolt against compulsory vaccination required military intervention to restore order. That was in the early 1900s. Parents are very protective of their children and they hold dearly the right to make careful and considered decisions without state sanctioned medical interference, especially when the child is well and the interference is unnecessary.

Vaccines are aggressively marketed. In fact, possibly no commercial product or service in the history of mankind has been so vigorously and thoroughly marketed. The backdrop of the campaign is fear—fear that your child, if not vaccinated, may suffer and ultimately die from an illness. The fundamental slogan 'Vaccines save lives' expands into a story of how children frequently died from these illnesses until vaccination arrived and changed everything. Ironically, one of the few things we know without doubt is that this story is false. All who care to look for themselves find that vaccines played no significant role in the great fall in deaths. The deaths did fall dramatically but, as can be

seen in the appendices to our submission, it had nothing or little to do with vaccination. Yet the story persists and parents are faced with a bizarre situation. Vaccination's most compelling argument—that is its fundamental slogan—is in clear conflict with the empirical evidence.

This seems to be of little concern to vaccine promoters. Increasing vaccination coverage is their goal, so the slogan remains, which in turn leads parents to question the integrity of the whole marketing campaign. For example, promoters claim that there is a scientific consensus that vaccination is safe. However, consumers are aware that countless studies have been published in the scientific literature indicating a relationship between vaccines and a host of serious conditions, including anaphylaxis, encephalopathy, lupus, type 1 diabetes, chronic fatigue syndrome, paralysis, multiple sclerosis, Bell's palsy, arthritis, autism, asthma, seizures and many more. Courts have repeatedly decided in favour of some of these relationships, including autism, and huge amounts of money have been paid out for death and serious injury. Still, the promoters deny their existence, saying they are not proven. But scientists do not talk of proof; they talk of evidence and there is clearly sufficient evidence to make a reasonable person cautious about vaccines, despite glib reassurances from promoters.

Many parents are more concerned with the vaccines than with the illnesses. But regardless of which concerns them most, if things do not turn out well they are the ones left holding the baby. Of course, when they read that three-quarters of the children with whopping cough had, in fact, been vaccinated against it, they begin to wonder what benefit there is. Vaccination is an invasive medical procedure carrying unquantifiable risk and dubious benefit. Legislation designed to force this non-essential procedure is not in the public interest, especially given that honest differences of opinion exist. As mentioned in our submission, it will foster division in the community and the uncertainty for service providers and for these reasons we oppose the bill. Thank you.

CHAIR: Thank you, Mr Beattie. Mrs Haines, would you like to make an opening statement?

Mrs Haines: Thank you, chair, and committee for the invitation to speak today. First up, I am a retired medical laboratory scientist; I am not an expert in vaccinations. Secondly, I am not opposed to vaccinations, but they are a medical treatment and they should be a matter of informed consent without undue and intense pressure.

I put in my submission that I think this legislation is unfair and unjust and dictatorial. It will put enormous pressure on parents to have kids vaccinated and to the very month that vaccinations are scheduled by the government. A lot of people now are under huge financial pressure with large mortgages and insecure jobs. Many parents have to have secure child care to keep their jobs and their homes. The proposed legislation will have an extremely negative effect on those families least able to survive, yet with more financial pressure. Should parents really have to decide between their children's health and their job? Young kids can get a series of coughs, colds and runny nose one after another. My son went through a phase when he was up to six months behind in his vaccinations because he was almost continually sick. Children should not be vaccinated when they are not perfectly well. This bill will be putting a lot of pressure on parents to vaccinate their children when they may prefer to wait until they are sure that they are totally well or they may just prefer a delayed schedule like they do in Japan. I feel that children would be put at risk by the pressure of this bill to vaccinate on time, especially when the government's schedule is for children to receive 25 vaccines by the time they are six months old.

The title of this bill is misleading, too. It is not just child care; it is also kindergarten and preschool that are included. All of these operators will have to become de facto vaccination police. They really will not get much choice, even though refusal is not mandatory. With government-run preschools, or if private operators receive any government funds, operators will almost certainly bow to pressure to have an exclusion policy.

In my submission I included an article from an associate professor and research fellow from Sydney university. The article stated—

Nationally, 92 percent of children are fully vaccinated by the age of two... childhood vaccination rates have been stable and even increased slightly in the four year-old age group.

I believe that one of the researchers, who in no way could be referred to as antivaccine, has also entered a submission opposing the passage of this legislation.

This whole bill seems to be based on the false assumption that vaccination rates are declining and that there will be devastating consequences very soon. It is a panic bill. In 2012, only 1.5 per cent of parents were conscientious objectors to vaccines, but this bill makes no provision at all for conscientious objectors. By all means encourage parents to vaccinate. Introduce or improve on any reminder systems, but use the carrot approach; do not use the big stick to beat parents into

submission. This bill would impinge on human rights. It will make parents repeatedly disclose sensitive medical information and, as education centres are involved, can affect an unvaccinated child's right to education.

Babies are now required to have Hep B vaccinations at birth, two months, four months and six months. I would like to ask: are children catching Hep B from other children in preschools? Has any baby ever caught Hep B from any other baby in Australian child care? Why is Hep B even part of the required schedule for a child to be allowed into child care or preschool? I think it is ridiculous. I would like to ask also: if vaccinations work, how could vaccinated children be at a great risk from unvaccinated children?

Lastly, if passage of this bill means that we have segregation in preschool and child care with fully vaccinated kids in one facility and fully unvaccinated in some other facility—if they can find them—perhaps the only positive thing that could come out of this discriminatory policy is that they could perhaps do a valid comparison of the overall health of the vaccinated as opposed to the unvaccinated child. It has been asserted that the unvaccinated children are healthier than their vaccinated peers. If that happens, perhaps parliament will take their duty of care seriously and fund truly scientific studies of the relative risks and benefits of this medical procedure. Until that happens, we must allow parents, who are the largest stakeholders in their children's health, to make choices that they feel are in their family's best interests and they should not be pressured and forced into vaccinating. Thank you.

CHAIR: Thank you. Mrs Hansensmith, would you like to make a statement?

Ms Hansensmith: Certainly. Members of the committee, ladies and gentlemen, thank you for the opportunity to speak further on my submission. There are three key messages in my submission. The first is choice. Parents should have the right to medical freedom. The second one is why? Why would a parent choose to delay or miss a vaccination? Thirdly, what effect will this bill have on parents as it currently stands?

The right to medical freedom in our society is fundamental. Our Constitution protects our right not to have any forced medication from any government. Our forefathers recognised this as an important fundamental right. All medical procedures, which include vaccination, come with both risks and benefits. But is force the best method to address these risks and benefits? The legislation as it currently stands does not allow for either a religious or conscientious exemption. This may force parents into a situation where they must accept a medical procedure to access child care and education for their children in Queensland. Is this what Queensland citizens want?

Why would a parent choose not to follow the exact vaccination schedule? The vaccination debate in the public arena is portrayed as extremes, with those vaccinating on one side and those not vaccinating on the other side. This does not reflect the fact that the vaccination schedule includes a number of different diseases and a number of different vaccines. The current schedule is a one-size-fits-all approach to vaccinations that may not be appropriate for all individuals.

As mentioned earlier, a national survey of Australians for the SBS *Jabbed* program did report that 53 per cent of Australians had concerns in relation to vaccinations. It is therefore not surprising that some parents may choose to take a more personalised approach to this medical procedure as they do with other medical matters.

This may include variations to the timing of the vaccinations, excluding a particular vaccine or all childhood vaccines. A question all parents face is, does the benefit always outweigh the risk of vaccination? Vaccination damage is a reality. The vaccine damage to Saba Button in WA highlights the fact that vaccines do not come without risk. Prior to Saba's reaction, other reports of adverse reactions were reported but no action taken. Worldwide there has been billions of dollars paid in compensation for vaccine damage. At the moment, Japan has suspended the HPV vaccine due to high amounts of reported adverse reactions.

Of course, parents need to balance this with the risk of disease. These differ for different individuals and at different ages. For example, most healthy individuals recover from the flu with no adverse effects. Tetanus is a very serious disease, but is it necessary for my two-month-old baby to have a tetanus needle at that time? Fully breast-fed babies rarely suffer serious effects from diarrhoea illnesses such as rotavirus and, prior to vaccination, most children have recovered from at least one bout of the virus by the age of four. On the NPS Medicinewise website, we see that one of the side effects of rotavirus is vomiting and diarrhoea, possibly up to one week. There is little clinical difference from the actual symptoms that you would suffer should you have contracted the disease.

Australia, unlike other countries, does not have a vaccine compensation scheme. The full effect of any decision by the parent will be borne by the parent. In light of the above, should any parents choose a customised response to vaccination they may be penalised, as the bill currently

stands. So what effect will this bill have on parents? This bill raises three questions: firstly, how will this benefit children in childcare? Childcare facilities already have in place policies in relation to unvaccinated children and outbreaks of disease. Secondly, will the current bill increase vaccination rates and reduce outbreaks of disease? Childhood vaccination rates are high in Australia; the average is in excess of 90 per cent. Recent outbreaks of disease in Australia have incurred in both vaccinated and unvaccinated individuals. The premise of the legislation is that it will encourage parents to fully vaccinate as per the vaccination schedule. However, mandatory methods have rarely worked and often result in negative outcomes, not the original intention. Will parents be coerced into forced medication? The bill as it currently stands defines 'unvaccinated' as any child who does not have all the vaccines and future vaccines on the schedule at the time advised. This legislation has the potential to penalise parents and children from exercising their democratic freedom to choose the most appropriate medical options for their individual 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 without prejudice. Thank you.

CHAIR: Thank you. Mr Broer?

Mr Broer: I thank the committee for its consideration of my submission and for the invitation to speak here today. I would like to speak about the science around the vaccination program as it stands. There is, as Greg pointed out, widely accepted scientific evidence that supports the existence of auto-immune and auto-inflammatory disorders caused by vaccination. This evidence really needs to be investigated further before some of the blanket statements commonly made in the media about vaccine safety can be accurately assessed for their reliability.

As well as some of the research that I submitted in my written submission, I direct the committee's attention to the findings of the Institute of Medicine of the National Academies. In August 2011, the Institute of Medicine conducted an enormous review of the evidence pertaining to routine vaccinations and adverse events. For the vast majority of the vaccine adverse event pairs that were reviewed, that is, 135 of the 158 causality conclusions that were sought, there was inadequate evidence to accept or reject the causal relationship. In the conclusion of the review summary of the Institute of Medicine, they state—

> Much research already occurs to determine the safety of vaccines for the populations for whom they are recommended. However, there is much to learn about the human immune system, autoimmunity, and the effects of genetic variation, all of which may influence how people respond to vaccines.

Also, the summary states—

> As some of the conclusions suggest, individuals with certain characteristics are more likely to suffer certain adverse effects from particular immunizations. Individuals who have serious immunodeficiencies are clearly at increased risk for specific adverse reactions to live viral vaccines, such as MMR and varicella vaccines. Thus, the committee was able at times to reach more limited conclusions for subgroups of the population.

How serious and of what nature are these immunodeficiencies so as to warrant caution when prescribing vaccines? If the best available evidence provides limited conclusions on the matter, then how can medical providers possibly reach consensus on what constitutes qualification for medical exemption from the national scheme?

There is a lack of evidence showing that partially vaccinated or unvaccinated children are a threat to the health of those who are fully vaccinated. If this amendment is passed, will childcare providers have the right to ban children for six weeks following their varicella vaccine, when they are considered a risk for shedding the viral strains contained in the vaccine? By the same line of thinking, will childcare centres be allowed to ban any sick child from attending while apparently infectious? Will every child presenting with a cough, vaccinated or not, be required to undergo laboratory pathology testing for pertussis before being allowed to attend preschool? While I am mentioning pertussis specifically, I would like to add that there are very high-quality recent studies that have shown that the current pertussis vaccine program is not preventing pertussis outbreaks. If it is not providing protection to vulnerable infants, why should be it insisted upon by preschool and childcare providers? I would add, too, if current medical thinking on vaccination is correct and herd immunity is an actual mechanism by which vaccination programs are effective, could the proposed amendment not result in a clustering of unvaccinated children, thereby increasing the likelihood of outbreaks of so-called vaccine preventable diseases?

The proposed amendment does not require childcare or preschool providers to make concessions to families who choose alternative or delayed vaccination schedules based on qualified medical opinion, for example, schedules adopted by other countries as their national schemes. As well as the points that I have outlined in my written submission, I point out that there is a complete

absence of a vaccine injury compensation scheme, as Rebecca pointed out. The World Health Organisation believes that, given that there are risks involved with vaccination, it is an ethical necessity to have a vaccine injury compensation scheme. Australia stands apart from many other developed nations in that we do not have such a scheme in place. If the government wants citizens to vaccinate, it must provide appropriate mechanisms whereby consumers are protected and compensated in the event of an adverse reaction. It is an unacceptable state of affairs when a family with a vaccine damaged child, such as the Button family in Western Australia, is forced to undertake private legal action against either a vaccine manufacturer or a government health agency. This is at odds with what would happen in many other developed countries. If a child suffers a serious adverse effect as a result of vaccinating from being coerced by a local preschool or childcare-centre policy, would the centre management be in any way liable for any damages to the child?

In Australia, the laws around reporting of adverse events associated with vaccination differ between states and territories. There is no active surveillance system in place at a national level. In 2010, during the height of the flu vaccine adverse reactions, Peter Collignon, Professor of Infectious Diseases from the Australian National University, was interviewed by ABC News. During the interview he stated that the number of adverse reactions was probably underestimated. He said—

We need a better system than voluntary notification to the TGA (Therapeutic Goods Administration) that there's a problem.

Because whenever you do that you really underestimate how much of a problem there is.

Australia's vaccination policies are formulated by the Australian Technical Advisory Group on Immunisation. This group is also responsible for providing advice about funding to research bodies and to advise research organisations on additional areas where research funding is required. There are members of this committee that have conflicts of interest with vaccine manufacturers. It is important that these conflicts of interest are demonstrated to the public, because public health policy should be founded on disinterested science.

As well as the issues around relevant conflicts of interest, in Australia there is also the lack of an independent body overseeing scientific research. While the peer-review process may be considered adequate by some, when one takes into account conflict of interest in government agencies, the overwhelming influence of industry funding into research, as well as the lack of legal requirement for all clinical trials to be registered and all results published, there is certainly much room for improvement in the removal of bias from the scientific evidence used to formulate policies such as those regarding the national vaccination schedule.

To summarise my main objections to this bill, participation in vaccination programs involves a certain amount of risk. Accurate risk assessment cannot be made without complete unbiased safety data. Without an adequate adverse event reporting scheme and without a vaccine injury compensation scheme, the risk associated with vaccination is higher than it needs to be.

Aside from the unanswered questions around vaccine safety, it is totally unethical, not to mention counterproductive, as the other speakers have pointed out, to use coercive policies in an attempt to force people into the consumption of any medical product involving any risk. Recently passed legislation in New South Wales requiring childcare and preschool providers to keep accurate and up-to-date records of vaccination status has broad national support. It is a more sensible way forward and it has a strong focus on consumer education and results in more effective monitoring of vaccination rates during outbreaks, while allowing room for conscientious objection based on the arguments I have presented. Thank you.

CHAIR: Thank you all. We now have time for committee members to ask questions. I open it up to committee members.

Mrs MILLER: Mr Broer, you made a statement before that members of this committee have a conflict of interest. Which member—

Mr Broer: No, not members of this committee; members of the Australian therapeutic advisory body that advises the national scheme, ATAGI.

Mrs MILLER: So no members of this committee have a conflict of interest?

Mr Broer: Not to my knowledge, no.

Mrs MILLER: I just wanted to verify that.

CHAIR: It is a fair comment. I assumed the same.

Mr Broer: I am sorry if that was not clear. I was referring to members of ATAGI. I apologise to the committee.

Mrs MILLER: That really was not clear. We believed that you were saying that members of this committee had a conflict of interest.

Mr Broer: Certainly not, no.

Ms BATES: Thank you for the presentation. Obviously there are prodromes that are very similar in lots of other childhood diseases that do not have vaccinations—coughs, colds, runny noses, et cetera, that do not always turn into chicken pox or rubella. Many children have already been exposed to childhood illnesses that they have developed their own antibodies to, anyway. In my own experience with my older son, he got just about every disease known to man from swimming lessons, from when he was about six weeks old. He actually developed some of those conditions anyway. I agree with you that obviously diseases like pertussis do not give lifelong immunity. My daughter had pertussis four times, even though she had the vaccination.

This bill basically is trying to exclude unvaccinated kids from childcare centres, but I would like your opinion on unvaccinated staff who could also bring diseases into childcare centres. We know that there are many adults walking around with pertussis right now who have no idea that they have the disease. Therefore, they could impart that to people they are caring for. Would anyone like to comment on that?

Mr Beattie: Thank you for the question. It is a very interesting question. There are many vectors in and out of childcare centres for disease transmission, regardless of how strongly a person's view is on the theory of transmission and the involvement of specific microbes. The vectors into a childcare centre: we have staff as you mentioned, we have the parents of children who are in contact with lots of other people in the outside world and then go and pick up their children or drop their children off, and we have various service people in and out. It is interesting, because this legislation only considers one of those vectors, that is, the actual children at the centre. But it does not even consider them in their entirety. What about the children who have not been vaccinated, for whatever reason? As I mentioned in my submission, there are children who are unvaccinated for medical reasons. Perhaps they were not well enough to be vaccinated, they have some condition that prevents them from being vaccinated. They are just as likely to be a disease carrier under the same set of assumptions as an unvaccinated child. What about the children who are too young to have been vaccinated or have not had their complete course? Based on the same set of logic and assumptions, they should be excluded too, surely. That is my comment.

Ms Hansensmith: My issue is the contact that you have in any one day. I would drop my child at child care. I would catch public transport. They have a brother in high school. They have a sister in the adult workforce. You would then be talking about everyone being vaccinated all of the time to minimise the issue.

CHAIR: Dr Douglas, you can ask the first question.

Dr DOUGLAS: I would like to start with Mr Beattie. I thought that was an extraordinary presentation based on the fact that last month the Health Care Complaints Commission in New South Wales made some pretty damning statements about your organisation. In view of the fact that you have made a presentation which is incredibly similar to what was stated as certainly being reprehensible—I could use a variety of words—I would like to know what you have done since then to actually reappraise your position in view of what you have just stated today?

Mr Beattie: Thank you for the question about the Health Care Complaints Commission and my presentation. First of all, can we clear up the premise of your question. You are saying that I made an extraordinary presentation in view of the Health Care Complaints Commission's statements. Where do they tie together?

Dr DOUGLAS: Basically, you are restating the same argument. It is the same argument.

Mr Beattie: Perhaps you could point that out to help me.

Dr DOUGLAS: I am not going to go through it piece by piece. Are you aware of what was stated by Steve Hambleton of the AMA on 2 August in response to that and in response to your continuing statements, which are of the same ilk as presented here today?

Mr Beattie: Sorry, I do not know what Steve Hambleton said on 2 August, but—

Dr DOUGLAS: He said that your repeated presentations bring you great discredit and are, in fact, not helping the nation at all. In summary form, the results of what you are doing are doing irreparable harm to the communities across Australia and are, in fact, driving down getting our immunisation rate above the magical number of 93 per cent.

Mr Beattie: That is because Steve Hambleton is a promoter of vaccination. Our organisation is a promoter of free choice. At the moment our organisation is under severe attack from all those who want to promote vaccination. The Health Care Complaints Commission is a great example of that. The Health Care Complaints Commission investigated our organisation, issued a report to us and asked us to respond. Our response was over 300 pages. It was ignored and not addressed at all, and a decision was made against us. We were ordered to put in a disclaimer saying that we had incorrect information.

That has been to court. I do not know whether you are aware of that. It has been to the Supreme Court in New South Wales. It turned out that not only was the decision illegal, the whole investigation was illegal. That is where it is at at this stage. I am not sure whether you are aware of that.

Dr DOUGLAS: Let us leave that to one side and more to the next issue. I think Merilyn talked about the vaccination rates actually increasing in Australia. Is that what you said?

Mrs Haines: That is what these two researchers said—the associate professor and the research fellow. They said it was stable and had actually slightly increased in the four-year-old age group. I believe that the professor has actually put in a submission. I have not read the submission, but I heard that she has put in a submission.

Dr DOUGLAS: The latest, quantitative published research in Australia is that vaccination rates are not only declining but declining at a massive rate in certain lower socioeconomic communities. Multiple authors have stated that. You say an associate professor of what from where?

Mrs Haines: At Sydney University.

Dr DOUGLAS: Into what? Who is the associate professor? What is the department? Who is it?

Mr Beattie: The National Centre for Immunisation Research & Surveillance.

Dr DOUGLAS: Who is the author?

Mr Beattie: Julie Leask.

Dr DOUGLAS: So you have said that that is accurate and everyone else is wrong?

Mrs Haines: No, I did not. I have just said in my submission that this is what these two researchers have said. If they have put this in a submission to the committee then you can verify for yourself what they have said. Vaccination rates might be decreasing in some communities, but from what I understand the feeling is that it seems to be that it is more educated and wealthy people who are becoming conscientious objectors not so such those from lower socioeconomic areas. In the lower socioeconomic areas they are not refusing because they have been educated, they are just behind schedule in terms of immunisation. These are the people who need to be reminded.

Dr DOUGLAS: Mrs Haines, you are a scientist, are you not?

Mrs Haines: Yes, I am.

Dr DOUGLAS: That is pseudoscience, is it not? When I say to you that the current evidence is that in—

Mrs Haines: Which evidence is that?

Dr DOUGLAS: The most recent report in the latest AMA—

Mrs Haines: Which report?

Dr DOUGLAS: Published in the most recent AMA journal.

Mrs Haines: And how much have they declined?

Dr DOUGLAS: Sorry, what was that?

Mrs Haines: How much has it declined? They are saying it is 92 per cent. It depends on the age group too, does it not?

Dr DOUGLAS: In fact we have actually fallen behind Rwanda in our terms of our measles vaccinations. We are behind Rwanda. I think that was published in the *Age* and the *Sydney Morning Herald*. So we have actually fallen so far behind that we are behind Third World African countries.

Mrs Haines: So this is the media's evidence?

Dr DOUGLAS: No. What they did is take selected pieces out of the latest aggregate research. The problem is that what you are quoting is selective things from one paper. If you are a scientist you would realise that you need aggregate papers, do you not? Tell me the aggregate results that support your evidence?

Mrs Haines: I did say I am not an expert in vaccination. I have not got all the statistics, but this is what these two researchers said. They said at age two—the age you are looking at and is most significant in child care—nationally the immunisation rate is 92 per cent and yet you are saying the magic figure is 93 per cent.

Dr DOUGLAS: Yes.

Mrs Haines: It is not very far behind, is it?

Dr DOUGLAS: But you do not understand. Ninety-three per cent is a massive number. I do not want to get into the semantics of this. If you are a scientist you would realise that it is evidence that actually supports arguments and if there is no evidence the argument cannot be supported. Currently, I cannot see on what you have presented that the evidence is good enough. It is contrary to everything that has been published.

Mrs Haines: My argument is about choice and about not forcing parents to vaccinate children who are not well. They have pressure to provide a vaccination certificate to their child-care centre, their preschool centre, their kindy centre to allow their child into those facilities. Whether it is 92 per cent or 93 per cent it does negate our issue around choice and forcing parents into having their children undergo a medical procedure. The AMA code of ethics says that a doctor should respect a patient's right to choose or reject a medical treatment. With this bill it will be forcing, coercing parents into accepting a medical treatment from a doctor so that they can get their child into child care, preschool or kindergarten.

Mrs MILLER: That is nonsense and you know it.

Mrs Haines: It is. It will be an enormous amount of pressure.

Dr DOUGLAS: I utterly reject your selective use of certain things from medicine.

CHAIR: Can I remind committee members that we really need to move on. Let us not have an argument backwards and forwards. Let us explore the issue and continue on.

Mr Beattie: May I briefly add to that?

CHAIR: Sure, if you would like.

Mr Beattie: I will be as brief as I can. Vaccination rates are increasing; it is well documented. You mentioned that Mrs Haines was quoting selective research. You are quoting media reports.

Dr DOUGLAS: No, I am not.

Mr Beattie: Vaccination rates are increasing.

Dr DOUGLAS: No, I am not. I am quoting the JAMA.

Mr Beattie: They have never been higher in this country.

Dr DOUGLAS: You quote me the articles that say that?

Mr Beattie: Read the submissions to this committee. It is there from the people who do the research.

Dr DOUGLAS: I have read the research. You quote the—

Mr Beattie: If you want to talk pseudoscience and media science—

CHAIR: Committee, standing order 115 does not allow us to argue backwards and forwards. Could we please explore the issues and ask the questions. Dr Douglas, do you have another question?

Dr DOUGLAS: No, I will sit tight.

Mr HATHAWAY: This is to anybody from the panel. I note on Thursday or Friday that the Prime Minister announced his approach. I note most of your submissions have indicated that you do not want the stick approach you want a carrot approach. I am interested in your point of view about the Prime Minister's proposed policy with regard to removing the family tax benefit and end of year supplement for children who are not immunised?

Mrs MILLER: That is out of order, Mr Chairman. This committee hearing is in relation to this bill.

CHAIR: That is actually a fair point. Mr Hathaway, would you like to ask a different question?

Mr HATHAWAY: I am interested in the carrot versus stick approach.

Mrs MILLER: It is still out of order.

Mr HATHAWAY: I will happily move on. I have another question.

CHAIR: Thank you.

Mr HATHAWAY: Ms Hansensmith, you raised in your submission the injury compensation or vaccination compensation scheme not enabling vaccination manufacturers to find the vaccine of best choice or safest choice?

Ms Hansensmith: Yes.

Mr HATHAWAY: Mr Broer, in your submission you say that we should have a vaccination compensation scheme. I am wondering about the difference?

Ms Hansensmith: My point is that when you have a vaccination injury compensation scheme, as we do in the states, you actually take the responsibility away from the vaccine manufacturers. Therefore there is less incentive to make the best possible product for the consumer.

Mr HATHAWAY: In your submission, Mr Broer, you indicated that we should have a vaccine compensation scheme. There is a difference in view.

Mr Broer: I believe we should, especially if we are going to start using coercive methods and financially penalising parents into vaccinating their children sometimes against their better judgement. It elevates the risk. As the other members of this panel have pointed out, it is parents who are responsible for their children's health. If a child is injured by a vaccine the costs can be enormous.

Mr SHUTTLEWORTH: All of the submitters this morning have mentioned choice as a primary driver. My understanding of the bill is that an amendment has been made with regard to conscientious objectors and choice on medical grounds. The capacity for a parent to choose remains in the bill is my understanding. I would like to get your view on that?

Ms Hansensmith: Can you just clarify; my understanding is that there is not an option for a conscientious objection the way the bill is currently drafted.

Mrs Haines: There is no provision for a conscientious or religious objection.

Mrs MILLER: You can be exempted on religious or medical grounds.

Mrs Haines: Medical grounds but not—

Mrs MILLER: Or religious grounds.

Mrs Haines: It does not say conscientious objection.

Mrs MILLER: Religious and medical grounds are there.

Ms Hansensmith: So that excludes choice.

Mrs MILLER: I am sure if they want to that those on the panel here today would go to their doctors and get their doctors to say that on medical grounds their child cannot be vaccinated.

Ms Hansensmith: Medical exemptions are usually for a certain criteria under the Medicare act—certain conditions are exempt. I do not think that GPs would be able to say that unless it fitted the criteria that is already enacted. So again you would not have choice.

Mr Broer: There does not seem to be a broad consensus on what constitutes a medical exemption for either leaving out vaccinations or delaying them. Some doctors that I have spoken to are not in favour of the varicella vaccine. Some doctors do not believe the latest science in terms of the flu vaccine. Some doctors will not vaccinate a child if they are sick. The Immunise Australia Program website has set criteria for what constitutes a medical exemption, but it is still subjective on the part of the medical practitioner. So there is inconsistency as to what could qualify as a medical exemption and what cases warrant caution or delaying the schedule. This could lead to problems with the child accessing child care.

Ms BATES: In the legislation there is an amendment which clarifies what an unvaccinated child is. Paragraph (b) states that it includes a child who 'has not otherwise acquired an immunity from contracting each vaccine preventable condition for which the child has not been vaccinated'. I would like your opinion on how does the parent prove that their child has developed immunity to any of these preventable diseases unless they have actually had blood tests for antibody screening, and obviously that would increase the cost to a parent as well?

Mrs Haines: Blood tests would be the only way to prove that you have an immunity.

Mr Beattie: I would like to add to that briefly. Immunity itself is a state of being where you cannot catch an illness apparently or you cannot develop an illness. Determining that solely through a blood test is not accurate. All we can determine is that there is a certain level of antibodies in the body, but it has been documented in the scientific literature that that does not equate with immunity. So there are differences of opinion there.

Dr DOUGLAS: In relation to that last statement about immunity, I am a doctor and I have never heard that. That is mythical, isn't it? That is a mystical statement. Tell me where that came from.

Mr Beattie: Thank you. I am happy to send you more information on that if you are interested. Does the committee want me to go further into the question?

CHAIR: I think it would be helpful if you provide the extra information to us. If you can send it through to us, we will be happy to take that.

Mr Beattie: Certainly.

CHAIR: I have one more question. Ms Hansensmith, in your submission on page 2 you note that parents may wish to choose the option of a more customised approach to vaccinations and the immunisation schedule. Can you give us some examples of that from a parent's point of view?

Ms Hansensmith: Certainly. Brothers and sisters may have had chicken pox, so they do not have an issue with the child contracting chicken pox. You have a fully breast fed baby up to the age of six months and therefore is rarely likely to suffer rotavirus. So you may wish to exclude rotavirus from your particular schedule but you may wish to choose to take on the other ones. Again, tetanus tends to turn up in older Australians. Is it the most appropriate time to be doing it at two, four and six months? Would a more appropriate schedule be in a later age group? In terms of Hep B at birth, are they at the highest risk of Hep B if they are not the child of an infected mother? They may wish to delay that to a future time.

CHAIR: Thank you. We appreciate that. Our time has ended with this current panel. Thank you for your time. Thank you all for attending and thank you for your submissions. Our next witness is via teleconference.

DEL MAR, Professor Chris, Centre for Research in Evidence-Based Practice and Faculty of Health Sciences and Medicine, Bond University (via teleconference)

CHAIR: Good morning, Professor Del Mar. Thank you for your time. As you were not here at the opening of the hearing, I will just remind you that these proceedings are similar to parliament and are subject to the Legislative Assembly's standing rules and orders. Under the standing orders, members of the public may be admitted to or excluded from the hearings at the discretion of the committee. Witnesses are not required to give evidence under oath, but I remind you that intentionally misleading the committee is a serious offence. Professor, I appreciate your time and your willingness to participate in this hearing via teleconference.

Prof. Del Mar: I thank the committee for allowing me to do it via teleconference rather than in person.

CHAIR: Professor, would you like to make an opening statement to the committee?

Prof. Del Mar: No. I have kept my comments very brief in my submission to you, and I do not really have very much to add.

CHAIR: Thank you. I will open it up to the committee. Is there anyone on the committee who would initially like to ask a question to the professor?

Ms BATES: Good morning, Chris. I am Ros Bates from Mudgeeraba. In your submission you stated that it is more important to address the issues of why parents avoid vaccinating their children. I can recall back in the eighties in Melbourne there was a whooping cough outbreak and we were getting babies in the paediatric ward who were between two and four weeks of age. There was a big scare campaign against vaccinating at that stage. Obviously vaccines have changed since then. I agree with you where you say that education is paramount so parents can weigh up the risks associated with either having the vaccine and the reaction to it or the morbidity associated with not having the vaccine should the disease progress that way. Chris, could you elaborate further on education and also why you think parents are avoiding vaccinations?

Prof. Del Mar: Certainly. This is a very complicated area. That is the first thing to say. I am doing some research in the area at the moment about what is called 'health literacy', which is the ability of people, the lay public, to make informed decisions about their own health. What we tend to find is that very often in this particular area people tend to overestimate the risks and underestimate the benefits at the time. That is possibly because vaccination has been around for so long now that people do not have any memory of the diseases that have been minimised by vaccination, such as whooping cough, and they worry more about the side effects of the vaccination. Now, it is true that there are side effects, or adverse effects as we call them, related to vaccination. That means that a weighing up of the pros and the cons has to take place for each individual to make a decision about whether or not to vaccinate, as indeed is the case for any other health intervention.

This particular area has had its clear waters muddied by a rogue doctor in Britain called Dr Andrew Wakefield, who has now been disgraced and removed from the medical register in the UK for publishing misleading information about the harms related to this kind of vaccination, the MMR vaccination, which includes whooping cough. He implied that vaccination might have the side effect of causing autism. This caused a significant reduction in numbers of children being vaccinated in the United Kingdom, and I think it has spread to other parts of the world as well. His piece was published in an influential journal called the *Lancet*, and that piece has now been retracted from that journal. So that has caused a lot of problems. There has been a flurry of research in the area subsequently to uphold the view that the concern about autism is not real, although there are other side effects that you can get from vaccination—usually local reaction and fevers and things of that kind.

So our problem is to communicate the risks and the benefits in a way to people so that they can make an informed decision. My view is that the benefits greatly outweigh the risks by several orders of magnitude and that it is worthwhile vaccinating children. I have vaccinated mine. This is not true for all vaccines, by the way. There are some vaccines for which I have some doubts of the efficacy. For example, the influenza vaccine is a very controversial area and I think we probably over promote its benefits and minimise its harms. I am not sure I recommend vaccination against influenza, except for some specific subgroups of people. But for these childhood vaccinations, yes, I am convinced that the benefits outweigh the harms for the individual.

In addition to that, there are of course benefits for the population so that, if you are vaccinated, your neighbour or your colleague at the next desk at school is also partly protected as well. That is called herd immunity, and that is a very important public health principle. If you can get

the herd immunity above a certain percentage—and that percentage will vary for each disease—in the population, then you can protect the whole population. In fact, if you get it high enough, you can actually wipe out the disease if you do it worldwide.

Dr DOUGLAS: Chris, I thank you for your submission. If you think that the major problem is that there is an issue of health literacy and also that there is a multifactorial reason, including maybe the medical profession and health professions not sufficiently doing their bit to try to improve that, what short-term measures other than this type of process do you think would work?

Prof. Del Mar: That means spending more funds on education instead of on coercion. I think that is basically what I am proposing here. If we could spend more resources on educating people—getting the information out there and getting people to talk about it, for example, on talkback radio; I am not an expert on the ways of doing this—and communicating the information about the pros and cons of all health interventions actually but vaccination in particular, I could see that that could have large benefits long term and they will be more sustained. My worry about coercion is that it can build up resentment. It can be counterproductive. There are a whole lot of ethical issues about which I am not really very well qualified to talk, but I know plenty of people who are—the ethics of making people do something that they do not really want to do. I think it would be much better to do it the other way around: get everyone to think that they do want to do it.

Dr DOUGLAS: Chris, I will come at this another way. We have a long history in Australia, albeit I accept that you are originally a UK graduate. We had a two-phased polio epidemic in the past, and we introduced what were short-term measures, of which there was exclusion as well, but we compelled the community to be vaccinated. In fact the overall results were overwhelmingly successful and then were improved when we changed the vaccine from the original Salk to the Sabin vaccine. Are you so convinced that within a short period of time you could improve health literacy as opposed to taking these types of measures on the basis of what has happened in the past as well?

Prof. Del Mar: No, I am not convinced. I am happy to be provided with information that will make me think the other way. But I just see that compulsion is a problem. There is an ethical element to it. I believe that health literacy is an urgent problem in our community that needs addressing, not just for vaccination but for other areas as well. When I say 'health literacy', I am really talking more about what I call the empirical evidence—in other words, how many people are harmed balanced against how many people benefit—rather than saying that vaccination is a process which induces antibodies in the blood, which is the mechanistic form of health education which is why I think a lot of health literacy gets stuck.

Mr SHUTTLEWORTH: Professor Del Mar, I am Dale Shuttleworth, the member for Ferny Grove. I would just like to explore a little more the term 'herd immunity'. If the herd immunity declines below a certain level, does that necessarily mean that to get back to the level of immunisation that would be satisfactory would require greater effort because diseases may mutate or the lack of immunity for a period of time may cause other exacerbating issues and how would we then lift the population back to that point?

Prof. Del Mar: Herd immunity just means that if you can get enough people vaccinated in a population, then the bug cannot easily get from person to person. If the bug can go easily from person to person—in other words, most of the population is susceptible—then it can spread across the population like wildfire. There is a point—and it is a percentage of people who are vaccinated. As I said, it varies for each disease but it is around 90 per cent or 80 per cent of the population—and when you get above that point, then the bug cannot easily hop from person to person. That means that it does not influence the severity of the illness on that population directly; all that does is prevent the rate at which the disease can get through the population.

If you have a population that is largely vaccinated and if somebody flies into the community with that virus, then only the odd pocket will be vulnerable to that virus of people who have not been vaccinated—the few that have not—and you might get the odd sporadic case, but it will not take off. Recently this year in the UK, for example, there have been several outbreaks of measles with very large numbers of people having to be admitted to hospital, and there have some deaths from measles because the vaccination rates have dropped below the critical level. Sporadic cases came in, and then the population was susceptible.

The severity will be affected because measles, for example, is a much more severe illness in adolescents and adults than it is in infants and children. Measles is a nasty disease, but something that can be managed at home can become something which needs hospital care and turns into a very serious infection which takes out a month or two of someone's life because they are so debilitated. So the severity has got an influence simply because the illness might come at a later age. Does that answer your question?

Mr SHUTTLEWORTH: Yes, except it also brought up a supplementary question. You mentioned earlier that you were less convinced about the value of influenza type immunisations, but surely those things sort of have different annual strains.

Prof. Del Mar: Yes.

Mr SHUTTLEWORTH: And therefore the effect on the population, you would think, would be more significant and easily spread further and wider. So then why are you less convinced of the value of influenza—

Prof. Del Mar: I am influenced simply by my expertise in reading the literature and the research that has been done in this area. For example, I am the coordinating chair of a group called the Cochrane Acute Respiratory Infections Group, which is an editorial group, part of Cochrane Library, and we have published several meta-analysis. That is a statistical review of all of the research done in a particular area. Some of these have addressed influenza vaccination in different groups of the population. They have not shown that there is much benefit from using influenza vaccine. There is a small reduction in cases, but it is not discernible in things like time off work, or admissions to hospital and so on. Partly this is because of the poor quality of the research that has been done in this area, but also exactly as you say: influenza is a unique virus that mutates very readily. It undergoes a slight change in the proteins on the surface which is called antigenic drift, and these changes in the surface mean that the antibodies that you may have produced against influenza in the past will not work against this season's virus. It is very difficult to catch up with the virus. Each year a new vaccine has to be produced, with the vaccine producers best guessing what the antigenic drift will be for the coming season, so it is a much less effective vaccine for that particular reason.

CHAIR: Professor, in preparation for these hearings I have done a fair bit of reading. As much information as I can find for the argument I can find against the argument, and it seems to be always supported by a study of some sort or a statement of a lack of evidence of some sort. You have obviously done a lot more reading than I have. Why are you so firmly convinced in favour of vaccines? Have you read scientific results against vaccination that seem to have some credibility?

Prof. Del Mar: That is a very broad question, but I have read information for the common vaccines against childhood viruses that we are talking about here, the measles, mumps and rubella vaccines. For those I have read the evidence, and I am convinced that the benefits outweigh the harms. For one or two vaccines, in particular the influenza vaccine, I am less convinced. But that is really not part of this discussion; that is not one of the vaccines that is under consideration here for the legislation that is proposed.

CHAIR: So based on your years of review—

Prof. Del Mar: Yes.

CHAIR:—you are sufficiently enough convinced, obviously, to believe completely that the benefits of vaccination, especially the early childhoods ones, are substantial as opposed to the possible impediments?

Prof. Del Mar: Yes. In other words, the pros outweigh the cons by several orders of magnitude. I just have one supplementary thing to say to that. You are quite right in saying that sometimes you get studies that contradict each other. We have a scientific process for dealing with that. It is called meta-analysis, and it is a statistical process—in which I have some expertise—by which we can look at different studies and join together all of the research; for example, all of the trial evidence that addresses one question, we can pool the data and get a summary of what they all show. That means if you have got one result which is abnormal or out of synch with the others, it gets swamped by the majority data, if you like. That is one way that we can resolve your issue about reading a study that says A is better than B and another one that says B is better than A.

CHAIR: I will just follow up and then I will ask someone else, but do you have an opinion on the current schedule? Some countries have schedules that are different to ours; in other words, Japan, Germany and New Zealand seem to be slightly different to ours as in the timeframes when immunisation is given. Do you have an opinion on that?

Prof. Del Mar: Not really. The schedule for giving these things is not based on very hard evidence. What actually happens when you vaccinate a child is that you are exposing them to some antigen which mimics the virus that you are trying to protect them against. You hope that the child's immune system will make antibodies against that virus, and the circulating antibodies then induce a whole lot of responses in the body to make sure that if that antigen is ever encountered again, there will be an immune response that will stop it causing an illness. That is the whole basis of vaccination.

The problem is if you start vaccinating too early, then the immune system is not mature enough to make the antibodies and mount an appropriate immune response. If you give it too late, the problem is that they may have caught the virus. They may have been exposed to the virus in the window before they got the vaccine. We tend to try and best guess when we think it will work. Some of the vaccines require several exposures to increase the rate at which the vaccine will be effective—will take, if you like. It is a bit like throwing mud at a wall: if you throw it three times you are more likely to get some to stick; it does not guarantee it will stick. There are some children who have been vaccinated but somehow nonetheless did not get an immune response for one reason or another and they can still be susceptible to the virus, in the same way there are some children who have acquired the wild virus somehow or other and did not need the vaccination. There is no way for us to tell. But it means that these immunisation schedules have to be constructed in such a way as to minimise that window in which a child might get infected, but late enough for him to mount a mature immune response.

CHAIR: Thank you. As a layman that was easy enough to understand.

Mr HATHAWAY: By way of follow-up to your last discussion just then, in earlier testimony we have heard that part of the issue against a coercive regime for vaccinations is obviously the efficacy of various vaccinations, and you have highlighted a few such as the flu. But a case we have had tabled here today was whooping cough, which indicates that 75 per cent of the cases subsequently caught had been immunised. Could there not be a case made that in the case of whooping cough per se, obviously the immunity degrades over time and that rather it could be a case of a booster?

Prof Del Mar: Yes, whooping cough does decay with time. There has been some interesting research done in Britain recently which shows that quite a lot of adults get whooping cough because their immunity has worn off. That is something which we did not know before. So quite a lot of people who get long-standing coughs—they get a cold, and they get a cough that goes on and on for weeks and weeks—there is a subgroup of those people who have actually got whooping cough. They do not have the classic symptoms of whooping cough: they do not have the whoop; they do not get respiratory failure. They are not in any danger like a small infant is with whooping cough. Whooping cough in an infant can be lethal. Children can die. They can be brain damaged from a shortage of oxygen to the brain from the paroxysms of coughing. In an adult it is just a nuisance. It is just a long-standing cough. As a GP I have patients coming in who say, 'I've got this cough I just cannot shake, Doctor.' I often think this could well be whooping cough in an adult. So you could mount an argument for giving a booster pertussis to adults to stop that happening. We do not at the moment, largely because whooping cough is not a serious illness in adults; it is more of a nuisance thing.

CHAIR: Mrs Bates, and this will be our final one, Professor.

Ms BATES: I have just one to clarify and a second question. Before when you were talking about values to measure data that probably is not significant or to qualify data, obviously I am assuming you are talking about the P-value of what was statistically significant. Is there any data that compares whether or not you should vaccinate as to whether or not you should not?

The second part is that obviously we have got cases of people coming illegally to Australia at the moment from places like New Guinea who are carrying diseases such as TB or maybe polio that we have virtually eradicated here in Australia. Do you think that is more about complacency as well, that people do not realise that we are at risk for these sorts of diseases coming back into Australia?

Prof. Del Mar: I will deal with the first question first, which is you are asking about statistical significance. Yes, there is good data about the efficacy of childhood vaccination with significant differences in the immune rates, so I am quite confident that the statistical significance is appropriate.

The second question is whether we are under threat from people coming from abroad with different illnesses, and you mentioned tuberculosis and polio. Polio should not be a problem because we all vaccinate against that, so we are protected against polio. If enough of the population is immunised against polio, then we will have herd immunity. If we did not have that situation, yes, we would be at risk. In fact, in some countries in the West—I am thinking about America in the 1950s—polio was terrifying. It happened every summer. It is a gastrointestinal virus but it can cause us neurological damage and some children would end up becoming paralysed, some would die and some would have to go into an iron lung because they did not have enough neurological signals to enable breathing. So it was a terrifying disease. But now with the polio virus vaccines available, we have enough herd immunity to minimise the danger of people coming in with the disease.

Tuberculosis is not one of the things that we are talking about here, but you are quite right: that tuberculosis is an emerging threat in the world actually. In most Western countries where people have a good immune system—they are well fed and have good hygiene such as enjoyed by nearly all Australians—that is not a threat. But for some groups within the community—so people who have HIV-AIDS, for example, whose immune system has been damaged or people undergoing chemotherapy for cancer and things like that and possibly people who are in poor socioeconomic circumstances, and I am thinking particularly about Indigenous Australians living in remote Australia—then tuberculosis is more of a threat. But most health authorities are aware of tuberculosis and there are surveillance units all over the place to look for it and to monitor new cases of tuberculosis as they arise.

Ms BATES: Thanks, Chris.

CHAIR: Thank you. Professor Del Mar, thank you very much for your time. Thank you for making yourself available. Our time has now concluded. The committee will now take a 10-minute break and reconvene at 10.30.

Proceedings suspended from 10.17 am to 10.32 am

BERRY, Ms Karen, Immunisation Program Nurse, Australian College of Children and Young People's Nurses

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

MOHLE, Ms Beth, State Secretary, Queensland Nurses Union

CHAIR: Thank you for attending this morning. I will just run through a couple of things, as I am aware you were not here right at the start. This hearing is part of the committee's inquiry into the public health bill introduced by Mrs Miller. Witnesses are not required to give evidence under oath, but I remind witnesses that intentionally misleading our committee is a serious offence. I remind those present that these proceedings are similar to parliament and are subject to the Legislative Assembly's standing rules and orders. Under the standing orders, members of the public may be admitted to or excluded from the hearing at the discretion of the committee. Please switch mobile phones to silent. I welcome our witnesses, Ms Beth Mohle and Ms Karen Berry. Ms Mohle, would you like to make an opening statement to the committee?

Ms Mohle: Thank you, Chair. The QNU thanks the Health and Community Services Committee for providing this opportunity to comment on the bill. I do have with me today our health and safety officer, James Gilbert. If the committee would like to hear from James, he has some very interesting angles on this particular legislation from a health and safety legislation perspective which may not have already been canvassed this morning. James is just sitting in the front row if the committee has any questions for him. The QNU recognises the importance of immunisation as a public health initiative that saves lives. Immunisation protects not only individuals but also others in the community by reducing the spread of disease. Other than clean water, vaccination has 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 as it now stands.

In many ways immunisation programs have become 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 growing resistance to such interventions. However, our written submission is evidence based. We know that routine childhood immunisations protect babies and children against potentially serious diseases such as measles, polio, tetanus and whooping cough, or pertussis. 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 a preference for natural immunity. Parents and 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 for government and the vaccine manufacturers and, by extension, a distrust of conventional preventative medicine. We know that giving child-care providers the option of excluding unvaccinated children from care may be confronting or contentious. Of course, children have an internationally recognised right to education. Children also, under Article 22 of the Convention of the Rights of the Child, have the right to good-quality health care. We argue that those 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 the initiatives that will protect the public from any outbreak of a vaccine preventable disease.

CHAIR: Thank you. Ms Berry, would you like to make an opening statement?

Ms Berry: Thank you. Before I begin, I will just say that my submission is short because we have already put in our submission in terms of the information that you need, so this is additional information. I am representing the Australian College of Children and Young People's Nurses and want to thank the committee for allowing us to have the opportunity to present. The college supports vaccinations for individuals to protect them from vaccine preventable diseases and the long-term effects of such diseases—for example, subacute sclerosing panencephalitis, SSPE, which is a rare chronic, progressive encephalitis that affects primarily children and young adults which is caused from infection with measles virus and manifests often many years after the measles illness.

Increasing immunity through vaccination not only protects individuals; the more individuals who are vaccinated ensures protection for the whole community. Whereas a significant proportion of the community have become immune to specific diseases through immunisation, this protects those who still may be susceptible to the disease, as they are less likely to come in contact with an individual carrying the infection. Increasing herd immunity has resulted in the eradication of vaccine preventable diseases such as polio from Australia.

The college would like to point out that the process of checking immunisation status by the person in charge of an education and child-care service or child-care centre means that a parent needs to make an active decision to either have their child vaccinated or seek an exemption and present this to the director of the facility. Seeking this type of exemption gives a health professional the opportunity to provide parents with good, solid evidence based information on which they can make an informed consent about vaccination rather than looking at very controversial information that is provided in the various forms of media. The college would like to bring to the attention of the committee the complexity of the immunisation schedule, and this type of checking process is not a one-off. Rather, it is an ongoing process and it requires at time interpretation by a qualified healthcare professional. I have a copy of the schedule with me if you would like that. Children who may not have been vaccinated for a number of reasons may be on a catch-up schedule that takes some time to complete and there is risk that this could be misinterpreted by a non-healthcare professional and a child could be excluded unnecessarily from child care. It is important—it is very important—that all children should be fully vaccinated prior to entry to child care.

CHAIR: Thank you, Ms Berry. Just so that you are aware, we actually have the schedule in our papers, but thank you though for your offer. I am going to open up to the committee now for questions.

Mrs MILLER: I would like to hear from James, if we could.

CHAIR: We are okay to do that as long as the committee gives approval. Is the committee okay for James Gilbert to appear as a witness? If everyone is okay with that, Mr Gilbert, would you please come to the table as a witness.

Mr Gilbert: Thank you to the committee for making that allowance. I am not here to discuss the efficacy of vaccination in terms of the clinical process; my interest lies more in the health and safety aspects and the current legislation we have in Queensland around the Work Health and Safety Act that requires employers and workplaces to not only ensure the safety of workers but those affected by the workplace itself. In Queensland we have a strong emphasis on risk management and in terms of managing risks, and in this instance the hazard would be a biological hazard. So an employer must take steps to reduce or eliminate the risk of injury or illness, and in this case it would be illness. Around that risk management process an employer is required to go through the likelihood and consequence of any such hazard. Others have spoken in terms of the likelihood and hazard and the consequence of childhood diseases. I would like to emphasise the fact that vaccines and immunisation are certainly a very strong control measure in terms of managing a risk.

For instance, Queensland Health employees are required to have Hep B vaccinations and those workers who choose not to have vaccination can be put through what is called the reasonable adjustment process. So what the employer would do is they would look at the likelihood and consequence. So if you, for instance, worked in the emergency area of Queensland Health and you were not vaccinated against Hep B, there would be a potential that the employer could move you and if they were unable to find somewhere for you to work where the risk was less—so if you are a registered nurse and you cannot work in an emergency department—it would be difficult to move you to a medical ward or something like that because there is still quite a risk. In the worst instance, your employment may be terminated. It is around that sort of concern that I raise the health and safety legislation with the committee, because I do not think it is something that had been considered in any of the submissions that I viewed. There is already legislation that talks about likelihood risk, consequence and how to manage a particular hazard. I understand earlier there was some discussion around vaccination and its efficacy. I would suggest that, after listening to the professor speak earlier, the science is accepted that vaccination and immunisation provide greater protection.

CHAIR: Can I just start the questioning off then with you, Mr Gilbert. I am following up from the first panel that was here in that there are multiple ways to introduce risk into a kindergarten—for example, employees who not vaccinated or parents who are not vaccinated and service providers. What sort of risk profile would that create under OH& S? Are we just dealing with one or should we be looking at those as well?

Mr Gilbert: You would probably have to look at them all, I agree. I suppose, when you are doing a risk management process you would consider the area—for instance, areas around Maleny. It is generally accepted that in those sorts of areas there are lower rates of vaccination. I do not know if you have heard that. I do not know where I picked that up. So that would be an aspect in terms of how an employer should consider the risk profile for an area like that. You would look at that and say, 'Okay, we have lower rates of vaccination here.' It might be that you also consider the statistics in terms of whooping cough, measles—whatever—the status in that community and then go through your risk. In terms of performing a risk management process, you consider the likelihood. So it could be argued that in an area such as that the likelihood of exposure is greater and I am sure the committee has heard about the consequence of children suffering such diseases.

CHAIR: Thank you. Committee, I am going to ask another question. Ms Mohle, my question is to you. In your submission one of the things you talked about was that, while you are firm on the bill the way it is now, people should have the right to make a personal informed choice about whether or not to have a vaccination. Are you able to suggest to us ways where the bill could still be implemented but still espouse that principle?

Ms Mohle: Certainly, it is about a balancing of rights, is it not? We appreciate that it is a difficult situation when you are balancing two very important and competing rights, but we think on balance that, immunisation being such an important issue, the right to proper health care is the most important one and is the pre-eminent one.

I know that in other legislation interstate they have introduced conscientious objection provisions. So that is something that the committee might want to look at, but you really do need to do that carefully and look at the implications that that will have on the integrity of the legislation as a whole. But there are other issues—and I would defer to Karen about that, given that she is an expert on immunisation—in terms of what the impact would be in relation to having that sort of conscientious objection provision in there.

CHAIR: Ms Berry?

Ms Berry: From an immunisation nurse perspective, I think parents need to be given the information that they need to make an informed choice. The child-care director and the child-care centre, or whoever owns the child-care centre, then has to make a decision about the risk that an unimmunised child poses to the children in the centre and to the unimmunised staff in the centre. I think that if you look long term we are seeing a number of babies—if you look at the Royal Children's Hospital—admitted for whooping cough, because unvaccinated adults are giving little tiny babies whooping cough. We are still losing babies from whooping cough. Having nursed babies who have died from whooping cough, I would strongly recommend vaccination—strongly recommend vaccination—rates in the community be raised. We do have lowered levels in pockets around Brisbane. If you look at the statistical data, you will see that the rates of whooping cough in those areas is greater. I think parents need to have the right to choose, but then the child-care centre has to have a right around risk.

CHAIR: Can I just ask a supplementary question on whooping cough? Could one of the recommendations coming out of this inquiry be a new education campaign, or an ongoing education campaign, in regard to the areas of risk? I am not an expert on immunisation, but I understand that as you get older the whooping cough vaccine deteriorates and you no longer have it. Is there an option that we could be making a recommendation maybe that adults would then seek a booster?

Ms Berry: It would be great if we could get new parents or parents prior to having children revaccinated. We know that immunity from whooping cough starts waning at around 28 years of age and continues to decline over time and it is about the age that people start having babies. So then we get adults who get a cough or a cold and they have whooping cough and give it to their newborn babies who are not often old enough to be vaccinated yet or who may have had only one vaccine, which then does not give them immunity.

Ms Mohle: Or grandparents too. I just had my booster recently. It would be good to integrate that into regular GP check-ups, for example, that you have a checklist, if you like, that you are due for a booster.

CHAIR: One of the concerns that was expressed by the first panel was around choice and the AMA code of conduct in regard to allowing parents choice to refuse medical treatment. How do you balance that choice against the intent of the bill? Have you any comment on that?

Ms Berry: I think it is a difficult position to be in, because I think all parents want to do the right thing by their children. Some parents, although, are uninformed. I think the professor's comments around health literacy is true, because it is very difficult to make a decision based on

what you see in the media, unless you go actively seeking evidence based information and look at immunisation rates. Not many parents will do that. So I think it is very difficult. If parents are going to have their children exempt, then they need to understand the ramifications of that exemption and I do not know that parents understand that well enough. So if you choose not to have your child vaccinated, what are the ramifications? There are policies already in place in child care and in schools where, if there is an outbreak of disease, particularly vaccine-preventable diseases, those unimmunised children are immediately excluded until after the event is over. I think that needs to stay, but it needs to be strengthened and I think parents need to be given information around the ramifications of not vaccinating their child.

CHAIR: I will ask one more and then I will give up and let the others have a go. In the schedule there are multiple points where for one vaccine you are required to go through two or three processes. Certainly, in today's society, where we have increased pressure on both parents needing to work to afford to pay off a house or something like that, where do you stand in regard to a child who has started the vaccine process but who still may be considered to be either not immune or could pass on a particular disease during the process? How do we deal with that?

Ms Berry: That is the point that the college was making around the catch-up schedule, because it is complex. Often when I am in a clinic doing immunisations and a child is on a catch-up schedule I have to get out my 10th edition handbook, go through step by step in the handbook to find out the time gaps between vaccinations and what that means. Sometimes I will seek clarification from the doctor in the public health unit, because it is that complex sometimes. So I guess children should be fully vaccinated. Some child-care centres take young babies. Fully vaccinated for them would be depending on their age. So they could be somewhere in the schedule and not be fully vaccinated, if you like, because you are not going to finish your vaccination schedule until your 3½, four.

CHAIR: So this would be fully vaccinated according to where you are on that continuum?

Ms Berry: And depending on how many vaccines you have had will depend on your level of immunity, because some of those vaccines require three doses to be fully covered and often it takes a month after the third dose to actually have full immunity against that disease. As the professor quite rightly pointed out, there are a very small number of children in our community who would be vaccinated and will not ever have immunity, particularly for things like rubella.

CHAIR: Can I say that I was one of those children with chicken pox. Just for the committee's benefit, we will go to Mr Shuttleworth and then back to Mrs Miller and then to Ms Bates.

Mr SHUTTLEWORTH: My question is to you, James, again. Most of the morning so far has been spent discussing the merits or otherwise of vaccination and the decisions of choice. I am a little alarmed in how you framed your presentation, largely because it seems to put a level of liability and onus on the director or the child-care centre itself. Given that, as it was explained by a number of panellists earlier throughout the day, the touch points of a child are enormous—it can be family; it can be all of these other things—I am quite concerned if your body is already considering liability and an onus or a duty of care consideration. To me that would be a very significant and largely unintentional consequence of this bill if you put too much onus back on the director, given that the parents are largely the ones responsible for their children.

Mr Gilbert: I had not considered that in respect to my comments, but the work health and safety legislation puts the onus on the person conducting the business or undertaking. So in that instance, say it was a sole provider, it would be the directors, I assume. They would be the PCBU, which is the terminology for person conducting the business or undertaking. If they had done an adequate risk assessment and they were able to show that they considered it, that would be a protection for them in terms of potential prosecution. That would be my view. They would have to do it thoroughly. If the exposure is through some extraneous element, such as a parent or something like that, in my view you have attempted to manage the risk as best you can. I think it would be very unlikely that they would be pursued.

Mr SHUTTLEWORTH: I would put it back and say that it would be almost impossible to prove where the exposure had occurred and, therefore, the child-care provider would be left with no other option other than to take an exclusion. Therefore, that almost eliminates a significant part of this bill, which refers to religious or medical exemptions. If I were the director of a child-care centre and someone presented with a medical or a religious exclusion, you would then have to weigh up, 'Am I going to be discriminatory on those grounds or am I going to exclude that child?' because you have the personal risk and liability attached to it.

Mr Gilbert: The Anti-Discrimination Act does have caveats in there around health and safety to allow you to potentially discriminate because of a health and safety concern. The committee might find it useful to have a discussion with Workplace Health and Safety Queensland. They have fact sheets around vaccine-preventable diseases and immunisation programs for a child. You go to the industry—so you go to the health and community sector—and they have information sheets around vaccine-preventable diseases. So they have considered it, but obviously it does not go to the extent of the bill in terms of exclusions. It is talking about risk management, as I was. You have to go through a risk management process. As I said, as part of that risk management process you may consider the area in which your child-care centre is.

Mr SHUTTLEWORTH: I just say that, if I were a business owner and my risk profile is that my family needs my income or they go hungry, that would eliminate almost any other risk consideration. It would be exclusion on every case.

Mr Gilbert: I just thought it might be useful, because the act talks about what is reasonably practicable. If I could just read to the committee in terms of reasonably practicable, you need to consider—

… the likelihood of the hazard or the risk concerned occurring… the degree of harm that might result from the hazard…what the person concerned knows, or ought reasonably to know about…the hazard or the risk; and ways of eliminating or minimising the risk.

We know that vaccination is a very good control measure in terms of eliminating the risk.

CHAIR: Thank you. Mrs Miller?

Mrs MILLER: Thank you very much, Chair. Karen, you brought up the education of parents and the times of vaccinations, as well. These days, most mothers having given birth are only in hospital for maybe 12 hours, even one day. It is very different to our generation when we might have been in for a week or more. In that age group, after you had a baby the midwives would say to you that this is the vaccination schedule. Basically, it was drummed into you that at two months you had to go to the child health clinic to get the baby vaccinated. When you have mums, particularly new mums, in hospital for say 12 hours, where does that information come in? Where do the mums get the information in relation to whether or not vaccination should apply—all the information—as the professor spoke about?

Ms Berry: In their parent-held record book, there is information about immunisation, but not many parents will read the parent-held record book because they are too busy with, often, an unsettled crying young baby they are trying to get settled. Certainly every visit to a child health centre—and our child health centres and our child health nurse are so important because they do a lot of that education, as well as the general practitioners. They may see their paediatricians, if they go privately and see a paediatrician. Certainly, we are doing a lot of education in child health centres, at the Ellen Barron Family Centre, at GPs and at hospital departments. Emergency departments are seeing kids and they are having to do primary education with parents, which takes up a lot of their time when they should be doing something else. I think that we are not seeing what we used to see on the TV. We used to see a lot of information about immunisation and that is not the case at the moment.

Mrs MILLER: As a follow-up question, one of the issues brought up with me is the fact that some of the child health centres work nine to five, five days a week. The council vaccination clinics are the same; they work nine to five, five days a week. As Trevor brought up before, with mums and dads working probably the same times, would it assist if we actually had seven-days-a-week child health centres and also council vaccination programs?

Ms Berry: We certainly have 13 HEALTH. 13 HEALTH is a valuable resource for parents. I think the vaccination clinic times vary depending on the council that is providing the vaccines. I know Brisbane City Council does do some in the evening and varying days of the evening. I am not sure about other councils. I think it probably would help if we had more access for parents, rather than less.

Mrs MILLER: Also some GPs have said to me that sometimes on the weekends they are vaccinating children, whereas that could be easily done by the council, so that they could then treat patients rather than doing the vaccination role. Do you know what I mean?

Ms Berry: Yes.

Mrs MILLER: I think it is becoming a greater issue in society now that, if you are a working mum and a working dad and you want your kids vaccinated, you have to go to the GP to get it on the weekend.

Ms Mohle: And better utilisation of practice nurses, as well. When I went for my booster not so long ago, it was the GP who gave it to me. I was a bit concerned about it, given their techniques quite often. The technique was excellent, by the way.

Dr DOUGLAS: They are pretty good. I have done a few thousand.

Ms Mohle: I did ask the question, 'Do you not have a practice nurse working on a Saturday?', because normally they do that on Monday to Friday. That was an issue there, as well.

Mrs MILLER: Exactly. I think that is becoming an increasing issue as well.

Ms Berry: I was a big part of the meningococcal C campaign. We have certainly seen a great decrease of meningococcal C meningitis since that campaign. We ran those clinics on weekends, public holidays—

CHAIR: When was that? What time frame?

Ms Berry: That was two or three years ago. I cannot remember exactly, I am sorry. I can provide that for you.

CHAIR: That is okay. I am just trying to understand the time frame.

Ms Berry: They were organised and ran right across the state.

Ms Mohle: It was a very widespread campaign.

Ms Berry: They ran on varying days and on weekends. We had a huge rollup of parents for that vaccination campaign. We vaccinated whole families.

Ms BATES: My question, I guess, is to Beth and James. In your submission you talk about nurses at risk of contracting nosocomial infections, and they are not just relegated to childhood communicable diseases. I once had the delight of contracting scabies from a patient. It is not just the case that nurses pick up infections in the workplace. They can introduce infections into the workplace. This question includes you, James: are there guidelines for nurses to be vaccinated or to prove immunity prior to working in either a paediatric unit or a labour ward so they do not pass on infections? Also, if you would elaborate: prefacing what you said, basically employers should take responsibility to make sure that there is a safe workplace. Should not the onus also be on the healthcare worker so that they do not pass on an illness, as a duty of care anyway?

Ms Mohle: We do have a policy with regards to personal choice in immunisation that tries to balance those particular competing interests. It is the case that there is a requirement—I will let James speak to that—from the occupational health and safety perspective, even in regards to student nurses, for example, having to demonstrate that they have been immunised before they start their placement. Certainly there has been a lot of work that we have done with our membership in regards to that as well, because even amongst our membership there will be some who will be conscientious objectors in relation to that.

Mr Gilbert: Queensland Health has a guide on vaccination of healthcare workers. As I said before, the only one that is really absolutely mandated is Hep B, for the very reasons you were saying: the potential exposure for themselves, but also the potential exposure to other parties that come under their care. It does certainly list a lot of the vaccinations that we are talking about here in terms of that guide.

As I said before, it would be looked at in terms of a risk management process. People would say, 'Look, all we have to do is gown and glove', but that is a very low-order control. It is a very-low order control in terms of managing a risk. You use the higher-order controls and, in this case, it would be vaccination. As I said, people could potentially be told, 'You cannot perform the role here anymore. We can't keep you safe and we can't ensure the safety of the people who seek our care. We need to go through what is called the reasonable adjustment process, which means potentially deployment to an area of lower risk or, in the worst case scenario, potential termination if we cannot find somewhere for you.' Of course, we would negotiate and look for something other than the final outcome, but ultimately that is the potential.

Ms BATES: These are really recommendations in your guide. Before you were talking specifically about Hep B, which makes sense, as if you are working in high-risk areas you are more likely to contract that. The labour ward obviously would be one of those areas as well for Hep B. I am talking about other childhood communicable diseases. Do nursing staff or any healthcare worker now have to provide an immunisation record before they can work in places like a paediatric unit?

Ms Mohle: Yes, they do, I think.

CHAIR: Dr Douglas? We have about three or four minutes left.

Dr DOUGLAS: I will pick up some of your points and some of the points made by Chris Del Mar, the previous speaker. They were very good submissions, by the way. You made the point that there is an incomplete vaccination schedule by those children to the age of four, which was stated by Chris as well. Then you made the other point, Mr Gilbert, on the issue of the risk averse nature of how things are being done. I will put it to you this way: if you take all those points, effectively what is being said is that the childcare centres—and this is the aim of the bill—are effectively high-risk environments, aren't they? Whereas what you are talking about is it what you have to do for relatively low-risk environments, because you are covering all comers who work in a hospital. A lot of people do not go anywhere near patients in hospital, do they? They do not all work in paediatric and obstetric wards and certainly they are not all looking after people with infectious diseases. But these are the minimum standards that are required for people. Those people who go into higher areas, particularly students, have to prove their immunities. You have seen what has been stated. I do not know that all members are aware of all those things.

Basically, we are talking about a high-risk environment and you are talking about a low-risk environment. The aim of the bill is to address the issue of the high-risk environment, isn't it? What we really need to do, and you have very elegantly stated it, and what we are trying to do is set a minimum standard for a high-risk environment; is that right? So the minimum standard for the high-risk environment is that all children be vaccinated, otherwise they are excluded. Effectively, that is it. Thank you.

Ms BATES: You asked your question and answered it.

CHAIR: Thank you. We are close enough to time to call this particular panel to an end. Ms Mohle, thank you very much for your attendance and to your organisation for their submission. Ms Berry, thank you also for your attendance and your submission. Mr Gilbert, at such short notice, thank you also for attending.

GARDINER, Mr Matt, State Director, Queensland Benevolent Society

TIZARD, Mr Michael, Chief Executive Officer, Crèche & Kindergarten Association

CHAIR: Gentlemen, I thank you for your attendance and I thank your organisations for their submissions. We have until about 12 o'clock, so we have a good period. I invite Mr Gardiner, please, to start with an opening statement?

Mr Gardiner: Thank you. I appreciate the invitation to be here today. My name is Matthew Gardiner, the State Director of the Benevolent Society. Our organisation, the Benevolent Society, is Australia's oldest charity. We are in our 200th year of operation. We are a secular, not-for-profit and independent organisation working to bring about independent social change in response to community need. We have around 1,000 staff delivering services from approximately 70 locations across Australia. In particular, we run three or four early years centres in Queensland, as well as five of the satellite services. The early years centres are essentially a community and family hub providing everything from infant and maternal health services to play groups, and also family support and mental health services and disability services. Within the early years centres in Queensland, we also operate three kindergartens and one long day care centre.

The Benevolent Society supports the object of the bill and the key features of the scheme. We believe that immunisations are an important way of protecting children against the most serious childhood infectious diseases. However, in particular having listened to the arguments put forward today, on balance we also put forward that we believe there is room for conscientious objection. We believe that the legislation will help reinforce the importance of vaccination as a public health issue and for it to act as a prompt for parents to talk to their healthcare provider about immunisation. We believe that access to early childhood education care is important for children and a right, but that we also have a duty of care to children and their safety and wellbeing must be paramount. As I said earlier, we also believe that children with a genuine medical reason for not being vaccinated ought still be able to access child care.

We make reference to Dr Steve Hambleton, on behalf of the Australian Medical Association, suggesting that for children who are not vaccinated their parents are forced to produce a conscientious objection form and we would support this as evidence of having engaged with a medical professional and, in so doing, being able to make an informed decision about the risks compared to the benefits. Thank you.

CHAIR: Mr Tizard, would you like to make an opening statement?

Mr Tizard: Thank you for the opportunity to speak on behalf of the Crèche & Kindergarten Association on the Public Health (Exclusion of Unvaccinated Children from Child Care) Amendment Bill 2013. My name is Michael Tizard and I am the Chief Executive Officer of the Crèche & Kindergarten Association. I commenced in that role on 5 August, so this is the beginning of my third week.

CHAIR: Welcome, Mr Tizard.

Mr Tizard: Forgive me if I do not have all the details. I will refer to the Crèche & Kindergarten Association as C&K, if that is okay.

C&K is one of the largest providers of early childhood education and care services in Queensland and has been providing those services for 106 years. The services that we provide currently include long day care, kindergarten, family day care, playgroups, out-of-school-hours care and specific services for Aboriginal and Torres Strait Islander children. There are approximately 380 kindergarten and long-day-care services across the state. Some of those are affiliates which are run by community committees of management but with support from C&K and some of them are our branch kindergartens and long-day-care centres which are owned and operated by C&K.

C&K supports the need for immunisation for children and the need to increase national immunisation rates. However, we do not support the proposed legislation to allow the person in charge of an education and care or child-care service to refuse access on the basis of nonimmunisation. C&K believes that this approach is contrary to article 28 of the UN Convention on the Rights of the Child which states that children have a right to education and also the Australian government's national partnership on universal access to early childhood education which is very much about universal access, particularly for children in disadvantaged communities.

C&K recognises that some parents take a strong view against vaccination of their children. While nationally vaccination is not compulsory, we do not believe that legislation should be introduced via early education and child-care programs to attempt to force vaccination. C&K

believes that public health education models and improving access to immunisation programs will deliver better results on vaccination rates and avoid discrimination for children who need early childhood education and care programs. Again, I would emphasise particularly those children living in disadvantaged communities.

We understand that there are lower rates of vaccination in disadvantaged communities and that in these communities more targeted education and support programs are needed to educate parents and to support them to have their children vaccinated. We also understand that in these communities early childhood education and care is particularly important to support those children get a good start at school.

C&K has a range of policies in place to ensure the safety, health and wellbeing of children and staff. However, it does not discriminate on the basis of the child not being vaccinated or the staff member not being vaccinated. C&K would welcome the opportunity to work with Queensland Health to develop increased education programs on the importance of vaccination and to provide more accessible and flexible immunisation program models to target those communities where immunisation rates are low or declining.

CHAIR: Committee members, I am happy to open up to questions if anyone would like to ask a question.

Ms BATES: This is to both Matt and Michael. In your submissions you talk about refusing to enrol children who are not fully immunised. With or without the legislation you can do that for all sorts of reasons not just communicable diseases. Would you be able to comment on the onus that may potentially be placed upon child-care centres if they unwillingly or unknowingly accept a child who ends up having a communicable disease? Would there be concerns regarding potential litigation?

Mr Gardiner: That concern also exists. We heard previously from the WHS officer from the Nurses Union. I think it is about putting control measures in place and weighing up the risks versus the likelihood of that occurring. From our perspective, this bill puts some of the onus back onto the legislator rather than on us as an organisation.

Mr Tizard: Yes, I agree with Matt in terms of the risk of litigation. We face that risk on many different levels within an organisation and within the sorts of services that we provide. What we need to be able to demonstrate is that we have the appropriate workplace health and safety policies and procedures in place and that they have been adhered to in order to try to minimise and mitigate the risk.

CHAIR: Can I explore that a little bit. I assume that you guys have done a lot of risk mitigation in your two organisations not just for this but for other things, but more specifically for this. I assume that there is a risk mitigation process or procedure. How would that change if this bill were introduced, specifically with regard to communicable diseases?

Mr Tizard: There are very stringent strategies in place in terms of keeping records on immunisation and nonimmunisation, ensuring that those parents who have not immunised their children are aware of the advantages of immunisation and the risks associated with not immunising. With staff members there is a requirement for them to declare if they have not been immunised. If there is a risk of them having a communicable disease they are asked not to work during the time that the disease is in their system. What was the second part of the question?

CHAIR: How would that policy or risk profile change with the introduction of this bill?

Mr Tizard: One of the things that concerns us is by having it sit with the director of an early childhood education and care facility you will get variations in the application of the legislation by those people. It may depend upon on what their personal views are around immunisation. It may depend on what they personally understand the issues to be. That is of concern.

Mr Gardiner: I should also mention that whilst we are an independent organisation our licensed child-care and kindergarten services are also an affiliate of C&K. We have access to their policies and do use those but refer to our own policies for governance. From our perspective, it is a step forward as a public health issue. At the very least, it will ensure that parents do actually engage with their healthcare provider to get the most accurate information. Anecdotally for us, the concern is that a lot of parents actually are not aware of the issues and are not able to weigh up the risks versus the benefits of vaccination. For us it is actually about legislating that sort of engagement with healthcare providers.

CHAIR: So more of an education focus?

Mr Gardiner: Yes.

CHAIR: I call Dr Douglas.

Dr DOUGLAS: I have two questions. Michael, I would just like to take you back through something you said. I know you have only been in the organisation for three weeks, and I respect that. You gave a description of the organisation and how it is structured. You said you operate so many centres yourselves and some are partnership—there is a framework. Would you say that inherently in that type of structure the minimum standard that you might require might have to be higher rather than lower because of the structure of your organisation? We are proposing a slightly higher standard. In your structure do you think that maybe setting the bar a little bit higher might make it easier for your organisation to function?

Mr Tizard: I am not completely sure. We aim to have the affiliate kindergartens operating at the same level as our branch kindergartens. The level of support in terms of officers who go out and provide advice to those services is at the same level. But, of course, they are run by a community committee of management. The community committee of management can make decisions that we do not have control over. Again, it would be the same thing with a staff member or a director being able to make the decision. You will get variations if it is not mandatory that they apply this legislation—that is, if it is discretionary.

Dr DOUGLAS: We will get to that in a minute. Let us talk about a minimum standard. If you set a minimum standard in terms of how many toilets there has to be and the ratio of staff to children, generally the organisations will stick to those standards even if there is a community management committee, am I correct or incorrect?

Mr Tizard: Yes. Those standards exist and it is expected that the services will apply those standards and stick to them. In some instances they do not and that is picked up through the regulatory environment.

Dr DOUGLAS: Therefore, if you set a minimum standard with regard to vaccination—let us just say that they are comparable in some way—then by and large you are going to get compliance most of the time?

Mr Tizard: Yes, I would say so.

Dr DOUGLAS: Right. Whereas if you did not have that you would get a much lower level or you might not get any compliance?

Mr Tizard: It may depend on the level of knowledge in the community or across those services about the importance of the issue. I think education is a really good component in terms of getting change and getting people to comply—not the big stick approach. Education and understanding why it is important I think is just as important as the regulation of the minimum standard.

Dr DOUGLAS: We will stay on that same point, but we will extend to the higher level where you said that if we impose this new standard then the directors may not comply with the standard because they do not agree with it.

Mr Tizard: It is discretionary as I understand it in the bill.

Dr DOUGLAS: In a lot of systems there are discretionary standards, are there not? I am a doctor and we have discretionary standards. But in general terms most people comply with them, do they not?

Mr Tizard: I expect so, yes.

Dr DOUGLAS: In the cycle of quality improvement and quality assurance, we do that, do we not?

Mr Tizard: In terms of thinking about this environment, yes most people aim to comply with the minimum standards but, for various reasons, you may get varying levels of compliance. If you have a community committee which is not experienced in governance—and we have kindergartens in isolated Aboriginal and Torres Strait Islander communities where we are working to support committees being established—then the level of knowledge or understanding might be quite different to that of a service in another community.

Dr DOUGLAS: What percentage of yours would be Aboriginal and Torres Strait Islander?

Mr Tizard: I do not have that figure in my head.

Dr DOUGLAS: It might not be that high because the percentage of Aboriginals in the general community is only four per cent. If you count the total number it may be relatively low. Let us just say that the most likely thing is that they will comply. Even with discretionary standards most people do comply. That is what happens, is it not? There is still the capacity for them not to comply, which is what you are saying.

Mr Tizard: Compliance is not just with the regulatory environment; it is about education and the understanding and importance and the motivation to want to comply.

Dr DOUGLAS: I am not denying that.

CHAIR: I have a follow-up question. The former panel talked about competing rights. A question I have asked relates to the right to refuse medical treatment, for example, versus the purported benefits of vaccination. You guys come from different organisations but in this instance provide similar services, even under the auspices of one—

Mr Tizard: I should say that I was the state manage for the Benevolent Society until February—not so different.

CHAIR: How do you balance those competing rights? We have similar organisations with different outcomes. I think you are both saying that you support the process of immunisation but Mr Gardiner is saying you support the bill as it stands but Mr Tizard is saying your organisation does not support it because of the right of children to be educated and this bill is potentially denying that right.

Mr Tizard: That is right.

CHAIR: How do you balance that? I guess I am trying to make the point that this is an incredibly difficult bill to try to get the right balance with?

Mr Tizard: I suppose I want to emphasise the issue about disadvantaged and marginalised communities as well. It is my understanding that the immunisation rates in those communities are lower and it is not so much an informed choice about whether vaccination is a good thing or a bad thing, it is probably about a lack of knowledge and in some instances negligent. We also know in those communities that a good start with early childhood education is really important to overcome some of the barriers of disadvantage for those children. So if you start excluding them on the basis that they have not been immunised then I think we are further adding to that disadvantage for those particular children.

Not all creche and kindergarten services are in disadvantaged communities. We probably have a reputation for being a more middle class service provider. Certainly organisations like the Benevolent Society—those integrated child and family centres—do tend to be based in more disadvantaged communities.

CHAIR: Does C&K now have the opportunity to exclude children if that became their policy with or without legislation?

Mr Tizard: I am not sure. I would have to check that. I do not know legally whether we could or could not. Probably not, I would have thought, on the basis that there is no national legislation enforcing vaccination.

CHAIR: If there are no further questions, we will pull up stumps a bit early. Thank you for attending Mr Tizard and Mr Gardiner. We appreciate your attendance. The time allocated for the hearing has not expired but the questions have on the Public Health (Exclusion of Unvaccinated Children from Child Care) Amendment Bill 2013. We have come to end at this time. Thank you to all the witnesses. I declare this hearing closed.

Committee adjourned at 11.30 am