Chapter 2

Key issues

2.1 This inquiry attracted a large volume of submissions and correspondence from individuals who held serious concerns about the Social Services Legislation Amendment (No Jab, No Pay) Bill 2015 (Bill). The majority of the submitters were concerned about the Bill's measure to remove conscientious objection as an exemption category for eligibility for social security payments.

2.2 The key concerns raised by submitters and witnesses were:

- efficacy of the Bill in increasing vaccination rates;
- impact on disadvantaged families;
- suitability of proposed exemption categories;
- need for a vaccination injury compensation scheme;
- impact on child care providers; and
- accuracy of the Australian Childhood Immunisation Register data.

2.3 The committee also received some submissions that supported the proposed measures, suggesting they would increase vaccination rates and improve public health outcomes. For example, Friends of Science in Medicine stated in their submission that the Bill is 'feasible, acceptable to the community, ethical and legal.'[1] Furthermore, The Parenthood, a group of 35,000 parent members said in their submission that the Bill 'sends a strong signal to all parents that vaccinations are necessary and safe'.[2]

2.4 The Department of Social Services (DSS) submitted that:

> The Australian Government considers that immunisation is an important health measure for children and their families as it is the safest and most effective way of providing protection against diseases.[3]

Efficacy of increasing vaccination rates

2.5 A large number of submitters and witnesses raised questions as to whether the Bill will achieve the desired result of increased vaccination rates.[4]

2.6 The Explanatory Memorandum of the Bill states that savings of $508.3 million over the forward estimates are expected as a result of this Bill.[5] Submitters said that the anticipated savings suggests that the Government expects the Bill will not

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1 *Submission 316*, p. 4.

2 *Submission 324*, p. 2.

3 *Submission 319*, p. 1.

4 See, for example: *Submission 317*, p.3; *Submission 344*, p.1; *Submission 318; Submission 327*; *Submission 344*.

5 EM, [ii].

persuade some families to vaccinate resulting in a reduction in social security payments.[6] DSS told the committee they expect that in 2016–17 around 10, 000 families will lose an average of $7,000 in child care payments and 75,000 families will lose the FTB-A supplement, which is currently $726.35.[7]

Conscientious objectors

2.7 The Bill's proposed measures seek to address the growing rate of conscientious objectors (COs) and the risk this poses to young children and the broader community.[8]

2.8 The committee notes that the percentage of children registered as COs has steadily increased from 0.23 per cent of total children in 1999 to 1.77 per cent in 2014. This equated to 39,523 children in 2014.[9] The Australian Medical Association (AMA) has expressed concern about the growing rate of conscientious objection to vaccination in Australia.[10]

2.9 Vaccination rates for one and two year olds have remained steady between 89-92 per cent for more than a decade and for five year olds have increased from 74 per cent in 2005 to 92 per cent in 2014.[11] However, the AMA says this is below the recommended 95 per cent needed to maintain herd immunity.[12] Herd immunity helps to protect babies who are too young to be immunised as well as the elderly and the immunocompromised, 'such as people undergoing cancer treatment, transplants, or those with allergies to vaccine components'.[13]

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6 See, for example: *Submission 327*, p. 4; *Submission 318*, p. 3; *Submission 416*, p. 2.

7 Ms Catherine Halbert, Group manager, Payments Policy Group, Department of Social Services, *Proof Committee Hansard*, 2 November 2015, p. 47.

8 The Hon Scott Morrison, MP (former Minister for Social Services), *No jab – no play and no pay for child care*, media release, 12 April 2015, http://www.liberal.org.au/latest-news/2015/04/12/no-jab-no-play-and-no-pay-child-care (accessed 30 October 2015).

9 Department of Health, 'ACIR - National Vaccine Objection (Conscientious Objection) Data', http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/acir-cons-object-hist.htm (accessed 3 November 2015) .

10 Australian Medical Association, 2015, 'Immunisation – why there is no room for complacency', https://ama.com.au/ausmed/immunisation-%E2%80%93-why-there-no-room-complacency (accessed 28 October 2015).

11 Department of Health, 'ACIR - Annual Coverage Historical Data', http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/acir-ann-cov-hist-data.htm (accessed 3 November 2015).

12 Dr Richard Kidd, Australian Medical Association, *Proof Committee Hansard*, 2 November 2015, p. 20.

13 *Submission 282*, p. 4; Dr Kidd, *Proof Committee Hansard*, 2 November 2015, p. 20.

2.10 Furthermore, evidence to the committee suggests that COs exist in clusters across the country,[14] and that the vaccination rates of the communities in which they reside are much lower than the state or national average.[15] The AMA submitted that these areas are more prone to outbreaks of vaccine preventable diseases.[16] Northern Rivers Vaccination Supporters is a community group from a region with some of the lowest rates of immunisation nationally, such as the Byron Bay Shire where the vaccination rate for 5 year olds in 2012–13 was 66.7 per cent.[17] Their submission discussed the impact of low vaccination rates:

> In the Northern Rivers the 'chink in the armour' is a perfect storm of dense clusters of unvaccinated children congregating together in a child care centre, putting the whole region at risk of subsequent outbreaks. This is already happening, and we see this with frequent outbreaks of Pertussis in our region. This has already proved fatal to those too young to be vaccinated themselves.[18]

2.11 The committee received submissions from COs stating that the Bill will not influence their decision to vaccinate.[19] Furthermore, submitters argue that families who can afford to relinquish social benefits will not be easily motivated to change their position as a result of the Bill.[20]

2.12 Associate Professor Julie Leask, told the committee that about half of all COs would be very difficult to influence.[21] She said that for the other half (those who could be influenced) evidence suggests that 'strategies that focus at the immunisation provider level are very important'.[22] DSS told the committee that the rate of objection

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14 Associate Professor Julie Leask, *Proof Committee Hansard*, 2 November 2015, p. 43; Dr Sue Ieraci, Executive Member, Friends of Science in Medicine, *Proof Committee Hansard*, 2 November 2015, p. 13.

15 National Health Performance Authority, *Healthy Communities: Immunisation rates for children 2013–13*, p. 35, http://www.myhealthycommunities.gov.au/Content/publications/downloads/NHPA_HC_Report_Imm_Rates_March_2014.pdf (accessed 3 November 2015).

16 *Submission 544*, p. 2.

17 National Health Performance Authority, *Healthy Communities: Immunisation rates for children 2013–13*, p. 35, http://www.myhealthycommunities.gov.au/Content/publications/downloads/NHPA_HC_Report_Imm_Rates_March_2014.pdf (accessed 3 November 2015).

18 *Submission 263*, p. 1.

19 See, for example*: Submission 412*; *Submission 9*; *Submission 172*; *Submission 279*; *Submission 370*.

20 See, for example: *Submission 318*, p. 2, *Submission 169; Submission 187; Submission 33*.

21 Associate Professor Leask, *Proof Committee Hansard*, 2 November 2015, p. 43.

22 Associate Professor Leask, *Proof Committee Hansard*, 2 November 2015, p. 43.

to vaccination is expected to decline slightly, from 1.8 per cent in 2015–16 to 1.5 per cent in 2018–19 as a result of the Bill.[23]

2.13 The AMA submitted that they support the removal of the conscientious exemption category as a measure to increase vaccination rates in children.[24] The AMA also stated that preliminary data suggests that some conscientious objectors may already be reconsidering their position because of the measures proposed in the Bill.[25] The Northern Rivers Vaccination Supporters told the committee that as a direct result of the proposed legislation, vaccine-hesitant parents have approached the group seeking more information about vaccination.[26]

2.14 DSS told the committee that allowing conscientious objection to vaccinations is contradictory to its position that 'immunisation is an important public health policy'.[27] The Government has also stated that the policy will give confidence to parents who vaccinate their children and send them to child care centres.[28]

Expanding eligibility range

2.15 The committee heard that this Bill would also further encourage vaccination rates in all children by requiring that children are up to date with their vaccinations each year until they turn 20.[29] This will capture parents who receive Child Care Benefit and Child Care Rebate for children aged eight to 20, some of which will be before-and after-school care, and those receiving FTB-A supplement and who have not fully vaccinated their children, whether or not they are registered as a CO.[30]

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23 Department of Social Services, answer to question on notice, 2 November 2015 (received 6 November 2015).

24 *Submission 544*, p. 2.

25 *Submission 544*, p. 3.

26 Mrs Heidi Robertson, Northern Rivers Vaccination Supporters, *Proof Committee Hansard*, 2 November 2015, p. 11.

27 Ms Catherine Halbert, Group Manager, Payments Policy Group, Department of Social Services, *Proof Committee Hansard*, 2 November 2015, p. 47.

28 The Hon Scott Morrison MP, *No jab – no play and no pay for child care*, media release, 12 April 2015, http://www.liberal.org.au/latest-news/2015/04/12/no-jab-no-play-and-no-pay-child-care (accessed 30 October 2015).

29 EM, p [ii]; Associate Professor Leask, *Proof Committee Hansard*, 2 November 2015, p. 40.

30 EM, p [ii].

2.16 DSS provided the committee with a table of children expected to fail the immunisation requirement to receive FTB-A supplement by year of age[31]:

	2015-16	2016-17	2017-18	2018-19
Age 1*	3,100	2,800	2,500	2,100
Age 2*	3,200	2,900	2,500	2,200
Age 3	7,100	6,300	5,500	4,600
Age 4	7,200	6,400	5,500	4,600
Age 5*	3,200	2,900	2,500	2,200
Age 6	8,200	6,400	5,500	4,600
Age 7	8,100	6,500	5,500	4,600
Age 8	8,500	6,100	5,700	4,500
Age 9	9,400	6,500	5,500	4,900
Age 10	10,000	6,900	5,600	4,600
Age 11	14,600	7,700	6,400	5,100
Age 12	16,300	10,900	7,100	5,700
Age 13	14,800	12,300	10,100	6,300
Age 14	18,500	11,200	11,500	9,200
Age 15	23,200	13,600	10,200	10,200
Age 16	20,500	15,300	11,300	8,200
Age 17	20,200	12,400	11,600	8,300
Age 18	8,000	5,900	4,600	4,200
Age 19	400	300	300	200
Total	***204,500***	***143,300***	***119,400***	***96,300***

2.17 Some submitters were supportive of the expansion of the eligibility requirements to be checked each year up to age 20.[32] DSS told the committee that the majority of families who immunise their children as a result of this Bill are expected to do so as a result of eligibility being checked each year until age 20.[33]

Alternative measures to increase vaccination rates

2.18 Submitters and witnesses suggested that the Government implement other means of increasing vaccination rates, including addressing access issues, improving education about vaccines and a national vaccine reminder system.[34]

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31 Department of Social Services, answer to question on notice, 2 November 2015 (received 6 November 2015). * denotes: At age 1, 2 & 5 the numbers affected reflect vaccination objections only as there is an existing immunisation requirement at those ages.

32 Associate Professor Leask, *Proof Committee Hansard*, 2 November 2015, p. 40; *Submission 282; Submission324; Submission316.*

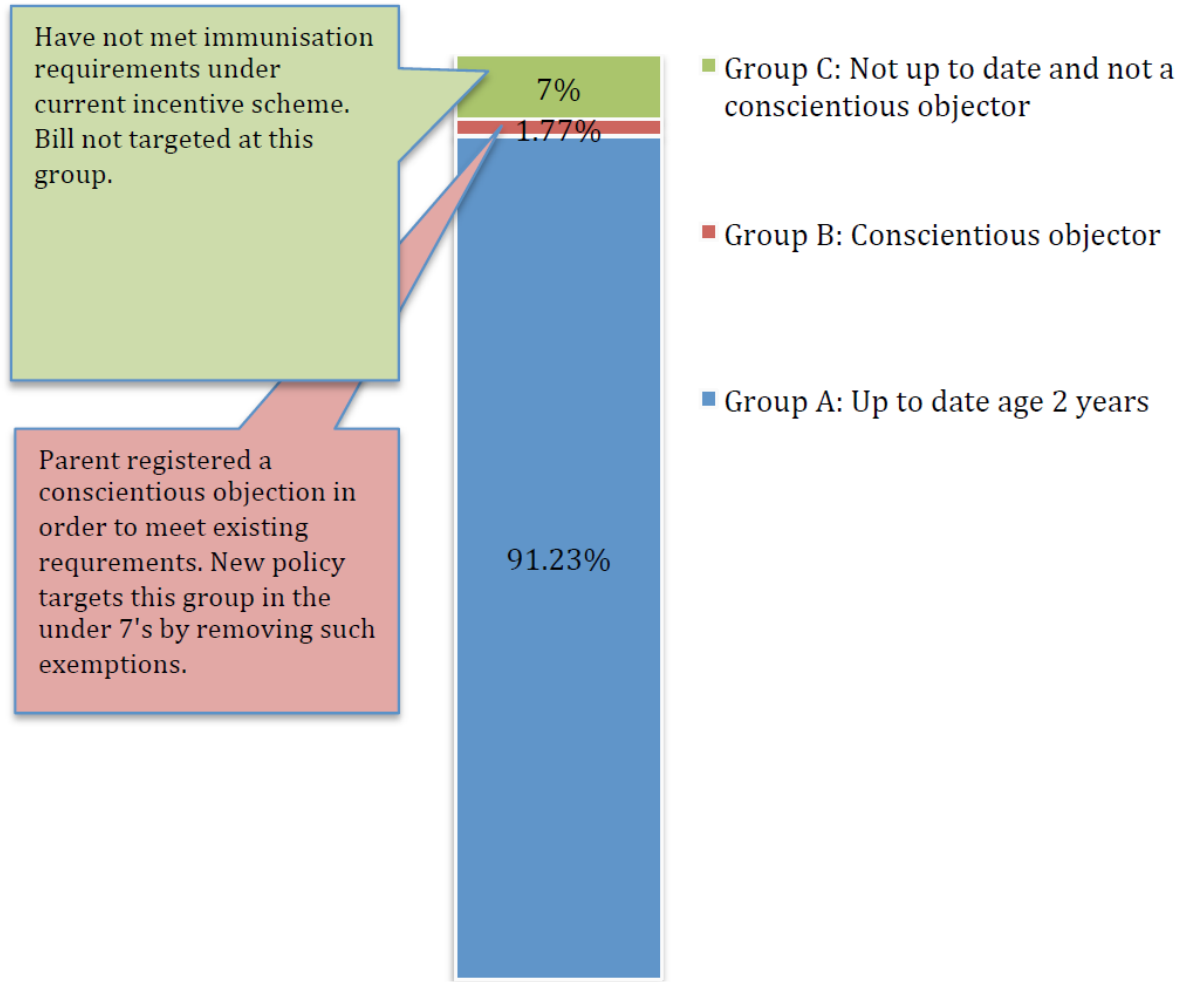
33 Department of Social Services, answer to question on notice, 2 November 2015 (received 6 November 2015).

34 *Submission 344*, pp 1–2.

Targeting unvaccinated children who are not registered conscientious objectors

2.19 Submitters and witnesses presented the committee with evidence that COs account for only a small portion of the total number of families who do not vaccinate (See Figure 1). As noted in Figure 1, unvaccinated children who are not registered as COs account for 7 per cent and COs account for 1.77 per cent of all children under 24 months in 2014 according to the Australian Childhood Immunisation Register (ACIR). Professor Leask submitted that these children are not fully vaccinated for a range of reasons including: incorrect data in ACIR; they are children of 'silent' unregistered objectors; and practical barriers to vaccination. Professor Leask told the committee that neither the current legislation that attaches vaccination to social security payments nor the proposed Bill have or will influence this group.[35]

Figure 1 Vaccination status of children aged 24 months, 2014 according to the Australian Childhood Immunistion Register



Source: *Submission 327*, p. 2.

35 *Submission 327*, p. 3.

2.20 The Public Health Association of Australia (PHAA) told the committee that the Government should seek to address the structural and practical barriers to vaccination that exist, including socioeconomic reasons that children are not vaccinated.[36] The Royal Australasian College of Physicians (RACP) suggested home visiting programs would be one way of overcoming practical barriers to vaccination.[37]

Communication and education strategies

2.21 Some submitters expressed concern that some immunisation providers do not possess extensive knowledge on vaccinations.[38] The PHAA told the committee this was crucial to successfully engage with vaccine hesitant parents.[39] Professor Leask suggested that the Government consider the value of increasing vaccination training in the medical curriculum.[40]

2.22 Professor Leask also recommended that the Government investigate the following strategies to reduce the incidence of vaccine refusal:

- parent peer-advocate training in regions with higher rates of vaccine refusal;
- competitively awarded funding for local community campaigns designed by and for each community;
- inclusion of education about vaccination in high school core curriculum; and
- funds to support more access to immunisation nurse accreditation training and better access to, and incentivisation of, training and updates for midwives.[41]

2.23 Professor Leask suggested that Primary Health Networks could play a key role in education and training about vaccinations at a community level.[42]

2.24 Evidence provided to the committee indicates that there is significant confusion as to which vaccines are mandatory for eligibility. The committee notes the different information provided on the each of DSS,[43] the Department of Human Services (DHS)[44] and the Department of Health (DoH)[45] web sites. The committee

36 *Submission 317*, pp 5–7.

37 *Submission 344*, pp 1–2.

38 See for example: *Submission 265*, p. [1]; *Submission 193*, p.2; *Submission 404*; *Submission 436*, p. 19; *Submission 491*; *Submission 511*, p. 3.

39 *Submission 317*, pp 5–7.

40 *Submission 327*, p. 7.

41 *Submission 327*, p. 7.

42 *Submission 327*, p. 7.

43 http://www.humanservices.gov.au/customer/subjects/immunising-your-children

44 https://www.dss.gov.au/our-responsibilities/families-and-children/benefits-payments/strengthening-immunisation-for-young-children/strengthening-immunisation-for-children-frequently-asked-questions

45 http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/nips

notes that on the DHS website it states that 'most of the immunisations on the National Immunisation Program Schedule are linked to family assistance payments'.[46]

2.25 The committee notes that the Government has announced $26 million in funding for Immunise Australia, as part of a 'balanced carrot and stick approach'.[47] The funding will include: incentive payments to immunisation providers who identify under-vaccinated children and initiate a catch-up schedule; improving public vaccination records and reminder systems; and communication strategies to promote the benefits of vaccinations.[48]

2.26 The PHAA told the committee that implementing a successful reminder system would have obstacles, as contact details for parents may be incorrect due to the fact that vaccination providers are no longer able to update address details of their patients in ACIR – parents have to contact DHS directly.[49]

2.27 DSS, the lead agency for this legislation, told the committee communication activities are a joint responsibility of DoH, DHS, The Department of Education and Training (DET) and DSS. DSS has been tasked with the following communication activities:

- child care centres will be sent an e-kit via the Child Care Management System. It will include a printable PDF poster the centres can display and immunisation specific text that they can send out to all their families in newsletters and questions and answers;
- Members of Parliament and Senators will be sent a similar e-kit that will also include a shell release;
- a social media campaign that targets families with children under 20. The Facebook campaign will direct families to the Department of Human Services website www.humanservices.gov.au/immunisation, which is the key source of all information relating to immunisation and No Jab No Pay measure;
- the social media campaign will complement the activities of the Department of Health, Department of Humans Services and the Department of Education (noting that all families that do not meet the immunisation requirements and receive child care payments will get a letter from Centrelink before their payments are affected letting them know what to do and when); and

46 http://www.humanservices.gov.au/customer/subjects/immunising-your-children

47 The Hon Sussan Ley MP, Minister for Health, *$26m booster to Immunise Australia*, media release, 21 April 2015, https://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley044.htm (accessed 4 November 2015).

48 The Hon Sussan Ley MP, Minister for Health, *$26m booster to Immunise Australia*, media release, 21 April 2015, https://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley044.htm (accessed 4 November 2015) .

49 Mrs Angela Newbound, Co Convenor, Immunisation Special Interest Group, Public Health Association of Australia (PHAA), *Proof Committee Hansard*, 2 November 2015, p. 46.

- additional communication activities for early 2016 may be deployed as required to ensure the community and stakeholders understand their obligations under the changes.[50]

2.28 The committee sought clarification on the detail of the Government's education campaign for vaccination but has not been provided information on the activities and budget of the other departments.

Impact on disadvantaged families

2.29 Submitters were concerned that the Bill unfairly and disproportionately affects low-income families whilst simultaneously not addressing the barriers to vaccination that may exist for families who are not opposed to vaccination.[51]

2.30 Submitters argued that the Bill is unfair because only wealthy families could afford to exercise their objection to vaccinating their children.[52]

Children of conscientious objectors

2.31 Where the measures in the Bill are unable to persuade parents to vaccinate, submitters and witnesses have raised concerns that this may lead to further disadvantaging children of COs.[53]

2.32 Submitters argued that children should not be further disadvantaged by the choices made by their parents.[54] The Law Institute of Victoria's submission raised concern that the Bill may have the unintended consequence of further disadvantaging the children of parents who choose to forgo the social security benefits.[55]

2.33 Inspired Family Day Care Service is a national child care service provider that does not support the Bill, argued that the Bill infringes on a child's right to education:

> By refusing child care assistance to non–vaccinated, partially vaccinated and conscientious objectors, the Commonwealth is determining who may or may not attend child care, in particular further marginalising at risk and low socio-economic families and creating a cycle of non-access for educational engagement.[56]

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50 Department of Social Services, answer to question on notice, 2 November 2015 (received 6 November 2015).

51 See, for example: *Submissions 317*; *Submission 340*; *Submission 321*; *Submission 264*; *Submission 326*; *Submission 344*.

52 See, for example: *Submission 33; Submission 159; Submission 169;Submission 187; Submission 313; Submission 315; Submission 402.*

53 Dr Anne Kynaston, Member, Royal Australasian College of Physicians, *Proof Committee Hansard*, 2 November 2015, p. 21; See Submissions 318, 344, and 326.

54 See, for example: *Submission 97,* p. 2; *Submission 248*; *Submission 252*; *Submission 353*; *Submission 549*, p. 17.

55 *Submission 318*, p. 2.

56 *Submission 236*, p. 1.

2.34 However the committee also heard that in areas where vaccination rates are well-below the national average, parents of young children are avoiding mothers groups for fear of the risk posed by unvaccinated children. As a result, those children are missing out on 'valuable social interactions' and the parents are missing out on valuable support groups.[57] The AMA told the committee that 'all children have the right to be protected from vaccine preventable diseases' but urged the Government to monitor the impacts of the Bill to ensure that children are not being increasingly disadvantaged by reduced access to child care.[58]

2.35 The committee inquired into the analysis that DSS undertook into the demographic of those affected by the Bill, such as their income levels and geographic dispersion. DSS told the committee that they did not have sufficient data to determine the income levels of COs or provide meaningful analysis of the geographic dispersion of those affected by the Bill.[59]

Changes to the 63-day grace period

2.36 The National Welfare Rights Network told the committee that they were concerned about the Bill's proposed changes to the 63-day grace period, whereby under the proposed Bill, there is no grace period for children who are applying for the first-time for child care payments. However, once the child commences a catch-up schedule they are considered eligible for payments. National Welfare Rights Network submitted that this potentially disadvantages these families who may be new foster parents, adopted parents or grandparent guardians, if they face a delay in visiting a general practitioner to commence a catch-up schedule.[60]

Evaluation of the Bill's impact

2.37 Submitters suggested that the Government monitor the impact of the Bill on vaccine hesitant families and vaccination rates.[61] Professor Leask recommended a full evaluation of the policy's impact in 2018–19 on:

- vaccine refusing families on low incomes;
- vaccine confidence;
- immunisation providers and primary care service delivery;
- vaccination rates;
- refusal rates;
- child care arrangements of vaccine refusers;

57 Mrs Heidi Robertson, Northern Rivers Vaccination Supporters, *Proof Committee Hansard*, 2 November 2015, p. 11.

58 *Submission 544*, pp 2–3.

59 Department of Social Services, answer to question on notice, 5 November 2015 (received 6 November 2015).

60 *Submission 545*, pp 4–6.

61 *Submission 544*, p. 3. and *Submission 327*.

- outbreaks; and
- any other impacts.[62]

Suitability of proposed exemption categories

2.38 The committee heard concerns about the removal of conscientious objection as an exemption category and issues about the medical exemption category.

Removal of conscientious objection category

2.39 Submissions to the inquiry indicated a range of reasons as to why people conscientiously object to vaccination. These can be generally divided into four broad categories:

- concern for the safety and/or efficacy of vaccines;[63]
- those who were unable to obtain a medical exemption where they believe it is warranted;[64]
- religious beliefs that are not recognised by the Government;[65] and
- ethical reasons such as the use of animal products.[66]

2.40 Many submitters states that conscientious objection is based on considered personal beliefs and circumstances which inform people's decision not to vaccinate their children.

Concern for safety and efficacy

2.41 Submissions expressed concern about the safety of vaccines and argued that the Bill may put children at risk of injury by encouraging parents to vaccinate.[67] Other submitters told the committee that they hold concerns about the efficacy of vaccines and the regulatory requirements necessary to have a vaccine approved. As a result, some parents have chosen to partially vaccinate their children while others have never vaccinated.[68]

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62 *Submission 327*, p. 7.

63 See, for example: *Submission 2*; *Submission 9*; *Submission 49*; *Submission 109*; *Submission 120*; *Submission 135*; *Submission 204*; *Submission 285*; *Submission 371*; *Submission 390*; *Submission 426*; *Submission 446*.

64 See, for example: *Submission 107*; *Submission 111*; *Submission 123*; *Submission 269*; *Submission 290*; *Submission 314*; *Submission 389*; *Submission 397*; *Submission 400*; *Submission 410*.

65 See, for example: *Submission 165*; *Submission 185*; *Submission 213*; *Submission 329*; *Submission 333*; *Submission 386*; *Submission 406*; *Submission 432*.

66 See, for example: *Submission 223*; *Submission 272*; *Submission 391*; *Submission 402*; *Submission 439*.

67 See, for example: *Submission 3*; *Submission 103*; *Submission 119*; *Submission 240*; *Submission 392*; *Submission 433*; *Submission 549*, pp 20–23; *Submission 436*, pp 14–18.

68 Associate Professor Leask, *Proof Committee Hansard*, 2 November 2015, p. 42.

2.42 Submitters and witnesses were particularly concerned about the safety of administering multiple vaccines in a short period of time and called for evidence that shows the safety of the national vaccine schedule as a whole.[69] The AMA told the committee that 'the human body can cope with multiple antigens being exposed all at the same time and develop quite good immunity without any ill effects'.[70]

2.43 Some submitters claimed that Australia's immunisation schedule has more vaccines that are given at a younger age than other developed nations, notably Japan. Submitters and witnesses told the committee that Japan does not vaccinate children under two years of age and have ceased the Human papillomavirus (HPV) vaccine.[71] However, evidence from the World Health Organisation that was provided to the committee refutes these claims, showing that Japan's vaccine schedule does include these types of vaccines.[72]

2.44 Submitters and witnesses were particularly concerned about the safety and effectiveness of the pertussis (whooping cough) vaccine. The committee heard a range of concerns about the vaccine that included:

- the number of booster shots needed for effectiveness;
- the accuracy of information about the seriousness of the disease;
- adverse reactions to the vaccine;
- that whooping cough is more prevalent today than in previous years[73];

2.45 The AMA told the committee that the pertussis vaccine gives a high level of protection but is not 100 per cent effective and is not lifelong; rather the vaccine greatly enhances the immune system but the vaccinated person can still catch the disease. Because of this, babies are targeted as early as possible along with their families as an 'imperative'.[74]

2.46 The RACP told the committee that in older versions of the pertussis vaccine, there were cases of children having a 'dramatic colour change', and RACP noted that the newer vaccines do not produce this reaction.[75]

2.47 The committee sought information from DoH regarding the effectiveness of the pertussis vaccine. DoH advised that information is publicly available from the Pharmaceutical Benefits Advisory Committee.[76]

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69 See, for example: *Submission 41*; *Submission 117*; *Submission 251*; *Submission 251*; *Submission 339*; *Submission 394*; *Submission 404*; *Submission 436*, p. 27.

70 Dr Kidd, *Proof Committee Hansard*, 2 November 2015, p. 22.

71 See, for example: *Submission 16*; *Submission 139*; *Submission 188*; *Submission 410*.

72 Dr Rachel Heap, *Additional Information*, World Health Organisation, 'WHO vaccine-preventable disease: monitoring system. 2015 global summary', http://tinyurl.com/pndnnkq

73 See, for example: *Submission 277*; *Submission 278*.

74 Dr Kidd, *Proof Committee Hansard*, 2 November 2015, p. 24–25.

75 Dr Kynaston, *Proof Committee Hansard*, 2 November 2015, p. 23.

2.48 Many submitters raised concerns about the safety of vaccines that are not mandatory for eligibility of social security payments. Of particular concern were the Hepatitis B vaccine given at birth[77] and the HPV vaccine to 10 to 15 year olds.[78] Hepatitis B is a mandatory vaccination for babies at two months, four months and either six or 12 months but is not mandatory for newborns.[79] The RACP told the committee that the Hepatitis B vaccine is recommended in physiologically stable babies and that it is not offered to very premature babies.[80] RACP told the committee that the HPV vaccine is very safe and they have no concerns.[81]

2.49 In a written question on notice to DoH on 5 November, the committee sought clarification of the information that the Department of Health provides on its website about the Hepatitis vaccine. A response had not been received at the time of tabling.

2.50 Submitters and witnesses told the committee that the true number of adverse reactions to vaccines was much higher than reported.[82] One submitter referred the committee to a media release by the Therapeutic Goods Administration in 2014 that says:

> It is generally acknowledged that adverse events [for medicines and vaccines] are under-reported around the world, with estimates that 90-95% of adverse events are not reported to regulators.[83]

2.51 The AMA told the committee that depending on the severity you are considering, the risk of a severe reaction to a vaccine can be somewhere between one in a million and one in 100,000.[84]

2.52 DoH told the committee that serious adverse events are recorded by the Therapeutic Goods Administration. DoH said that in 2014–15 of the 10.8 million

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76 Ms McNeill, *Proof Committee Hansard*, 2 November 2015, p. 49.

77 See, for example: *Submission 17; Submission 127; Submission 132; Submission 258; Submission 357; Submission 418.*

78 See, for example: *Submission 325*, p. 8; *Submission 139; Submission 186; Submission 254; Submission 393; Submission 453.*

79 Department of Human Services, 'Standard vaccination schedule for family assistance' https://www.dss.gov.au/our-responsibilities/families-and-children/benefits-payments/strengthening-immunisation-for-young-children/strengthening-immunisation-for-children-frequently-asked-questions (accessed 9 November 2015).

80 Dr Kynaston, *Proof Committee Hansard*, 2 November 2015, p. 42.

81 Professor Christian Gericke, Royal Australasian College of Physicians, *Proof Committee Hansard*, 2 November 2015, p. 25.

82 See, for example: *Submission* 114, p. 3; *Submission 292*; *Submission 271b*, p. 13; *Submission 349.*

83 Therapeutic Goods Administration, 'New web service helps consumer reporting of 'side effects'', 24 September 2014, https://www.tga.gov.au/media-release/new-web-service-helps-consumer-reporting-side-effects in *Submission 349*, p. 6.

84 Dr Kidd, *Proof Committee Hansard*, 2 November 2015, p. 21.

doses administered under the National Immunisation Program, there were 243 serious adverse events reported or 0.002 per cent.[85]

Medical exemption category

2.53 Submitters told the committee that as the Bill proposes to remove conscientious exemption, there needs to be greater scrutiny of what they perceive to be the narrowness of the medical exemption category. The committee heard that some people are COs because they are unable to receive a medical exemption for their child where they believe it is warranted. This group tend to believe that vaccines are safe and effective, but that their own child falls into the small percentage of children who suffer adverse events that should warrant a medical exemption.[86]

2.54 Submitters expressed concern about the restrictiveness of receiving a medical exemption for their child and also indicated that doctors can be reluctant to give medical exemptions in some situations.[87] Submitters told the committee reasons they as parents or guardians had sought medical exemption but were denied included:

- the child had a severe reaction to a different vaccine;[88]
- the child's siblings severely reacted to certain vaccines;[89] and
- a family history of severe reactions to vaccines.[90]

2.55 Under the proposed Bill, medical exemptions can be approved by a general practitioner. The committee notes that currently medical exemption can be approved by a medical practitioner for the following medical contraindications:

- unstable neurological disease;
- encephalopathy within 7 days after a previous vaccination;
- immediate severe acute allergic or anaphylactic reaction after any previous vaccination;
- malignant disease and/or immunosuppressive therapy and/or immune suppression; and
- allergy to preservative or antibiotic contained in the vaccines;
- OR

85 Ms Felicity McNeill, First Assistant Secretary, Department of Health,, *Proof Committee Hansard*, 2 November 2015, p. 50.

86 See, for example: *Submission 164; Submission 45; Submission 123; Submission 261; Submission 214; Submission 314.*

87 See, for example: *Submission 107; Submission 111; Submission 123; Submission 269; Submission 290; Submission 314; Submission 389; Submission 397; Submission 400; Submission 410.*

88 See, for example: *Submission 164; Submission 45.*

89 See, for example: *Submission 123; Submission 261.*

90 See, for example: *Submission 214; Submission 314; Submission 107.*

- the child has other non-permanent contraindication and vaccination is deferred.[91]

2.56 In regards to a family history of severe reaction to vaccines, the AMA told the committee that 'anaphylactic reactions tend to be one-off', idiosyncratic and do not generally run in families.[92]

2.57 The AMA told the committee:

> The AMA recognises that the Australian Immunisation Handbook (currently 10th Edition, updated in June 2015) a key document in terms of providing guidance to GPs [General Practitioners] about exemptions to immunisation. Contrary to what the earlier witnesses indicated, the Handbook provides information on a range of contraindications and precautions that need to be taken with certain groups such as those who are at risk of anaphylaxis, those who are immunocompromised, those who are receiving immunoglobulin or other blood products etc. This material is contained in sections 4.9.9 Contraindications and 4.9.10 Precautions. Further material on at risk groups or possible exemptions is also provided under each listed individual disease names.
>
> It is also critical to recognise that GPs will also use their clinical judgement in assessing children who are eligible for a medical exemption. As Dr Kidd testified, medical exemptions are rare, but with the guidance provided by the Immunisation Handbook, and their own clinical judgement, GPs are well equipped to identify the small number of children who should not receive vaccination.[93]

2.58 DoH told the committee that they are looking to strengthen and clarify to vaccine providers and the broader community what is an acceptable medical exemption including what types of allergic reactions warrant a medical exemption.[94] Part of this process includes consulting with the General Practitioner Roundtable, National Immunisation Committee and DHS.[95]

2.59 The committee sought further explanation about the types of medical contraindications that warrant a medical exemption from DoH. A response had not been received at the time of tabling.

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91 Department of Human Services, *Australian Childhood Immunisation Register: Immunisation Exemption, Medical Contraindication*, Medicare form, http://www.humanservices.gov.au/spw/health-professionals/forms/resources/immu11-1310en.pdf (accessed 4 November 2015).

92 Dr Kidd, *Proof Committee Hansard*, 2 November 2015, p. 23.

93 Australian Medical Association, answer to question on notice, 2 November 2015 (received 6 November 2015).

94 Ms McNeill, *Proof Committee Hansard*, 2 November 2015, p. 55.

95 Ms McNeill, *Proof Committee Hansard*, 2 November 2015, p. 55.

Allegations of coercion

2.60 Submitters expressed the view that the significant loss of financial benefits, particularly for low-income families who are COs, would be tantamount to removing the choice of parents to give free, informed consent to the vaccination of their children.[96] Submitters referred to the Australian Immunisation Handbook that states that vaccinations must only be administered 'in the absence of undue pressure, coercion or manipulation'.[97] Submitters also suggested that the proposed measure contravened a number of human rights conventions, including the Universal Declaration of Bioethics and Human Rights and the International Covenant on Civil and Political Rights (ICCPR).[98]

2.61 Article 6 of the Universal Declaration of Bioethics and Human Rights states:

> Any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information. The consent should, where appropriate, be express and may be withdrawn by the person concerned at any time and for any reason without disadvantage or prejudice.[99]

2.62 The Parliamentary Joint Committee on Human Rights (PJCHR) found the Bill engages and places limits on the right to freedom of thought, conscience and religion as set out in article 18 of the ICCPR and has sought advice from the Minister on whether the measures are justifiable.[100]

2.63 The AMA submitted that some parents will continue to hold strong views against vaccination but that they will continue to have the choice to vaccinate.[101] DSS submitted that the limitation of some rights is 'necessary and proportionate to the legitimate aim of promoting the right to physical and mental health'.[102] In regards to article 18 of the ICCPR, DSS said:

> …these freedoms may be subject to limitations as prescribed by law and which are necessary to protect public health or the fundamental freedoms of others. The objection to vaccination can limit the rights of others to

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96 See, for example: *Submission 13; Submission 158; Submission 188; Submission 549*, p. 17.

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

98 See, for example: *Submission 3; Submission 88; Submission177; Submission 257; Submission 442; Submission 432; Submission 455.* Submitters also reference the Nuremberg Code, which relates to the conduct of physicians carrying out experiments on human subjects and the level of consent needed to do so.

99 http://portal.unesco.org/en/ev.php-URL_ID=31058&URL_DO=DO_TOPIC&URL_SECTION=201.html (accessed 4 November 2014).

100 Parliamentary Joint Committee on Human Rights, *Human Rights Scrutiny Report: Twenty-ninth report of the 44th Parliament*, 14 October 2015, pp 31–33.

101 *Submission 544*, p. 3.

102 *Submission 319*, p. 4.

> physical and mental health. As the most effective method of preventing infectious diseases, vaccination provides a necessary protection of public health.
>
> Further, these families continue to have the right to uphold their conscientious or religious belief by electing not to receive child care benefit, child care rebate or the family tax benefit Part A supplement.[103]

Vaccination injury compensation scheme

2.64 Submitters and witnesses suggested that Australia establish a vaccination injury compensation scheme.[104] The RACP advocate for the introduction of a compensation scheme and provided the committee with the following statement:

> Since immunisation benefits the population as well as the individual, it is entirely just and reasonable that society as a whole accepts vaccine damage compensation for affected individuals and their families. This has long been the case in New Zealand; it is yet to be accepted in Australia. The RACP strongly supports introduction of an Australian no fault vaccine compensation scheme, either as part of a national disability scheme or injury insurance scheme, or separately.[105]

2.65 Submitters and witnesses argued that because vaccinations carry a small risk of serious adverse reaction the Government should compensate the small number of individuals who experience a severe adverse reaction in the interests of protecting the broader community.[106] Furthermore, some submitters argued that the Bill coerces parents to vaccinate and therefore it is an ethical necessity to provide an accompanying vaccine compensation scheme.[107]

2.66 The World Health Organisation reports that 19 countries currently have a vaccine compensation scheme and considers them 'an important component for successful vaccination programs'.[108]

Impact on child care providers

2.67 Childcare Alliance Australia told the committee that they sought reassurance from the Government that child care providers will not be financially impacted by the Bill, particularly during the transition phase.[109]

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103 *Submission 319*, p, 4.

104 See, for example: *Submission 317a*, p.2; *Submission 327; Submission 238; Submission 321; Submission 317.*

105 Dr Kynaston, *Proof Committee Hansard*, 2 November 2015, p. 26.

106 Associate Professor Leask, *Proof Committee Hansard*, 2 November 2015, p. 41.

107 *Submission 326*, p. 2.

108 Looker, C. and Kelly, H., 2011, *Bulletin of the World Health Organization* 2011;89:371-378. doi: 10.2471/BLT.10.081901, http://www.who.int/bulletin/volumes/89/5/10-081901/en/ (accessed 27/10/2015).

109 *Submission 343*, p. 1.

2.68 DET told the committee that 'consultation with the child care sector and families was undertaken by DSS during June and July 2015.[110] DET also informed the committee that they will distribute information about the Bill 'directly to child care providers when the Bill passes the Senate'.[111] DET further said:

> …there is not expected to be a lengthy delay in approval of an individual's eligibility for Child Care Benefit and a child care service's ability to claim that payment on behalf of the family when the child commences child care. In the interim, the child care service can charge the family the full fee.[112]

Accuracy of the Australian Childhood Immunisation Register data

2.69 Submitters and witnesses expressed concerns about the accuracy of data in the ACIR as well as the capacity to continue to monitor COs if the Bill is passed.

Inaccurate records

2.70 A number of submitters and witnesses raised concerns that not all the vaccines a child has received have been recorded properly in ACIR, resulting in fully vaccinated children being recorded as ineligible for social security payments.[113]

2.71 Associate Professor Julie Leask told the committee she has been involved in research that suggested that an estimate of between '18 per cent and 50 per cent of those who are shown as not up to date on the register might actually be up to date.'[114] The submission from NSW Health noted this can occur due to data transfer errors or from the fact that prior to 2015, 'vaccines given after seven years of age, including those in high school programs, were not able to be recorded on the [ACIR].'[115] Associate Professor Leask told the committee the issue this creates is that some children received catch-up vaccines after the age of seven and therefore they are not recorded.[116]

2.72 PHAA said that targeted data cleansing has been undertaken by divisions of general practice, Medicare Locals and primary health networks which has revealed a number of inaccuracies. PHAA told the committee of one example recently in South Australia:

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110 Department of Education and Training, answer to question on notice, 5 November 2015 (received 6 November 2015).

111 Department of Education and Training, answer to question on notice, 5 November 2015 (received 6 November 2015).

112 Department of Education and Training, answer to question on notice, 5 November 2015 (received 6 November 2015).

113 See: Mrs Newbound, *Proof Committee Hansard*, 2 November 2015, p. 39; *Submission 317*, p. 6 and *Submission 327*.

114 Associate Professor Leask, *Proof Committee Hansard*, 2 November 2015, p. 45.

115 *Submission 345*.

116 Associate Professor Leask, *Proof Committee Hansard*, 2 November 2015, p. 46.

> …a total of 886 Aboriginal children aged under seven years were identified on ACIR reports as not fully immunised. After an extensive data cleaning exercise was undertaken, 395 records were corrected, resulting in children confirmed as fully immunised. With this proposed policy, these families would have been financially penalised not because their child was not fully immunised but because of a flawed database.[117]

2.73 Submitters and witnesses referred the committee to a recent report by the Australian National Audit Office (ANAO). In June 2015 the ANAO released a report into the audit of the administration of the ACIR. The report said that while overall the DHS' administration of ACIR has been 'generally effective', there 'remains scope to strengthen ACIR quality and control framework' and that 'maintaining ACIR data quality remains an ongoing business risk for the department'.[118] ANAO recommended:

> To contribute to ACIR data integrity and improve the efficiency of information processing, Human Services should establish a pathway for the resolution of persistent and known data synchronisation issues between ACIR and other departmental ICT systems, incorporating a planned process and timetable. There would also be benefit in the department working with PMS suppliers to identify options for addressing errors arising during data exchanges between the ACIR and provider systems.[119]

2.74 ANAO also reported that while DHS relies on providers and parents to assist in maintaining the accuracy of ACIR, DHS has not clearly and consistently 'communicated its expectations on the key role played by parents and immunisation providers'.[120]

2.75 The committee notes that the Bill proposes to increase the age and frequency that eligibility for social security payments is checked. PHAA expressed concern that 'the current structures in place to record immunisation would struggle to cope with the expanded requirements that the Bill will place on it'.[121] Furthermore, PHAA told the committee that inaccurate data can lead to children having unnecessary vaccines that

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117 Mrs Newbound, *Proof Committee Hansard*, 2 November 2015, p. 39.

118 Australian National Audit Office (ANAO), Administration of the Australian Childhood Immunisation Register, ANAO report, 46, 2014–15, ANAO, Canberra, 2015, pp 19–20, http://www.anao.gov.au/~/media/Files/Audit%20Reports/2014%202015/Report%2046/AuditReport_2014-2015_46.pdf (accessed 29 October 2015).

119 ANAO, Administration of the Australian Childhood Immunisation Register, ANAO report, 46, 2014–15, ANAO, Canberra, 2015, p. 20, http://www.anao.gov.au/~/media/Files/Audit%20Reports/2014%202015/Report%2046/AuditReport_2014-2015_46.pdf (accessed 29 October 2015).

120 ANAO, Administration of the Australian Childhood Immunisation Register, ANAO report, 46, 2014–15, ANAO, Canberra, 2015, p. 19, http://www.anao.gov.au/~/media/Files/Audit%20Reports/2014%202015/Report%2046/AuditReport_2014-2015_46.pdf (accessed 29 October 2015).

121 *Submission 317*, pp 5–7.

are a wasted cost and a painful experience for the child.[122] PHAA told the committee ACIR was 'in urgent need of an upgrade'.[123] Associate Professor Leask recommended a delayed start to the Bill to enable the required changes to be put in place.[124]

2.76 DoH assured the committee that the Government is aware of the concerns raised about data accuracy and that as part of the rollout of the Australian Immunisation Register will be providing additional support to assist with 'data cleansing', that is, to make the data more accurate. DoH is also investigating the interaction between vaccine providers' software and DHS to improve the accuracy of data collection.[125]

2.77 DHS notified the committee that in response to the ANAO report, DHS have developed a Quality Strategy Plan, and they expect the actions of the plan will be implemented before 1 January 2016.[126] DHS further provided the committee with the following response about how it intends to improve the accuracy of ACIR:

> In accordance with the phased expansion of the Australian Childhood Immunisation Register (ACIR) into a Whole of Life Australian Immunisation Register (AIR), a range of improvements will be implemented to the Register's functions and operations. This includes new functionality to enable providers to correct errors online through the AIR secure site, such as correction of an incorrect dose number or incorrect vaccine recorded. This will begin to be implemented in September 2017.[127]

2.78 Professor Leask recommended that the Government undertake a 'full review of the implementation issues in 2017 with subsequent amendments to legislation as needed'.[128]

Monitoring conscientious objection

2.79 Submitters and witnesses were concerned that the Bill will effectively mean that COs will not be recorded on ACIR and therefore not recorded by the Government.[129] PHAA told the committee this information is important for policymakers when planning communication strategies.[130] Associate Professor Leask

122 Mrs Newbound, *Proof Committee Hansard*, 2 November 2015, p. 39.

123 Mrs Newbound, *Proof Committee Hansard*, 2 November 2015, p. 39.

124 Associate Professor Leask, *Proof Committee Hansard*, 2 November 2015, p. 41.

125 Ms McNeill, *Proof Committee Hansard*, 2 November 2015, p. 48.

126 Department of Human Services, answer to question on notice, 5 November 2015 (received 9 November 2015).

127 Department of Human Services, answer to question on notice, 5 November 2015 (received 9 November 2015).

128 *Submission 327*, p. 7.

129 Mrs Newbound, *Proof Committee Hansard*, 2 November 2015, p. 40; Associate Professor Leask, *Proof Committee Hansard*, 2 November 2015, p. 41.

130 Mrs Newbound, *Proof Committee Hansard*, 2 November 2015, p. 40.

added that monitoring COs is important to 'detect early warnings of a dip in confidence and address that at local levels'.[131]

2.80 Furthermore, Associate Professor Leask said in her submission that state and territory governments have relied on the ACIR records of COs when applying COs exemption to state and territory legislation regarding access to child care centres. Submitters and witnesses suggested that the Government finds an alternative means of counting conscientious objection.[132]

Committee view

2.81 The committee notes that vaccination is a highly emotive issue. The committee wishes to reaffirm that the role of the committee is to consider and report on the evidence provided that engages with the proposed legislation and related policy issues. The committee does not make its considerations based on the number of submissions received, but on considerations of the concerns raised. The committee reaffirms that all issues raised in submissions and correspondence received by the committee have been considered.

2.82 The committee notes that there is confusion about what vaccinations are required for a child to be considered eligible for social security payments. The committee suggests that the departments work together to create clearer and more coherent communication about immunisation requirements.

2.83 The committee acknowledges that education and communication play a key role in reducing vaccination refusal rates and increasing vaccination rates. The committee notes the Government's budget commitment to communication strategies and encourages the Government to consider the strategies proposed by submitters to this inquiry.

2.84 The committee acknowledges concerns raised by the PJCHR and submitters, that the Bill risks infringing upon the human rights of parents making decisions about their children's health and the rights of children to access child care services and early childhood education. However, the committee is satisfied that these infringements are necessary and fairly outweighed by the rights of all members of the community to health and that vaccination is a critical and important health measure. However, the committee suggests that the Government monitor the impact of the Bill on disadvantaged families.

2.85 The committee notes the concerns raised by submitters and witnesses of possible unintended consequences of the Bill and considers that there is merit in conducting an initial review after 12 months to assess the immediate impact of the Bill and an evaluation of the impact and effectiveness of the Bill after three years of implementation.

2.86 The committee expects that DHS will meet their target of implementing the plan developed in response to the ANAO report and that DHS should examine a

131 Associate Professor Leask, *Proof Committee Hansard*, 2 November 2015, p. 41.

132 *Submission 327*, p. 7; *Submission 317*.

means of monitoring conscientious objection in the community. The committee considers these issues should be addressed prior to the implementation of the Bill.

2.87 The committee acknowledges that vaccination carries a small risk of severe adverse reactions. The committee recognises that Australia, unlike other developed countries, does not have a national vaccine injury compensation scheme and encourages the Government to examine the merits of such a scheme.

Recommendation 1

2.88 The committee recommends that the Government consider an initial review after 12 months to assess the immediate impact of the Bill and a full evaluation of the impact and effectiveness of the Bill after three years of implementation.

Recommendation 2

2.89 The committee recommends that the Government consider the educational and communication strategies to improve vaccination rates proposed by submitters to this inquiry.

Recommendation 3

2.90 The committee recommends that the Government investigate a means of continuing to monitor conscientious objection if the Bill is passed.

Recommendation 4

2.91 The committee encourages the Government to investigate the merits of a national vaccine compensation scheme.

Recommendation 5

2.92 The committee recommends that the Bill be passed.

Senator Zed Seselja

Chair