



COMMONWEALTH OF AUSTRALIA

# Proof Committee Hansard

## SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

**Social Services Legislation Amendment (No Job, No Pay) Bill 2015**

(Public)

MONDAY, 2 NOVEMBER 2015

BRISBANE

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**SENATE**

**COMMUNITY AFFAIRS LEGISLATION COMMITTEE**

**Monday, 2 November 2015**

**Members in attendance:** Senators Di Natale, Lindgren, Moore, Seselja.

**Terms of Reference for the Inquiry:**

To inquire into and report on:

Social Services Legislation Amendment (No Jab, No Pay) Bill 2015.

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**TOMLJENOVIC, Dr Lucija, Guest Speaker, Australian Vaccination-skeptics Network Inc.**

*Evidence from Dr Tomljenovic was taken via teleconference—*

**Committee met at 09:06**

**CHAIR (Senator Seselja):** Good morning. Do we have Senator Di Natale on the line?

**Senator DI NATALE:** You do.

**CHAIR:** Great. I declare open this public hearing for the committee's inquiry into the Social Services Legislation Amendment (No Jab, No Pay) Bill 2015 and welcome everyone here today. I thank everyone who has made a submission to this inquiry. This is a public hearing and a *Hansard* transcript of the proceedings is being made. The audio of this public hearing is also being broadcast via the internet.

Before the committee starts taking evidence, I remind all present here today that this hearing is a proceeding of parliament and attracts the same privileges and immunities as parliament itself. It is my role as chair to ensure that witnesses participating in the hearing are able to give evidence freely and honestly, without fear of recrimination and without interjections from members of the public. I remind everyone that, in giving evidence to the committee, witnesses are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to the committee. Such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to the committee. The committee prefers all evidence to be given in public, but, under the Senate's resolutions, witnesses have the right to request to be heard in private session. It is important that witnesses give the committee notice if they intend to ask to give evidence in private. If you are a witness today and you intend to request to give evidence in private, please speak to the secretariat staff.

The committee has scheduled two 25-minute sessions today, at 10.45 am and 1 pm, for people who are not listed as witnesses on the program to make a short statement to the committee. There will be a strict two-minute limit on these statements. To participate in these sessions, I ask that you register with the secretariat. The secretariat will provide you with a copy of information on parliamentary privilege and the protection of witnesses and evidence and will ask you to complete a *Hansard* witness form. The order for speaking will be on a first come, first served basis.

I remind witnesses and senators that parliamentary privilege does not apply to countries or persons outside of Australia. I understand you are coming to us internationally, Dr Tomljenovic.

**Dr Tomljenovic:** Yes, from Canada.

**CHAIR:** Would witnesses like to state anything about the capacity in which you appear?

**Dr Tomljenovic:** I am a senior research scientist at the University of British Columbia. I work in the school of medicine.

**Ms Dorey:** I was the founder of the Australian vaccination network and I am just a concerned citizen testifying today.

**Mr Beattie:** I was past president of the Australian vaccination network.

**CHAIR:** The committee has received your submissions. I would now invite you to make an opening statement and at the conclusion of your remarks I will open it to the committee for questions.

**Mr Beattie:** As I said, I am a past president of the AVN and I am the author of two books on this issue. We are dealing with a belief system. We frequently hear that the science is settled, that science has spoken and that the consensus is in but, although science is involved, the truth is that it is a belief system. People repeatedly refer to 'the science', but they cite no relevant scientific studies; instead they quote each other, claiming that 'the science' supports them. Such claims have value only as a rhetorical device, known as appeal to authority. By contrast our submissions are referenced with dozens of high-quality peer reviewed studies.

So let me challenge you to ask yourself: why do you believe in vaccines? Do you have the evidence for their protectiveness in the field and for their long-term safety? Can you use that to build a robust case that will stand up

to scrutiny? If you do not, then your belief is not science based; it is based on faith. You have faith that those telling you that vaccine save lives are speaking the truth. We are all familiar with belief systems. We are entitled to buy into them, if we feel compelled to do so, but the role of government is limited to facilitating them. Only in dictatorships do belief systems get imposed on others by mandate. This does not happen in a democracy. As senators, your responsibility must surely be to protect the integrity of our democracy by not allowing such a impositions to take place. So the question for you is: do you want to take the leap from democracy to dictatorship—from facilitating a belief system to mandating it?

Today we have a scientist with internationally recognised expertise here by teleconference. Dr Lucija Tomljenovic has published extensively on the subject of vaccine harm. She serves as a peer reviewer for several journals and is one of the editors of the immunology textbook, *Vaccines and Auto-immunity*. That means that she probably has few peers in the world in relation to expertise on that subject. She has graciously offered her time today to give evidence concerning vaccine safety. Please take the opportunity to ask her about some of the research that has led parents to question vaccination.

**Dr Tomljenovic:** I would first like to make it clear that there are many in the scientific community who do not question at all the idea that vaccines can cause adverse events. The only thing they question is how often these events occur. The idea of imposing financial sanctions on parents who refuse to vaccinate their children according to the official vaccinations schedule, as prescribed by the Australian government to health authorities, is flawed of scientifically and ethically. And I will explain why.

Again like all other drugs, vaccines can cause adverse events but, unlike conventional drugs, which are only prescribed to people who are ill, vaccines are administered to healthy individuals for preventative measures. So the tolerance for adverse events in this case is much narrower than for conventional drugs. Most side-effects attributed to vaccines are mild and transient, but reactions such as anaphylaxis and induction of autoimmunity can occur although with much lesser frequency. These can be rather severe and, in some cases, fatal. The occurrences of such serious events, despite what has sometimes been promulgated, are quite extensively described in the scientific literature. In many cases, direct causal links have been established between vaccination and the adverse events. These are, again, not fables; these are facts. Given that vaccines are delivered to billions of people without preliminary screening for underlying susceptibilities, it is of concern. As we all know, vaccines are given to many people and, yet, not so many have serious adverse effects. However, it is, again, naive to believe that all humans are alike. It is known that autoimmune diseases have a certain genetic basis. Thus, certain genes can create a genetic predisposition which can bias someone toward developing an autoimmune disease.

Typically, in these cases, an environmental trigger is required to precipitate the manifestation of the autoimmune state. Examples of such environmental triggers commonly associated with development of autoimmunity are viral infections and vaccinations. The reason for this is that the mechanism for which the host immune system responds to vaccination resembles the mechanisms by which the response against the immune infectious agent can precipitate an autoimmune disease. This will be clear in a specific example. For example, one well-known mechanism by which infections or a vaccination can initiate and exacerbate autoimmune diseases is molecular mimicry, where a foreign antigen shares a structural similarity with a particular host antigen. Because of this, host antibodies which are raised in response to vaccination or infection—whatever the case may be—will recognise and attack not only the particular foreign antigen but also the host antigen which is structurally similar to it.

A well-known example of molecular mimicry is found in the archaeology of the antiphospholipid syndrome, which is a serious autoimmune multisystemic disease associated with recurrent foetal loss thromboembolic phenomena and neurological cardiac and dermatological adverse manifestation. Antiphospholipid syndrome is characterised by the presence of pathogenic autoantibodies against the molecule known as beta-2 glycoprotein. The infectious triggers of antiphospholipid syndrome have been identified—such as syphilis and leprosy and various cell infections. Tetanus vaccination can also trigger APS, or antiphospholipid syndrome, by producing antibodies which target both the tetanus toxoid and the beta-2 glycoprotein 1 due to structural similarity between these two molecules. This is only one of the many examples of molecular mimicry phenomena which shows that overly vigorous or aberrant immune responses to either infections or vaccinations can, while protective, also be detrimental to the host. It is obvious, again, that many people are vaccinated and, yet, relatively few show such aberrant immune responses. Unfortunately, the scientific research aimed at identifying such vulnerable individuals is still in its infancy.

In this context, imposing financial sanctions on families who refuse to comply to vaccinate their children—and, thus, forcing them to do so—will put such vulnerable but otherwise healthy individuals at risk of serious adverse reactions to vaccination. It is important to note that even those in the scientific community who are strong

proponents of vaccination have come to question the scientific legitimacy of one-size-fits-all vaccination practices. One such individual is Gregory Poland, a professor of medicine at the Mayo Clinic and also editor-in-chief of one of the most respectable journals in the field of vaccination, *Vaccine*. Poland is also co-author of the article entitled, *The age-old struggle against the antivaccinationists*. So one can hardly label Poland as being an antivaxxer.

In another article, entitled 'Vaccine immunogenetics', which was published in 2008, Poland and his colleagues ask whether, with the advances coming from the new biology and genetics of the 21st century, it is time to consider how much new genetic and molecular biology information may inform vaccination practices in future. In light of this question, Poland concludes that the one-size-fits-all approach for all vaccines and all persons should be abandoned. According to him, this conclusion applies to both vaccine efficacy and safety. Thus Poland's current data may have far broader implications for understanding vaccines, again, not only in terms of efficacy but also in terms of safety. Indeed, the vulnerable populations would neither have the same antibody response nor the same level of tolerance to adverse reactions as non-vulnerable populations.

Another point, which is important, is that it is likely that an increasing number of individuals, regardless of their genetic background, may react adversely if exposure to compounds with immune-adjutant or immune-stimulating properties exceeds a certain threshold. This concept has been, in fact, clearly demonstrated by a team of Japanese researchers led by Dr Ken Tsumiyama, who, in 2009, showed that repeated immunisation causes systemic autoimmunity in mice otherwise not prone to spontaneous autoimmune diseases. It is true that people are exposed constantly to infectious agents in the environment. However, there is a vast difference between natural exposure and that which is induced by vaccinations. The reason for this is that the immune response induced by vaccination is greatly amplified owing to the addition of adjuvants with immune stimulating properties.

In summary, not all vaccines are safe for all people. In spite of this, most vaccination policies worldwide operate on this principle: one size fits all. Moreover, that serious adverse events following vaccination do occur is evident, in light of published evidence, to anyone who has some degree of intellectual honesty. Those concerns about vaccine safety have a valid scientific foundation, and, although it is popular to label those who express concerns over vaccine safety as anti vaccines or anti science or 'baby killers', such labels should not have a place in any civilised society—they are simply irrational, bigoted and unscientific. Now, in truth, those who employ such labels suffer from cognitive dissonance, which is a psychological discomfort that most people experience when their deeply-held beliefs are contradicted by new information that disproves their old beliefs. The hostile reaction against the bearer of this new information often takes the form of personal ad hominem attacks. Attacking the messenger of the unwelcome truth, rather than rationally dealing with the truth, is a common tactic when the new information cannot be refuted using sound logic.

Finally, modern medical bioethics has rejected the notion that we can treat individuals as a means to an end, regardless of how honourable that end may appear to be to some. The Nuremberg Code and the subsequent Declaration of Helsinki clearly reject the moral argument that the creation of the alleged benefit for the many, such as herd immunity, justifies the sacrifice of the few. It should also be noted that the proof of safety and efficacy of the product is the responsibility of regulatory agencies and drug producers, not the consumer, and now the former have been shown to be unreliable on many occasions, due to financial conflict of interest. To this day, there are very few vaccine safety reviews that are done by people who do not have any conflicts with the pharma. With this I would conclude, and I thank you for your patience and time.

**CHAIR:** Are there any other opening statements? In order to get to questions we will obviously need to keep them relatively short.

**Mrs Kemp:** Sure. Of course, I appear on behalf of Citizens Concerned with Vaccination Legislation and Safety. We are a group of concerned citizens who came together because we found ourselves concerned with various aspects of this legislation. We consist of an Aboriginal elder, who is in the room, Uncle Max Dulumunmun Harrison; two naturopaths who deal with vaccine injury on a daily basis; a teacher of primary-school children who was finding more and more learning issues in her classroom; a childcare centre owner who was confronted with more and more allergies; and, throughout our time visiting many members of parliament and senators, we have been joined by a pharmacologist, a lawyer, a medical secretary and the president of the AVN.

We have been, really, trying to raise awareness of the various issues. To try to summarise the main problems we see with this legislation, we think this issue is far too complex to say, 'Let's remove a conscientious objection and remove payments and carry on.' There are many people who are affected by vaccination in an adverse way and we need to have a good look at that. There is much good science—and the committee will have been made aware of much of that in the submissions—that says we need to be concerned with vaccine ingredients and with the schedule, and we need to have a really good look at that.

The legislation says that we will repeal certain subsections and be left with children needing immunisation requirements if a GP has certified, in writing, that the immunisation of a child will be medically contraindicated, under the specifications set out in the *Australian Immunisation Handbook*. That handbook says:

True contraindications to vaccines are extremely rare (see relevant chapters), and include only anaphylaxis to any of the particular vaccine's components, and anaphylaxis following a previous dose of that vaccine.

That is what our handbook is saying people can have a medical exemption for. We have a society and, perhaps, there are many members of parliament who think that it is okay because the people who deserve to be protected are going to be protected by a medical exemption. But they are not.

I have kids with compromised immune systems. My doctor has said, 'Yes, I gave you the conscientious objection because I believed there was an issue there. But I am not able to give you a medical exemption. Your kids are not eligible for that.' My kids do fall under this issue. I have an article, here, by Dr Yehuda Shoenfeld. I will read one paragraph from that. He is a clinician with 30 years study on autoimmunity and its relationship with vaccination.

He has written a paper called *Predicting post-vaccination autoimmunity: who might be at risk?* It predicts postvaccination autoimmunity and who might be at risk. It lists four categories of people:

1) those who have had a previous autoimmune reaction to a vaccine, 2) anyone with a medical history of autoimmunity, 3) patients with a history of allergic reactions, 4) anyone at high risk of developing autoimmune disease including anyone with a family history of autoimmunity, presence of autoantibodies which are detectable by blood tests and other factors including low vitamin D and smoking.

Autoimmunity is increasing in droves, in our society. Nowhere in our immunisation handbook does it state that this is an option for children to receive a medical exemption. In fact, our immunisation handbook says, on page 482:

Can too many vaccines overload or suppress the natural immune system?

No. Although the increase in the number of vaccines and vaccine doses given to children has led to concerns about the possibility of adverse effects of the aggregate vaccine exposure, especially on the developing immune system, there is not a problem.

It goes on:

Do childhood immunisations cause asthma?

There is no evidence that vaccination causes or worsens asthma.

What we are seeing, from some good evidence—and Lucija referred to the fact that Dr Yehuda Shoenfeld is the editor of that new textbook *Vaccines & Autoimmunity*—there are huge amounts of good science that say it is a concern. At the very least, we need to revisit the documentation that is our doctors' guidebook.

A section of the *Australian Immunisation Handbook* refers to adverse events following immunisation. To give one example, babies are given the hepatitis B vaccine when they are hours or minutes old. It says that the side-effects of this vaccine are localised pain, redness and swelling, occasionally an injection-site nodule and a low-grade fever. The vaccine insert from the manufacturer of the hepatitis B vaccine goes on to refer to the fact that adverse reactions reported relating to this vaccine include meningitis, thrombocytopenia, anaphylaxis, encephalopathy, encephalitis, neuritis, neuropathy, paralysis, convulsions, hypoesthesia, multiple sclerosis, Guillain-Barre syndrome, hypotension, vasculitis, angioneurotic oedema, lichen planus, arthritis, muscular weakness, abnormal liver function and bronchospasm.

I do not want to use up too much of the time with examples like that. Citizens Concerned with Vaccination Legislation and Safety have made a very proactive proposal to this inquiry. We have suggested a full public inquiry, independently done, to thoroughly look at ingredients, the schedule and the newer science—the science that says things other than 'Vaccines save lives.' It all needs to be looked at. This is not somewhere we can just continue to say, 'We think it has worked for a long time, so let's continue to do it.' We have to take a look at this. In the meantime, what we need to do is look at protecting those children I referred to a moment ago, who society thinks are protected by this medical exemption. We need to include autoimmunity, allergies and genetic and racial predisposition. What we do not want to end up with is a system that is making people sick. Unfortunately, it appears that we may already have a system like that.

Professor Peter Collignon, from Canberra Hospital, has talked a lot about our vaccination program and is actually a supporter of it, but he has grave concerns. He has said things such as:

To stop two or three children going to intensive care we had to immunise 600,000 people. We need to be very careful before we recommend universal vaccination against influenza—

and other things—

every year until we have better data. Otherwise we're talking about faith-based medicine, instead of evidence-based medicine. He says that he is very aware of being in the bad books over his criticisms of vaccination. He says:

Like a lot of medical people, I believe vaccines are terrific—but it has come to the situation where it's almost like motherhood, that you cannot question it, especially in the public arena, for fear you'll undermine the vaccination program.

In conclusion, I want to reiterate that the decision made about this legislation in coming weeks cannot be the end of this. With all respect to the committee, I do not envy your position. You have had three weeks to look at 3,000 submissions and huge amounts of science. We need to look at a long-term solution and an interim solution. Thank you.

**CHAIR:** Thank you, Mrs Kemp. I will go to Ms Dorey and then we will try to have time for questions.

**Ms Dorey:** I appreciate that, Chair. I have come here today to explain why parents—not doctors or politicians—must always be the ones to make health decisions for their own families. I am the mother of four children and founder of the Australian Vaccination Network. I was that organisation's president for 18 years, and I am still a very proud and active member.

Over 26 years ago my eldest son was born, and, like many parents, I believed strongly that vaccination was the way to keep him safe and healthy. I did no research, nor did my doctor give me any information to help me to make an informed decision. I simply had my son vaccinated without thought. Unfortunately, he had serious reactions to his first DPT and polio vaccines, and later to his MMR. These reactions have left him with lifelong health issues which only hard work with natural therapists and his own dedication to healthy lifestyles and diet have helped him to minimise and, for the most part, overcome. He taught me a very important lesson, and it is one that I have tried to share with others over the last 25 years: when it comes to your health and the health of your family, make informed choices. Whether worried about diseases or treatments, when a decision is made you and your child will be the ones living day-to-day with the positive or negative outcomes—not the doctor, and not the government. It is such a simple message and yet it is one that has gotten many people up in arms. How dare I suggest that parents take responsibility for their children's health? Apparently, that is the last thing the medical fraternity, media and some sectors of government want.

When my son was born in 1989, 18 doses of seven different vaccines were administered to children between birth and school age. He was injured by his first lot of vaccines at two months of age, and then again by his MMR at 18 months. Vaccine injuries and deaths can occur at any time to any vaccine, even to adults. The AVN's adverse reactions register contains thousands of stories of children and adults who know that firsthand.

Today, children receive 30 doses of 13 different vaccines by one year of age, more if they are of Aboriginal or Torres Strait Islander descent. With up to eight vaccines being administered at a single visit, there are over 250 new vaccines being developed and readied for licensing. What you do here and what you recommend the Senate does will have far-reaching effects not only on the health and freedom of today's children and adults but for those who will be targeted with those 250-plus new vaccines in the future. Be sure that you are aware of the implications of these policies before you threaten to take away our freedom to make the most personal and God-given choices available to us.

I am a strong supporter of every parent's right to vaccinate fully, selectively or not at all. I cannot support my own freedoms whilst trampling on yours. During my tenure as AVN president, I was involved with several delegations that lobbied both state and federal parliaments to enact legislation protecting individual health rights. These rights are inalienable, and no democracy can or should violate them.

Eighteen years ago, we successfully lobbied federal parliament to pass a conscientious objector clause. Many of those who supported us were medical doctors themselves, including Dr Bob Brown, then head of the Australian Greens, who introduced our amendment and defended parental rights so passionately in the Senate chamber. Dr Brown was and is adamantly pro-vaccination, but he had unanswered questions about safety and above all, he honoured parents' rights to make vaccine choices without coercion, penalty or discrimination. Those were proud days for the Greens, days when they fully lived up to the motto on their website, under the heading 'Social Justice': The key to social justice is recognition and action to support the rights of all people.

Today, the Greens seem to have taken a leaf out of the book *Animal Farm*, inferring that some people are more equal than others, and only those who agree to obey government health policy deserve to be protected and supported. Senator Richard Di Natale has even put forward a resolution demanding the AVN, a community health organisation representing thousands of disenfranchised parents and health professionals, disband. He publicly thanked Daniel Raffaele, founder of the hate group Stop the AVN, for his hard work on this issue, whilst Daniel Raffaele was under a police AVO instructing him not to come near me due to threats of violence he had made against me. The purported reason for this No Jab, No Pay legislation is to protect the fully vaccinated from the

healthy unvaccinated. Think about that for a minute: if the vaccines do not protect you from infection, why would this legislation do it? Why, when our vaccination rate has increased by nearly 25 per cent over the last 30 years, is the rate of infection from diseases like whooping cough so much higher now than it was then? As democratically elected representatives of the citizens of Australia, I urge you to recommend that the Senate does not pass No Jab, No Pay. It is immoral and unethical legislation that is based on unfounded beliefs, not scientific fact. Thank you for your time.

**CHAIR:** Thank you.

**Mr Smith:** Can I just have two minutes? I promise it will be two minutes.

**CHAIR:** It will have to be brief.

**Mr Smith:** It will be very brief.

**CHAIR:** There are one or two senators who have questions.

**Mr Smith:** The problem with this issue is that, like most issues, especially those that the Murdoch media get involved with, it becomes a left versus right, anti-vax versus pro-vax issue. There are a lot of people in the middle with regard to this. A great example of that is that I have people in my clinic who fully support vaccination. They vaccinate their children. Why should those parents be penalised if they decide they do not want to vaccinate their child for hep B? That is the issue that this legislation has not looked at. It looks at the schedule as a whole. While you might be able to make a credibly statistical argument in relation to measles incidence and vaccination success, you cannot make the same argument for hep B, you cannot make the same argument for rotavirus, and the pertussis vaccine is a total disaster. Anyone who considers themselves a friend of science or a friend of medicine, please come forward and argue the benefits of those vaccines. Each vaccine on the schedule should be broken down and looked at on a risk, benefit or cost basis, because all vaccines are not equal.

The last point I would like to make on it is: if the rationale for this legislation is herd immunity, anyone who considers themselves a scientist, please step forward and tell me how herd immunity applies to a vaccine product that has waning immunity issues. The manufacturers of the vaccines themselves say they only work for two to 10 years. If that is the case then how many people in this room right now are immune to whooping cough? It is all very well to be saying we have got to vaccinate all of our two-kilogram and three-kilogram infants, but all of the 100-kilogram adults and 70-kilogram adults sitting in this room right now have no immunity to pertussis if they have not had a booster shot in the last two to 10 years.

**Senator DI NATALE:** I might start with the AVN. You referred to yourself as the AVN on a number of occasions through your submission but my understanding was that you were instructed to change your name. Can you explain to me why you keep referring to yourselves as the Australian Vaccination Network.

**Mr Beattie:** I will respond to that by saying: what on earth relevance does this have to this inquiry?

**Senator DI NATALE:** I will get to that in a moment but I am interested in the reasons for the representation of yourselves as the Australian Vaccination Network when you have been instructed to change your name. I just want an understanding.

**Mr Beattie:** When I was president, it was called the Australian Vaccination Network. Chair, is this relevant?

**CHAIR:** The members are entitled to ask questions. We tend to have a fairly wide-ranging discussion. You are entitled to answer the question how you like but I am not going to rule out Senator Di Natale's questions. He is entitled to ask his questions.

**Mr Beattie:** I will answer it with this: I would like to know why you have not recouthered yourself from this panel, Senator Di Natale, given the fact that you very publicly have shown your derision for the people who this bill is going to most affect. Why have you not recouthered yourself? You should have nothing to do with this process whatsoever.

**CHAIR:** I would ask witnesses and people in the gallery to keep order as best we can. There is no need for applause and the like. I understand there are strong feelings but we will try and have a back-and-forth with questions. Senator Di Natale, continue.

**Senator DI NATALE:** I have asked a specific question. I am keen to get an answer. It is actually quite a serious issue because a ruling has been made and I am concerned that this organisation is representing itself in a capacity in which they are not able to do so. I think it is important that we understand the rationale for them representing themselves as a group, which they are not entitled to do. That is where I would like to start.

**CHAIR:** I made the name clear when I introduced them. I am not going to stop them from saying certain things. These things are on the record and you have now noted that so it will be on the *Hansard* record and people can read that.

**Mr Smith:** It is good to see, Senator Di Natale, that you are doing great work for the sceptics. I have been a member of the Greens since 2001 and I will have to tell you now, I think you are a disgrace to the green movement and you will end up like the Australian Democrats—your primary vote is going to be gutted like the democrats—so well done.

**CHAIR:** We will try and stick to answering questions if we could.

**Senator DI NATALE:** Again, I urge you, Chair, to ensure that the hearing is conducted in the spirit in which most of these hearings are conducted.

**CHAIR:** I am certainly doing my best, Senator Di Natale, and I am giving you the call. Obviously I cannot instruct witnesses how to answer but I would ask people to all be respectful to one another.

**Mr Smith:** We have limited time so I am hoping that we can actually concentrate on the issues here and not worry about what Rupert Murdoch and News Limited want you to say today at this hearing.

**Senator DI NATALE:** Given that today's hearing is not actually about the effectiveness of vaccines, I am more interested in the credibility of the witnesses here today. In terms of the evidence provided by the Australian Vaccination-skeptics Network, there was a ruling made by the Health Care Complaints Commission in New South Wales that the infrastructure they provide on vaccination is:

... misleading to the average reader because it is either incorrect, inaccurately represented or because it has been taken out of context.

What has the organisation done to correct the way in which they present that information? How is that different today compared with the manner in which they have presented information on this issue in the past?

**Mr Smith:** About the AVN, there are a lot of groups here that are not represented by the AVN. You are wasting a lot of our time. I know Mr Murdoch wants you to ask these questions.

*Witnesses interjecting—*

**CHAIR:** Order! It is going to be virtually impossible if people speak over one another. I cannot order Senator Di Natale. He is entitled to ask his questions and you can choose to answer them in whatever way you like. We are almost out of time and it is unhelpful. There was a question but I missed most of it. I am not going to instruct senators how to ask their questions; they are all entitled to ask their questions.

*Witnesses interjecting—*

**CHAIR:** We are virtually out of time. If somebody would like to address the question that Senator Di Natale has—

**Ms Dorey:** No, we do not want to address that question.

*Witnesses interjecting—*

**CHAIR:** Order! It is unhelpful when we have several people speaking at once. I would ask that we have one person speaking at a time.

**Mrs Kemp:** I just want to say for the sake of moving on, because it feels like there is a very definite strategy here to hijack our opportunity to speak, there is a committee that has been put in place by parliament. I can see on the paper here that Senator Di Natale is a participating member. I would like to give the committee the respect it deserves and accept that it has been able to choose the appropriate people to speak. I think we should move on and ask questions about the particular subject we are here for.

**CHAIR:** I think there is going to be an agreement to disagree between the witness and the senator. We are out of time. Senator Di Natale, do you have a final question before we move on to other witnesses?

**Senator DI NATALE:** No, that question was specifically about the AVN and it could have been answered very directly by the Australian Vaccination-sceptics Network. Obviously there have been a number of interjections. If they choose to ignore the question, that is their prerogative to do so. I am more than happy to discuss the matter but it is not the matter that the presentation was about. It was not about the effectiveness of vaccines but specifically about this legislation and its intent to increase vaccination rates. It may be a surprise to some of the witnesses here today but I indeed have some concerns, not around the effectiveness of vaccines but more around whether this legislation will achieve its intent, which is to increase vaccination rates. However, I have given the opportunity to the Australian Vaccination-skeptics Network to perhaps provide an account of the Health Care Complaints Commission ruling against them and they have chosen not to do that. They are absolutely entitled to do that.

**CHAIR:** If you have a question, I invite you to ask it. I would prefer if you did not engage in statements as well.

**Senator DI NATALE:** I am more than happy to hand the floor over to one of the other senators if they have got questions.

**Ms Dorey:** Since Senator Di Natale has hijacked almost the entire question time, may I ask if any of the other participating or full members of the committee have any questions regarding vaccination that they would like to ask us or ask the expert witness we have here.

**CHAIR:** We are out of time and I am trying to manage the time. A significant share of the time has been given to opening statements. Of the 45 minutes, the vast bulk was opening statements so I do not think there is an intent to stop anyone from speaking.

**Senator MOORE:** Mrs Kemp in her evidence touched on the issue of the medical exemption, which, from my understanding of the legislation, is really the only exemption under the proposed legislation. I would like to hear from any of the witnesses about what their understanding is of the medical exemption.

**Mrs Kemp:** I will happily speak to that. As I said, in the immunisation handbook the legislation actually refers to the fact that a GP can certify in writing that the immunisation of the child would be medically contraindicated under the specifications set out in the *Australian Immunisation Handbook*. On page 477, it refers to anaphylaxis as the only true contraindication. What I do know from my personal experience is that I visited my doctor who I had previously consulted with in making a decision relating to vaccines. He had signed the conscientious objection form. I think there are many people out there who have a conscientious objection form who fall under the heading of people who for whatever reason do not want to vaccinate but they often do not vaccinate for medical reasons; they just do not fall under the medical exemption.

My doctor said to me: 'We are being told that unless the child has suffered a severed and immediate reaction to a vaccine, you are not eligible for a medical exemption.' I shared this information with a number of people that are interested in this space and they have been told the same thing by their doctor. I think although the medical exemption form is strict and limited, it does look like there might be a few other options, but what doctors are being told is something different and I think we have to take that into account.

**Senator MOORE:** We have got the AMA coming later and that is certainly a question I will be asking them what their understanding is.

**Mrs Kemp:** Great, I think that is very important. It is important that we look at the fact that some children are contraindicated to vaccination. Perhaps there are children whose parents know enough and have been educated enough that they do not want to risk a vaccine injury first, and we need to look at that being a valid option.

**CHAIR:** We will move on. I do appreciate the time. We have gone a little bit over time but I think it is about right. I appreciate all of the witnesses coming and giving their evidence. Thank you for making yourselves available today.

**Mrs Kemp:** Thank you for the opportunity.

**CUNNINGHAM, Mr John Edward, Administrator, Stop the Australian (Anti-) Vaccination Network**

**GAYLARD, Mrs Alison, Founding Member, Northern Rivers Vaccination Supporters**

**HAWKES, Dr David, Administrator, Stop the Australian (Anti-) Vaccination Network**

**HEAP, Dr Rachel, Community Representative, Northern Rivers Vaccination Supporters**

**IERACI, Dr Sue, Executive Member, Friends of Science in Medicine**

**ROBERTSON, Mrs Heidi, Community Representative, Northern Rivers Vaccination Supporters**

**STOKES, Dr Patrick, Administrator, Stop the Australian (Anti-) Vaccination Network**

[09:52]

*Evidence from Dr Ieraci was taken via teleconference*

**CHAIR:** Could I get each of you to please confirm that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you.

**Mr Cunningham:** Yes.

**Dr Ieraci:** Yes.

**Mrs Gaylard:** Yes.

**CHAIR:** The committee has received your submissions. I now invite you to make short opening statements and then we will move to questions.

**Mr Cunningham:** Thank you for this opportunity to brief you with regard to our opinion on the Social Services Legislation Amendment (No Jab, No Pay) Bill 2015. Stop the AVN was formed six years ago by ordinary citizens as well as many health workers in the wake of the tragic death of 42-day-old Dana McCaffery from whooping cough. We are concerned at the rising level of misinformation, falsehoods and hysteria being spread by organisations such as the AVN, and something needs to be done. As you have heard, although the national vaccination rates appears to be high there are clusters of the population that have a vaccination rate lower than many Third World countries. Babies are dying because their communities are not vaccinated, and in a first world country such as Australia this is simply not acceptable. Maintaining the status quo has not seen an increase in vaccination rates in many years. The time for researching and observing this low rate is over. We see this as a time for action, and this legislation, although not perfect, is an excellent step forward.

You will hear that many people are not up-to-date with vaccinations because of poor access. Or perhaps it has slipped their mind rather than them specifically being objectors. In submission 327 this is described as group C, and you will be hearing from the author of that later today. Contrary to the author of that submission, I believe this legislation is specifically targeted at this group C, the largest group of unvaccinated children in Australia. What better way to encourage people to take that long drive to the vaccination clinic or to pay more attention to their children's vaccination status than by threatening the withdrawal of payments? What may be seen as an inconvenience today may suddenly become so much more important when a dollar value is associated with it. An improvement in the vaccination rate in this group would see Australia become a world leader in vaccination. There is also nothing in this legislation that excludes the provision of more immunisation clinics and an improved reminder system, which we would recommend be implemented together with this legislation. These things are not mutually exclusive.

Other objections that have been put forward to this bill take two main forms. One is from misplaced fear spread by professional antivaxxers, as you have heard, and one is from ethical objections. To discuss these in turn I will hand over to Dr David Hawkes and then to Dr Patrick Stokes.

**Dr Hawkes:** I am a scientist, specifically a virologist, and have published peer-reviewed scientific papers on vaccination and its safety. I have also acted as a peer reviewer on a number of journals including specialist journals focused on pharmacology and vaccination. I have never received any money from a company that produces vaccines.

Stop the AVN's primary goal has always been about combating misinformation from anti-vaccination groups like the ones you have already heard from. What often gets overlooked is that many of these groups are professional, and their opposition to No Jab, No Pay could be viewed as a defence of their business model. The AVN, under the presidencies of Meryl Dorey and Greg Beattie, has had an income of over \$2.6 million. No-one is sure where that money has gone, but the AVN does not appear to have any tax. We would encourage the ATO to look into that. We do know that over \$200,000 was spent on computers for an organisation run out of Ms Dorey's

spare room. We also know that Ms Dorey paid herself over \$30,000 in a two-year period alone as the editor of a magazine notorious for really being published. As already stated, there is a HCCC warning about the AVN for providing misinformation about vaccination. Please remember that, as stated earlier, the Australian Senate itself in 2013 called for the AVN to be disbanded for the same reasons.

The evidence that Ms Dorey presented this morning again shows her ability to instil fear through the careful use of misinformation. I would be happy to explain point by point why what Ms Dorey has claimed is wrong, but I am afraid this is not the forum as we are discussing the proposed legislation and not the safety and efficacy of vaccination. Additionally, the inaccuracies in Ms Dorey's statement have been highlighted to her many times. One of the other speakers for the AVN, Dr Tomljenovic, also failed to mention that her group, the Neural Dynamics Research Group, has received more than \$950,000 from the anti-vaccination organisation, the Dvoskin Family Foundation, with an additional unknown amount of funding supplied by another anti-vaccine organisation, the Katlyn Fox Foundation. Dr Tomljenovic has acknowledged both these funding sources in her publications. She spoke about her expert publications, but in five years she has published 22 uniformly anti-vaccine papers, 19 of which were opinion pieces in one form or another, rather than actual research. In her statements to this committee and those from others in the previous session she again refers to opinion pieces rather than high-quality, reproducible vaccine studies. Another two of her papers covered four individual case studies. It is well-established in the scientific community that case studies are unreliable and prone to bias, which, again, is probably why professional anti-vaxxers love them: to try to support the claims of the evils of vaccines, but on the other hand somehow feel it is okay to ignore well-controlled studies of hundreds of thousands of people, like the one that showed there is no link between the MMR vaccine and autism.

The 22nd paper of Dr Tomljenovic involves giving mice, in two weeks, the equivalent of the entire vaccination schedule up to six years of age, which again shows the extremes to which anti-vaxxers will go to try to support their beliefs. Dr Tomljenovic spoke about the link between the tetanus vaccination and antiphospholipid syndrome. However, she did not mention that the only study that made this claim was a small study in mice published in a special edition of the journal *Lupus*, which was edited her own colleague, Professor Yehuda Shoenfeld, a man who gets paid to be a witness in cases where people try to claim adverse events to vaccination, but which is not supported by the scientific literature.

If you listen very carefully you would note that Dr Tomljenovic spoke about infections being linked to autoimmune diseases, but then used bait and switch to imply that vaccines can do the same thing. Unfortunately, there is no reproducible scientific evidence to support this.

You may be thinking that once a child reaches 18 they can choose to get vaccinated and they will be protected against diseases like measles. Unfortunately, by the time someone gets to the age of 18 they may already be infected with a vaccine-preventable HPV infection, which could lead to cancers of the mouth, throat, penis, vagina, cervix or anus later in life.

I would now like to hand over to Dr Patrick Stokes.

**Dr Stokes:** I will be commenting on the ethical dimensions of the proposed legislation, and on some of the moral objections that have been raised to it. We acknowledge that the measures contained in this bill are coercive. However, it is generally accepted that the state can legitimately apply some degree of coercive pressure in the service of discouraging behaviour that is harmful for all public health—for example, taxing cigarettes in order to discourage smoking. Mr Cunningham has already explained why defending herd immunity and improving vaccination coverage is so urgent. That makes coercive pressure appropriate in this case, on consequentialist grounds.

Some of the objections you have heard today and in the submissions instead focus on claims of inalienable individual rights or on the inappropriateness of treating people as a means to an end. However, both of these objections miss their target in important ways, simply because the behaviour that this bill seeks to discourage directly affects other people, not just the person making the choice—namely, it affects the children of those who refuse to get their children vaccinated and it affects the wider community. Even for those who take a more libertarian view, rather than a consequentialist view, this behaviour still falls within the scope of legitimate coercion.

As you have seen demonstrated quite colourfully this morning, many parents, misled by misinformation recklessly spread by professional anti-vaccination proponents, do sincerely believe that vaccinations are dangerous or ineffective. In meeting our duty of care to our children and our community, sincerity of belief is not enough. We must also proportion our beliefs to the evidence and to the knowledge-generating structures of society, which in this case means science.

Dr Hawkes has already explained why these beliefs that are driving the anti-vaccination movement are wholly unwarranted and are based on misrepresentations of the state of scientific knowledge. The scope of legitimate parental choice does not extend to endangering one's children and the community on the basis of objectively false unwarranted beliefs.

It should also be noted that vaccine refusers who do not have a legitimate medical contra-indication for vaccination continue to enjoy the benefits of herd immunity, without contributing to it themselves. This is a classic case of what is known in moral philosophy as 'freeriding'. Again, the state has a legitimate role to play in discouraging freeriding, both because freeriding is unfair and because it puts community immunity at risk. It is regrettable that legislation like this is necessary at all. However, it is also important that we place the blame for this necessity where it belongs: with those who recklessly spread falsehoods about vaccination.

**CHAIR:** Are there any other opening statements?

**Mrs Robertson:** Thank you for inviting us here today. We are here representing the Northern Rivers Vaccination Supporters. We are an unfunded community advocacy group, formed in 2013 as a result of concerns that we live in the region with Australia's lowest vaccination rates. Just under half of children in Mullumbimby aged five are fully vaccinated. The national average of over 90 per cent vaccination coverage is pretty much irrelevant in pockets like ours.

We support the proposed legislation for a number of reasons, but we also have a couple of concerns about it that we would like to share. Vaccinations do not only protect individuals. They also protect communities. We see vaccinating as a social responsibility. It protects children and other members of society who are vulnerable to infectious disease, such as babies too young to be vaccinated, the elderly, people with legitimate medical exemptions who cannot be vaccinated, and immune-suppressed people such as cancer patients.

Childcare facilities are where children are in close proximity with each other for extended periods of time, putting them at greater risk of contagious disease. This is even more concerning if a number of children there are not vaccinated, as the diseases potentially being shared can be very dangerous. We see it as particularly fitting then that the proposed legislation focuses on withholding a government subsidy that helps parents of unvaccinated children send their kids to attend childcare facilities.

We have heard that one of the main concerns is that parents' choices are being taken away from them if this legislation is passed. Our view is that parents do in fact still have a choice, but that choice not to vaccinate will now come with a consequence. It is the parents' choosing not to vaccinate their children, and not the legislation, that will be disadvantaging their children and endangering the community. Is the legislation coercive? Yes, but not unjustly so. In our region our group has had an impact on some members of the community, but vaccination rates remain dangerously low and we need a stronger incentive for people to vaccinate.

We believe that both a carrot and a stick approach are needed. We think that there needs to be more targeted educational campaigns and awareness raised, and any access issues addressed. But we also need consequences for those who make choices that put others at risk. This is a public health issue. There are consequences for speeding and for drink-driving. Surely there should also be consequences if your actions leave the vulnerable at risk of preventable infectious disease.

The impact of pockets of low vaccination rates on the incidence of disease must be considered, as babies and other vulnerable people are going to continue to get sick and die if something is not done. As you may be aware, Malakai Cockroft, Kailis Smith, Dana McCaffery and Riley Hughes all passed away from whooping cough—all too young to be vaccinated and all from areas with dangerously low vaccination rates. There was no community immunity to shield them. As another example, one of the members of our group has a little girl who contracted whooping cough at a day care centre after an unvaccinated child attended with whooping cough. This little girl now suffers from a condition called bronchiectasis, which leaves her with lifelong lung damage. She is another example of how this legislation can, in the future, prevent this from happening to other children.

We would also like to point out that, anecdotally, this proposed legislation is already having a positive effect in our region. We have had vaccine hesitant parents approach our group seeking more information about vaccination, as a direct result of it, and they have told us that they are now reconsidering their stance. Local immunisation providers have also reported similar stories.

One concern we do have specifically for our region is that many people have an alternative healthcare provider, rather than a GP, as their primary healthcare practitioner. This is problematic, for a number of reasons. It means that our notification rates of vaccine-preventable diseases may in fact be significantly under-reported. People are not being diagnosed or referred on by alternative healthcare practitioners, and so notifications to public health may not be happening. In addition, many receive unproven remedies and ineffective alternative vaccination

options, such as homeopathy, forgoing proven preventative medicine, effective evidence-based treatments, and potentially remaining infectious for longer. As a result of all of this, we have parents in our group who are too frightened to take their babies out in public. We have mothers not joining mothers groups, missing out on those valuable social interactions and support groups. Just yesterday we were contacted by a local dad who is putting the family home on the market to move from the area, because they can no longer cope with the prevailing sentiment regarding vaccination, and the various conspiracy theories surrounding the issue. We have parents contact us who have been told by other mums that vaccines cause autism or shaken baby syndrome. Doctors, midwives and alternative healthcare practitioners in our region are giving conflicting advice, leaving parents to wonder what the best thing is to do for their baby. Vaccination, as you may have seen online, has been equated to rape or said to be a government agenda to pander to pharmaceutical companies or as a form of population control. The fear mongering is relentless here. We are fighting an uphill battle for our community, and thus far there has been little research done into our region as to what approaches may help people gain confidence in the vaccination schedule or in how to stop the relentless tide of misinformation.

To help counter these issues, in addition to this legislation, we would propose an annual reminder system linked to the Australian childhood immunisation register in order to keep the lines of communication open with vaccine hesitant parents. We would also like to see the money saved from the legislation go towards targeted education campaigns and research, particularly into unique demographics like ours. One last concern is the probability of vaccine refusers forming unregistered casual childcare alliances exposing the children in the wider community to outbreaks of preventable disease. We would welcome any measures to have regulatory processes in place for such instances. In conclusion we do support this legislation, as we believe it will protect those who have no choice, especially those kids in child care who are vaccinated but are continually exposed to disease that should be relegated to the history books by now. The young, the elderly and those too sick to be vaccinated themselves—those are the people who deserve our protection. Thank you.

**CHAIR:** Do the Friends of Science in Medicine have an opening statement?

**Dr Ieraci:** Friends of Science in Medicine is a group of around 1200 people including scientists, clinicians, lawyers and many members of the community in diverse roles who not only support the use of science in medical practice but also support evidence based policy. Thank you for the opportunity to back up our submission today. Committee members will recall that our original submission argued that the implementation of this proposed legislation is feasible—it has been done elsewhere. There is evidence that it is acceptable to the community; it is consistent with the law; and it satisfies ethical principles.

What I would like to do today is to expand on some of those points and to specifically address some of the concerns that have been expressed in the many submissions that the committee has already read. I do not wish to look at the misinformation in general because anti-vaxx information is so broad, but to look at things like medical exemption. I will then talk about what is required to qualify for various allowances, what our community has in place for people who feel they are disadvantaged, the significance of conscientious objectors in outbreaks and the evidence we have that the vulnerable will be looked after. I make these comments on this specific background: that is, of all the many submissions that have been placed before the committee, members will notice that universally all of the proposals from clinicians, medically qualified people, support the increase of vaccination prevalence in our community. The only real disagreement is whether this is the appropriate way to achieve that. Committee members will note that some opinions within public health might question whether some people might be left vulnerable by this proposal and the significance of conscientious objection. That is some of the evidence I will go through now.

Committee members will know that the background of this funding source was originally called the Maternity Immunisation Allowance. We know worldwide and the evidence has been presented that the community both responds to and accepts the strategy of rewards for behaviour. We are talking about whether these are carrots or sticks. The actual fact is that the Maternity Immunisation Allowance always was a carrot; in fact it remains so. The money has been rolled up into an allowance that people still need to qualify for. Obviously, I cannot get the Maternity Immunisation Allowance or now a Family Tax Benefit Part A if I do not have a child of the required age.

So the only thing that has really changed now is that, instead of calling some of these funds a maternity immunisation allowance, we have rolled them up into funding under a different name—which we still need to qualify for, just like we need to qualify for a disability pension or an age pension. In fact, our community wants people to qualify for the allowances that they seek and benefit from. The big change between what is proposed now and what happened in the past is that we used to allow people who declared a conscientious objection to immunisation to receive an allowance that they did not qualify for. The significance of that is that we are now

saying that, unless one complies with the requirements for the allowance, it is simply a matter of not receiving that allowance—and there is evidence that the community supports this.

And here I need to qualify a recent comment the committee heard about medical exemption. It is definitely not true to say that one has to have an immediate anaphylactic reaction to achieve a medical exemption. There is a lot of documentation about this which gives examples of a range of conditions where a child can be exempted. But there is also scope and authority for a medical practitioner to certify any credible medical exemption—whether it is temporary or permanent and whether it is related to allergy or immune conditions or a whole range of other conditions. So it makes logical sense that, if somebody would be harmed by the procedure and there is evidence that they will be, their doctor can certify a medical exemption. It is definitely not true to say that you need to have an anaphylactic reaction.

Having said those things, the next question is: why would we be changing what we are doing? Just to remind people, what we are changing is only that people cannot declare a conscientious objection and still receive a reward for a behaviour that they are refusing to carry out. That is the only change. The reason we are changing is that there have been more and more outbreaks, as we have heard from our colleagues, in areas of high conscientious objection and low immunisation prevalence.

And here I would like to talk about evidence presented to the committee by our colleague Julie Leaske, who will also be presenting this afternoon. Julie and her colleagues' submission argues that conscientious objectors represent such a small percentage of the community that trying to target them will not necessarily have the effect that is wanted. Friends of Science in Medicine disagree with this on the following point: conscientious objectors are not evenly distributed through the community. If they were only a small percentage distributed evenly around the country, perhaps we could then say so; but, as we have heard from our Northern Rivers colleagues, that is not the case. In fact, areas with strong conscientious objection are where the outbreaks happen—and that is the reason we need to target this group. They are not only claiming an exemption and getting a reward for behaviour that they do not carry out—which our community does not accept—but also doing something with consequences for other people. They are not a negligible group. They are a group whose behaviour in the pockets where they congregate creates significant disability for other people in the community.

The next thing that is argued by some people who support vaccination but are concerned about the strategy is that Australia does not have a compensation scheme in the way that the US has. This, again, is an error of logic. The reason the US needs a compensation scheme is that the US, unlike Australia, does not have universal health cover. Australia has Medicare. There is no Australian child who is excluded from the best quality health care, essentially without cost to them, because Australia does not have universal health cover. That is part of our civil society; in the same way, immunisation is part of the requirement to maintain our civil society. We look after each other in both ways—by preventing disease but also by looking after those in our community who are vulnerable.

To expand on this point, I refer the committee to the submission by the Department of Social Services, which is in favour of this legislation. The Department of Social Services submission points out in detail what the approach will be to those who are vulnerable in our society. We accept the fact that vulnerable parents, who need every cent they can get, may feel that they are being punished; but, in fact, the Department of Social Services is sympathetic to this approach and already has structures in place for supporting people who will carry out catch-up vaccinations and so on. So it is not true that this legislation affects the most vulnerable in our society. The group it affects is specifically the people who refuse to vaccinate but insist on claiming the reward for vaccinating. In our community, we do not accept that people who do not qualify for a particular type of allowance should receive it anyway.

Friends of Science in Medicine also supports what has been recommended previously: together with the implementation of this legislation, any money saved should contribute towards education and support for the most vulnerable in our community, to correct misinformation and also to assist people with chaotic lives or with various stressors to get the medical help they need, the emotional help they need and to be able to protect their children. Thank you.

**CHAIR:** Thank you. Senator Di Natale.

**Senator DI NATALE:** That was comprehensive. You discussed the evidence from Professor Leaske. There is clearly a live debate about whether this is the most appropriate way of achieving the outcome which I and, I suspect, all of you would like to achieve, and that is increasing the vaccination rate.

**Dr Ieraci:** Yes, certainly.

**Senator DI NATALE:** There has been some criticism about whether this is just too blunt a tool to achieve that. Earlier you brought up the issue of conscientious objections, which is only a small proportion. If you were designing this legislation from scratch, would it look like this? Or what would you do differently?

**Dr Ieraci:** Is that question for me?

**Senator DI NATALE:** I am happy for anyone to answer it but, given that you presented Professor Leaske's evidence, I think I would like to start with you.

**Dr Ieraci:** One of the things we always say is that conscientious objection is such a small percentage that influencing it would not make a big difference. But the most important point, which is shown by the evidence, is that conscientious objection is a large proportion of outbreaks. You are not seeing outbreaks in areas where there is a tiny percentage of conscientious objection; you are seeing it in areas like the Northern Rivers, where it is a large percentage of a specific community—and that is what it takes to bring about an outbreak. So if I were designing this again, the only thing I would change is a guarantee that at least some of the money raised would go towards assisting those in the group who are not conscientious objectors but who have difficulty organising their lives to get to the doctor on time.

What I am presenting is an argument that it is not correct logic to spread the percentage of conscientious objection across the country and say it is very low; the correct logic is to say it has been demonstrated that, in areas of outbreak, it is a congregation of people with a conscientious objection who make outbreaks occur—and, if that did not occur, the rest of the community would not be exposed to that risk. So what we are arguing on the basis of evidence is that, while it seems to make sense that we are chasing a very small target, the problem with the logic is that it is a large target when groups like that congregate—and that is actually the basis of outbreaks.

**Mr Cunningham:** The submission that I discussed was also by Julie Leaske. She describes group C as people who are lazy, forgetful or have poor access to vaccination. I can only see this legislation encouraging those people to pay more attention to vaccination and regard it in the light it should be regarded in—an important and vital part of every parent's life and responsibility to care for their children.

**Senator DI NATALE:** What if it does the opposite? Obviously we hope that is the outcome, but we are not sure of that yet. Is there the possibility that some people will find that they have been deprived of a potential benefit of some sort and the consequence of them not getting that benefit is not that they decide to vaccinate but perhaps that other areas of health care or other important things such as kids' education or the trip to the dentist are foregone? The concern that some of us have is that it does not lead to the outcome. Ideally, we want it to.

**Dr Ieraci:** I am very conscious of that concern. As I said before, that is a real concern that is amongst medical people. It is not that we should not try to increase immunisation rates but that there might be unforeseen consequences. I think you are absolutely correct to point that out. Every time we make policy we should look for unforeseen consequences. In forensic science and medicine we have spent some time looking at that and we have seen that we need to look at what is fundamentally changing. We already have a need to qualify for an allowance except that one was able to go to a doctor and lodge a conscientious objection. The people who did not do that and who were disorganised, perhaps vulnerable or perhaps did not have time already did not qualify for the allowance. What we are changing now is the fact that people who consider themselves to be conscientious objectors will no longer qualify for an allowance. This is not the group Julie Leask is talking about who do not have a conscientious objection but who are vulnerable. They already were not exempted in the previous conditions. We found that, by being convinced to allow people to have a conscientious objection, that has been the unintended consequence of the previous policy. We have created a situation where outbreaks are able to occur. What we are doing now is trying to correct an unforeseen consequence of the previous policy. We are still not doing anything different for vulnerable people who have a chaotic life; we are making people who previously qualified for something that they did not achieve have to think twice about it.

The other part of that question is: do these children no longer get to go to child care and, because of that, suffer? I would argue and our group would say that there is no evidence that the group who are lodging conscientious objections are the same people who have chaotic lives and need greater contact with the medical service in the community. When we used to think of this as an incentive we actually measured the fact that people who qualified for the incentive achieved better outcomes and we increased our immunisation rate. Now we need to tackle the unintended consequence of exempting some people, which means that we created some outbreaks. This is actually a correction of unintended consequence rather than the creation of one.

**Senator DI NATALE:** Thank you. That is very helpful.

**CHAIR:** We thank each of your witnesses for being with us in this section.

**Proceedings suspended from 10:28 to 10:47**

**BIENHOLZ, Ms Lisa, Private capacity**

**BURNUM-BURNUM, Mrs Marelle, Citizens Concerned with Vaccination Legislation and Safety**

**DALE, Ms Christine, Citizens Concerned with Vaccination Legislation and Safety**

**HAINES, Ms Merilyn, Private capacity**

**KENT, Mr Phil, Private capacity**

**LEONFORTE, Ms Jane, Private capacity**

**LIPPEY, Ms Fiona, Private capacity**

**WANT, Mrs Ann, Private capacity**

**WANT, Mr Don, Private capacity**

**WILSON, Mr Trevor, Private capacity**

**CHAIR:** Welcome back. There is now an opportunity for the 10 people listed to give a short statement to the committee. This section will run for 25 minutes, and there will be a strict two-minute time limit on these statements. I remind everyone that in giving evidence to the committee witnesses are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to the committee, and such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to the committee.

**Ms Lippey:** The previous witnesses said that outbreaks happen in small areas where there are only conscientious objectors. This year's whooping cough epidemic was nationwide, so I think the previous comments are pretty laughable. I came here because there is something really wrong with our immunisation system. We are arguing for or against whatever in this bill, but it is not addressing the real problems. The Murdoch institute found that 2½ per cent of children under seven have autism; 80 per cent of them are boys. This works out at one in 100 girls and one in 25 boys. In the time we have gone from five vaccines to 40 we have also gone from one in 10,000 to one in 25. Coincidence or consequence? While we argue and debate, more and more kids get injured. I combined the Murdoch institute's statistics with ABS data, and that is 43,810 boys under seven with autism at the moment, and 10,338 girls under seven. This is a total of 54,148 damaged kids under seven in Australia at the moment. Something is really, really wrong: 7½ thousand children this year will become autistic; that is 21 kids per day who will end up with a lifelong disability, be cursed to poverty, be severely injured, while we debate back and forth and argue. Every day we delay, more get hurt. We need to do something. We have a crisis. We need to do our best to fix it and approach it objectively.

**Ms Leonforte:** I am a retired ICU nurse and coordinator of an ASD support group. Our own Professor Stanley stated that Australia had a very low incidence of disease in the 1960s before the widespread use of vaccines was introduced. This was due entirely to improved sanitation, hygiene and nutrition. The proposed amendment is based on outdated and false information. Where are the independent studies, the longitudinal studies, the studies on pregnant women, the synergistic vaccine studies? Where is the study that shows that over 60 doses of 16 vaccines do not cause cancer, autoimmunity and brain injury? Vaccines were created to minimise disease symptoms. Vaccines, by their design, do not and cannot affect the colonisation and transmission of viruses and bacteria in the vaccinated. Both the vaccinated and the unvaccinated population carry and transmit viruses and bacteria in exactly the same way. I cannot stress this enough. Independent immunologists and virologists can confirm this. Our vaccines do not prevent colonisation or transmission in diphtheria, pertussis or polio. Neither tetanus, human pap virus or hepatitis B are infectious. Gardasil has caused hundreds of deaths around the world and is under investigation in Europe and other countries. Since HIV came out, we were worse off due to a dominant shift in strains. Measles outbreaks have been happening in regions of China and Canada where 97 to 99 per cent are vaccinated. Undue industry influence distorts the healthcare research, strategy, expenditure and practice. There is an urgent need for an independent investigation of the commercial and political corruption and economic distortions directly attributable to the pharmaceutical industry. The government has not conclusively demonstrated that vaccines are safe, necessary and effective. Given that vaccination has no impact on herd immunity and vaccines do not affect colonisation or transmission of disease, I ask that this amendment to the bill be squashed.

**Ms Haines:** I am a retired medical laboratory scientist. I am in favour of vaccination, but I am opposed to any forced medical treatments. Parents' rights to decide their children's medical treatments would effectively be taken away with this No Jab, No Pay policy. The proposed legislation would be an abuse of parents' and children's

rights, and unethical. Unvaccinated children could be huddled together in unregistered childcare arrangements, and this would increase the risk of outbreaks. Children could be vaccinated when they are unwell because of the pressure to stay on the official government schedule. Children could be harmed by this legislation. My only child was diagnosed at the age of 19 with ulcerative colitis, which is an autoimmune condition. I support vaccination, but I have an ever-nagging doubt that his autoimmune disease could have been caused by the MMR vaccine he had at the age of 10 or the meningococcal vaccine he had at the age of 13, which I had voluntarily administered to him. I have no way of proving or disproving that. The parents should not be forced or financially blackmailed into having their kids vaccinated with any vaccine if there is any risk—and there is always a risk, because vaccinations are not 100 per cent safe. Consider Ashley Epapara, the two-year-old Brisbane girl who died 12 hours after receiving a flu vaccination in 2010, and also the hundreds of Western Australian children who have febrile fits from flu vaccinations, and Perth baby Saba Button, who suffered severe brain damage after receiving two vaccines. I urge you to remind, encourage and assist parents to vaccinate, but do not use the big stick to blackmail them into submission. If there is any risk, there should be a choice. Medical treatment should not be forced on parents or their children.

**CHAIR:** I now invite Donald Want to address the committee.

**Mr Want:** My name is Don Want. I deal in science every day. I am not used to getting involved in a lot of political arguments; I am used to dealing in scientific facts.

First of all, I am very surprised that this committee, that is supposed to be assessing this situation, has a committee member who is obviously not unbiased. With Senator Di Natale's comments this morning, clearly, he should not be on this committee.

When one side has no valid points, then science is dropped and personal attack proceeds. That is what I have witnessed today in the difference between the first and second set of witnesses. The first set of witnesses were logical and science based, but full of parents with children who had been affected. The second set of witnesses were scientists, some of them, but they were not talking about science backing up vaccination or the whole issue. They were talking about group and individual criticisms. It was just amazing, the contrast. They were talking about false statements made by the first group, not a scientific basis. Then we had the Northern Rivers vaccination support group present a belief situation, with no science behind them also.

There is plenty of proof on pertussis transmission by those vaccinated—not transmitted by the unvaccinated. With regard to their point, I have looked into the science on that, and it is clear. With claims of fear mongering: again, the Friends of Science in Medicine are not presenting any science—

**CHAIR:** I will get you to wrap up, sir.

**Mr Want:** just personal attacks. Thank you.

**CHAIR:** Thank you. I now invite Philip Kent to address the committee.

**Mr Kent:** Good morning. My name is Phil Kent. For the sake of transparency, I will mention that I know representatives of the Northern Rivers Vaccination Supporters, Stop the AVN and Friends of Science in Medicine. I am also secretary of the Brisbane Skeptic Society. However, I do not speak on behalf of any of those organisations today.

People who oppose vaccination exemplify faulty logic. They talk about freedom of choice but forget about our community's right to be free from infectious disease. They spend their spare time on Google, thinking that it is the equivalent of dedicating your life to getting a PhD in virology or becoming a medical doctor specialising in infectious disease. We call this the Dunning-Kruger effect, where you overestimate your competence. Ironically, experts are more likely to underestimate their competence. As they learn more about their speciality they realise just how much more there is to learn.

These people will cry foul when their child is diagnosed with any number of conditions and blame vaccinations that may have been administered, perhaps not even recently. They ignore the fact that coincidences do happen. Statisticians will tell you that a very rare event is virtually guaranteed to happen eventually, given enough repetition. Millions of doses of vaccine have been administered with incredibly few side-effects. Anti-vaxxers will cherry pick data that supports their view and ignore the overwhelming data in favour of vaccine efficacy and safety.

Take, for example, the claim that sanitation, not vaccination, is the reason for reduced disease rates: the slums of India are now polio free. These people go to rallies with placards that say, 'Give me 100 per cent effectiveness and I will give you 100 per cent compliance.' Bike helmets are not 100 per cent effective, but you could bet that most of them ensure that their kids have a properly-fitted helmet in accordance with the law. No medical

intervention is 100 per cent effective or safe, but vaccination comes pretty darn close. The disappearance of polio and smallpox gives you an idea of how effective vaccination is. Thank you.

**CHAIR:** I now invite Ann Want to address the committee.

**Mrs Ann Want:** My name is Ann Want. I have five children. Thirty-three years ago I was advised by a doctor not to vaccinate my eldest, due to medical reasons. My third child reacted badly to his 18-month vaccination. Those two children later proved to have many chemical sensitivities.

After then researching vaccinations for the last 25 years I have found that the one-size-fits-all approach that this legislation is applying is grossly flawed. There is a significant percentage of our population who are chemically sensitive, with several documented estimates at around 15 per cent of the population. My boys were in this population fraction, and vaccines pose a very serious risk to their health. This means that there is a significant portion of our population which is genetically susceptible to such.

But there are other differences which mean that a one-size-fits-all mentality should never be applied, such as for those with impaired immune systems and those with malathion problems. There is racial descendency, for example. Research that was suppressed by the US CDC system now exposes the links between vaccines, autism and African-American boys. Individuals with a family history of autoimmune conditions need to be considered and histories of inflammatory disorders need to be considered. Furthermore, why are the checks on family health histories not undertaken by healthcare providers before vaccinating—something that is set out in the handbook for them to do, but is not done?

This whole legislation defies logic in that, clearly, obvious health problems are happening to families and have not been studied adequately nor understood, and are not being taken into account.

**CHAIR:** Thank you. I now invite Trevor Wilson to address the committee.

**Mr Wilson:** Thank you. My name is Trevor Wilson. I have already made a submission to the inquiry. It is submission No. 89, if you want to have a look at it.

I just want to mention a couple of personal things now that I was not able to put in the submission. My wife and I had two kids in the 1970s and they are now around 40. They have families of their own. One of my children chose to vaccinate his kids. They are fully vaccinated. They are now young teenagers, but for several years they had a constant stream of visits to the doctor for things like tonsillitis, bronchitis and ear infections particularly. They are now young teenagers and they still, from what I hear from my son, have to visit doctors pretty regularly.

On the other hand, I have another family—my daughter's kids. She has three kids. None of them are vaccinated; they have never had any vaccines. They have never had any of those issues and they just about have perfect health. What more can I say? They might visit a doctor about once in every four or five years each and that is it.

I think there is a big need to sort out the health of vaccinated and unvaccinated kids. I would like to see that come out of this review—this inquiry—that some independent study be carried out. It would not be hard to do, either.

On the childcare issue: I have a five-year-old granddaughter. She has never been vaccinated and she is the healthiest little girl in Australia. She has been going to child care for a couple of years. In the time that she has been there, there have been kids at that childcare centre who have gone down with chickenpox and with whooping cough. In all cases they were 100 per cent vaccinated. This is another issue that needs to be sorted out. Do kids who have not been vaccinated carry disease? From what I can see, I do not believe that is the case.

I am a scientist too. I have never seen any evidence that it is the case; it is just what people tend to believe. Thank you.

**CHAIR:** I now invite Lisa Bienholz to address the committee.

**Ms Bienholz:** Thank you. My name is Lisa Bienholz. It is unlikely that we will ever reach 95 per cent, not while more vaccines and more vaccine doses are constantly added to the schedule. Vaccination rates are not a measure of herd immunity; they are a measure of compliance, or obedience, to the vaccination schedule.

We already have 95 per cent for some vaccine targeted diseases: diseases like hepatitis B and tetanus, to which herd immunity theories do not apply; and for diphtheria, pertussis and polio vaccines, as they cannot prevent the spread of a disease. Diphtheria vaccine is a toxoid vaccine. Have medical authorities forgotten how a toxoid vaccine works? Effectiveness in creating an immune response does not mean it is protective in preventing people from catching the disease. The pertussis vaccine is similar. The manufacturer's information clearly states that pertussis pathogenicity in immunity is not well understood.

So what of the risks? We are told that serious reactions are rare and very rare but when the same statistical criteria used for defining adverse reactions is applied to diseases, that would make the likelihood of contracting a disease like pertussis rare. This is using the National Notifiable Diseases Surveillance System.

This rare status is not because of the vaccine, because all the vaccine is capable of doing is minimising disease symptoms. Our children might face the risk of the disease, but they very definitely face the risks associated with every single dose of vaccine. Conscientious objectors are currently 0.12 per cent of the total Australian population. Do we really think that there will be a significant reduction in disease by addressing this tiny percentage? So this is not about the 0.12 per cent. No Jab, No Pay hinges on the whole of life immunisation register to take effect, and adult vaccination will need a punitive counterpart like No Jab, No Pay to increase adult vaccination rates from its current estimate of 30 per cent. Now, more than ever, we need our conscientious objection. It is our only safeguard against unsafe, ineffective vaccines and an unknown vaccination schedule of the future. Thank you.

**CHAIR:** Thank you. I now invite Marelle Burnum-Burnum to address the committee.

**Mrs Burnum-Burnum:** I would like to comment on the vilification that happened this morning. We were all witness to that. The AVN was attacked. This is an example of why we do not have doctors here at the moment, because they are vilified. I have doctors coming to my clinic. My brother is a doctor. They are vilified. I also point out that there is an enormous amount of discrimination around this legislation and around the vaccination issue. There are many clients at my clinic, and I have seen over \$100,000 in the 38 years I have been practising. Many of these clients cannot even choose their own profession to go into, because they are required to be vaccinated. I have a lot of science students who wish to go into medicine; they will not go in, because they have to be vaccinated. I have people wanting to go into the army; they will not go in, because they have to be vaccinated. This is discrimination.

If this legislation goes through, we are going to set Australians apart. Already, here now with this vilification process, we have child against child, parent against parent, school against school and preschool against preschool. Are we going to go forward united or are we going to go forward divided? This legislation will certainly divide the Australian population. This is force over power. If this vaccination process worked, you would not have to force anything. Power comes on its own and it comes with freedom of choice.

I live in a high socioeconomic area—the Sutherland Shire. I am not in chaos, and I drive a car, but I choose not to vaccinate. I have an Aboriginal son—or part Aboriginal son, although Aboriginal people would not like me to say 'part Aboriginal'. He is the son of Burnum-Burnum, he is not vaccinated, he is very healthy and he works at the Macquarie University; I was told he had to be vaccinated. Aboriginal people are extremely at risk here because they are predisposed with their poor immunity and they are also predisposed because they need the money. The people that come to my clinic are making choices. There are not outbreaks of whooping cough in our area. Therefore, a public inquiry is needed into this, not a public hearing, so people can step forward and tell their stories.

**CHAIR:** Thank you. I now invite Christine Dale to address the committee.

**Ms Dale:** Thank you everyone and good morning. After reading the explanatory memorandum on the Social Services Legislation Amendment (No Jab, No Pay) Bill, I consider myself fortunate to have escaped the clutches of such repressive, Nazi-like legislation. Having been raised by a father who fought in the jungles of New Guinea against an insidious threat to our freedom and democratic society, poring over the erosion of human rights in this legislation continues to be an alarming experience. How, in the 800th year of the Magna Carta, can we, as democratically raised human beings and citizens of this wonderful country of ours support legislation designed to take away the fundamental freedom of choice and conscience over the health and welfare of children and adolescents, whose parents will be giving them up to the state regardless of the parents' well researched study into the harmful effects of vaccines on their child's immune system? Every parent and guardian has a duty to nurture and protect the health and wellbeing of their child and children. This legislation makes dangerous ill-informed assumptions about what constitutes good health and how this is best attained.

Article 24 of the Convention on the Rights of the Child states that a child has a right to:

... the enjoyment of the highest attainable standard of health ...

And to measures to diminish infant death and child mortality and to combat disease. Why then, as a teacher with almost four decades experience working with children, am I seeing and experiencing so many children in my classroom with such ill-health: autism, Asperger's, cognitive impairment, ADHD, and an inability to process and learn educational concepts at their grade level? How ironic that Japan, a previous foe, has seen the link between vaccines and the cot death rate, has stopped vaccinating children under two years of age so that their immune

systems can develop, and has removed Gardasil vaccine from their register due to the serious side effects experienced by their young women.

Having experienced the mass vaccination campaign in schools—in my school—for meningococcal and measles-mumps-rubella, there are serious concerns about dealing with and reporting children who experience reactions to these vaccines. Why are we rushing into this legislation? The health implications for future generations are serious and we really need a public inquiry into this serious, divisive matter in our society.

**CHAIR:** Thank you. Thank you to all our witnesses. We will now move on to our next group of witnesses.

**GERICKE, Professor Christian, Member, Royal Australasian College of Physicians**

**KIDD, Dr Richard, Australian Medical Association Federal Councillor, and Deputy Chair, Australian Medical Association Council of General Practice, Australian Medical Association**

**KYNASTON, Dr Anne, Member, Royal Australasian College of Physicians**

[11:11]

**CHAIR:** I now welcome representatives from the Australian Medical Association and the Royal Australasian College of Physicians. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you? Could you confirm that?

**Dr Kidd:** Yes.

**Dr Kynaston:** Yes.

**Prof. Gericke:** Yes.

**CHAIR:** Thank you. I would ask each of you to state the capacity in which you appear today.

**Dr Kidd:** I am a general practitioner and I am a federal councillor of the Australian Medical Association. I am Deputy Chair of the Australian Medical Association Council of General Practice federally and Chair of the Australian Medical Association Queensland Council of General Practice and past President of AMA Queensland.

**Dr Kynaston:** I am a general paediatrician from Brisbane and I am here representing the Royal Australasian College of Physicians.

**Prof. Gericke:** I am a public health physician and I chair the Policy and Advocacy Committee for the Australasian Faculty of Public Health Medicine which is part of the Royal Australasian College of Physicians.

**CHAIR:** We have received a submission from the college. But I would ask each of you, if you would like to, to make opening statements and then we can move to questions.

**Dr Kidd:** Thank you. Thanks for the opportunity to talk. There should be a submission from the AMA on its way. The AMA supports the use of incentives and disincentives to increase the rates of childhood immunisation. Vaccination is safe and effective, protecting the individual who is immunised. It is a critical public health measure. High rates of immunisation are essential for herd immunity, which then conveys protection to others, including infants who are too young to be immunised, and the immuno-compromised.

Despite the strong efforts of the medical community, immunisation rates are below the 95 per cent recommendation for herd immunity in many parts of Australia. The 'Healthy communities' paper noted that the five Medicare Local catchments with the greatest number of children not fully immunised across the age groups of one year, two years and five years combined were Western Sydney, South-Western Sydney, Greater Metropolitan South Brisbane, Metropolitan North Brisbane and Inner-West Sydney. There are some 77,000 children who were not fully immunised on 2012. There are areas in Australia where one child in five is not fully immunised.

The diseases we are protecting individuals and communities from are devastating, and some kill up to one in 10 who contract them. Parents are not being forced to immunise their children; rather, the decision to not immunise a child on non-medical grounds will no longer be recognised as a suitable conscientious objection, and will make families ineligible for the family tax benefit supplement, family tax benefit part A.

The AMA believes that, once the measure is introduced, it is critical for government to monitor the data in order to identify: whether the measure is working as intended and parents are deciding to have their parents immunised; whether there continues to be pockets of low immunisation in more affluent suburbs, in which case more targeted measures will be required; and whether there is an increasing number of vulnerable children being removed from child care or preschool, in which case some changes to the measure will be required.

Any savings that are generated by the measure should be reinvested into research and other measures that seek to increase immunisation. The government should commit to fully funding all programs of catch-up vaccination for children impacted by this measure—those aged up to 19 years of age. We think that is a very important measure to have in place.

I would just add in passing that AMA Queensland is working closely with Queensland Health to try in a very positive way to improve the immunisation rates in Queensland.

Thank you. I am happy to take questions at some point.

**Dr Kynaston:** Thank you very much for the opportunity to appear before the committee. The Royal Australasian College of Physicians is the largest medical specialist training college in Australia, representing over

22,000 physicians and trainees in Australia and New Zealand. The RACP also represents Australian paediatricians and public health physicians, and both of us have keen interests in the issue of immunisation and vaccination. In addition, the RACP has a strong advocacy role in the development of health and social policies to advance the wellbeing of adults and children across the life span.

As outlined in the RACP submission, we are strongly supportive of safe and effective measures which raise vaccination rates, and we have advocated for this to be prioritised for some time. The RACP does, however, have some concerns relating to the measures set out in this legislation. The RACP is concerned that the bill in its current form has the potential to entrench disadvantage. Families that are already economically disadvantaged and are dedicated conscientious objectors are likely to continue to refuse vaccination for their children and will then be denied access to these essential social and tax benefits.

The RACP holds that linking taxation benefits to compulsory vaccination is an ineffective mechanism for increasing vaccination uptake. This measure is unlikely to promote vaccination uptake in wealthier communities and many conscientious objectors reside in areas of higher socioeconomic wealth. This measure will, therefore, not improve vaccination rates. The majority of families with incompletely vaccinated children are not conscientious objectors, and they face practical economic social and geographical impediments to full and timely vaccination and are much more likely to be experiencing poverty and social isolation.

As a mandatory measure this bill may have the unintended consequence and potential to strengthen the opinions and increase the group of conscientious objectors who disapprove of this form of government intervention.

The RACP is particularly supportive of the establishment of an effective national life-time register through the recently passed Australian immunisation legislation of 2015. However, it is crucial that this register be effective in accurately tracking vaccination rates, with appropriate and timely data and effective linkages in communication across services, health providers and families. I would add that currently conscientious objectors do register but with the new bill they would not need to register, so we would not have any idea of the rates of families becoming conscientious objectors or not.

The RACP encourages the government to promote alternative measures which do not seek to penalise but rather to support families and communities in accessing good-quality information and advice relating to vaccination and these measures could include: a national immunisation reminder system, catch-up campaigns, local initiatives to improve coverage, home visiting programs and addressing access barriers to health care.

It is important to note that a range of measures will be required to address the complex reasons for failing to vaccinate and that, while measures may vary, they should not include punitive measures that may entrench other issues or jeopardise children for the decision making of their parents.

**CHAIR:** Thank you. If there are no other opening statements, we will move to questions. I have some questions. Before I proceed, we have a representative of the *Courier Mail* in the room who is looking to take photos, so the usual rules would apply. I would suggest that photographs of either senators or witnesses at the table are okay, but obviously if any witnesses object to that then we will put some restriction on that. If there are no objections, we will proceed on that basis.

**Dr Kynaston:** That is fine. We have heard a lot of evidence and there are a lot of submissions. I am not a scientist or a doctor, but we are all trying to get across it as best we can. I want to ask a couple of questions to deal with some of the issues that have been raised either here today or in some of the submissions. Perhaps you can shed some light or help us to understand. We hear about quite severe adverse reactions to immunisations from time to time. I am interested in the views of anyone on the panel here as to the prevalence of any of those severe reactions. What has been documented either in Australia around the world?

**Dr Kidd:** I can refer you to a very well-referenced document that is on the website. It is *Myths and realities: responding to arguments against vaccination: a guide for providers*. It is on the immunisation website. As a GP doing many, many vaccinations, I have never had a single severe reaction in any of the children or adults that we have vaccinated. The rates, depending upon what severity you are talking about, are somewhere between one in a million and one in 100,000. There are minor reactions that are fairly common, like some redness and pain at the injection site, but, in terms of severe anaphylactic reactions or other severe reactions, they are very, very rare.

**CHAIR:** So it would be in the range of one in 100,000 to one in a million. Is that right?

**Dr Kidd:** Yes.

**CHAIR:** Other concerns that have been raised are with the increasing number of vaccines. Those of us who have kids have seen that there seem to be more and more every time. Do you want to address that? Are there any

risk factors there—anything that anyone needs to be concerned about when we see more vaccines in one dose or one session?

**Dr Kidd:** The human body can cope with multiple antigens being exposed all at the same time and develop quite good immunity without any ill effects. The new vaccines that are being developed—some of them are very, very important. The Haemophilus influenzae b vaccine was only introduced in a really significant way in about 1993. In the years leading up to 1993—the late eighties and nineties—there were over 500 cases a year of invasive Haemophilus influenzae b, and there would be at least 15 deaths a year and there would be an awful lot of ongoing suffering forever for those kids who had suffered really severe effects—meningitis; pneumonia; sometimes they would lose limbs or parts of limbs. Since 1993, when the Hib vaccination program was commenced, there are now only about 20 cases a year—so it has dropped by more than 95 per cent—and most of those occur in unvaccinated children. I would add in that regard that, with polio—I cannot remember the name of the village now, or the community—in Holland there is a kind of a natural experiment that has happened where there is a significant community that does not have vaccinations, and in the last 30 years they have had two quite devastating outbreaks of polio, with a number of deaths and a number of people left paralysed. It did not spread to the rest of Holland, into that community that has high vaccination rates.

**Prof. Gericke:** I echo that. On the prevalence: severe reactions to vaccinations are really very rare; in contrast, we know that the severe effects of not vaccinating, unfortunately, are quite common in people who are not vaccinated. I would echo the Dutch example. I am originally from Germany, and we have a very strong anthroposophic tradition. These are people who oppose all kinds of vaccinations and Western medicine in many respects. For decades, measles outbreaks have been documented in these communities and these schools and nurseries, with tremendous effects on the children, from hearing loss and encephalitis to death. We have witnessed all of these. Unfortunately, like in many countries, the number of conscientious objectors has grown and there are more and more measles epidemics in Germany, with all these consequences that we know too well.

**CHAIR:** I wonder whether someone could help shed some light. Senator Moore, I might be crossing over one of the questions you have, but we can perhaps explore it together. The issue of medical exemptions has been raised. There is a concern that medical exemptions have only extremely limited capacity. For instance, I have had people raise with me their own experiences where they believe two of their children have suffered pretty severe reactions to immunisation, to the extent that they no longer want to vaccinate their children because they have seen their children suffer not a short-term reaction of a fever for a day but an ongoing gastro type reaction over many weeks, and it happened on a couple of occasions with different immunisations. How do medical exemptions work when it comes to a doctor deciding whether there should be a medical exemption for immunisation?

**Dr Kidd:** It is about documenting it properly and listening very carefully to what the parents have said. Hopefully it is something you have been involved with yourself so that you have some independent evidence around it. In my practice in Nundah, our vaccination rate is over 96 per cent. I am not aware of anyone in our practice who has sought or has medical exemptions. I would again say it is a very uncommon issue. In terms of what we are looking at here today, it is probably a little bit of a red herring. Most of the people we want to get vaccinated are not going to be in a medical exemptive group who, for one reason or another, just have not got around to it.

**Dr Kynaston:** We do need to listen carefully to parents' concerns after their children have been immunised because it may be something that is coincidental or there may be another disease process happening at the same time that certainly warrants investigation. Any reactions to vaccinations are reported to the appropriate board.

**Dr Kidd:** In that regard, there is the rotavirus in a form that did not come to Australia. Because of very active monitoring, even though it passed through the initial safety screening that involved many young children, once it was in practice the practitioners reported some gastrointestinal problems and it became apparent that a form of rotavirus that is not used here was associated with intussusception, which is where the bowel slides over itself and it can become a surgical emergency. The rotavirus that we use here is not that one and we have very strict guidelines around what time it is given to children, because it seems that the risk is associated, to some extent, with the age they are when they have it.

**Dr Kynaston:** There is ongoing monitoring for those potential effects as well.

**Senator MOORE:** Regarding medical exemption, because that is going to be the only exemption under the new legislation, people are looking at it very carefully. There was evidence this morning that there are going to be very limited reasons for which a medical exemption would be granted. Then we had another piece of evidence that said, no, it is going to be much wider than that. That is one of the problems with these committees: you hear completely conflicting evidence and you have to work your way through it. I would like to know your view of how extensive the medical exemption should be. As a non-parent, I have not gone through this. How do you work

out a medical exemption for a baby? The first round of immunisation occurs at a very young age. How do you have the discussion and see whether there is a genuine medical exemption for a newborn?

**Dr Kidd:** There is a range of severity. As I said before, if there is an anaphylactic reaction, obviously it is life-threatening and severe, and it is incredibly rare with vaccinations. Obviously, if something like that happens, that person should not have vaccinations, although it may be a matter of trying to work on which particular thing the child might have reacted to. There are a number of different vaccines that come into play over the first year or two years of life. There are the ones that are given at birth and more are added at two months, six months and 12 months. If you can, you really want to work out which one it was and whether there is a more general problem. As I said, in my experience, there is no-one in my practice who has had that kind of severe reaction who is not having ongoing immunisations.

**Senator MOORE:** Dr Kynaston, from your experience?

**Dr Kynaston:** Not being at the forefront in terms of general practice, we only see children who may be admitted to hospital possibly after a seizure from a fever that may be around the time of immunisation. Those children are fully investigated for meningitis or encephalitis, and if there are ongoing seizures then investigations are done to try to find a cause for that underlying seizure disorder. In many cases that is what is emerging at that time, and the fever may have been a trigger. Having said that, the risk of having a fever with current immunisations is much less than it was many years ago, and also the chances of seeing a child having a dramatic colour change, which we did see in children with the older versions of pertussis immunisation, is now not seen at all.

**Senator MOORE:** The other point is in terms of family history. It has been raised that if you have a number of children and you have had an adverse effect with your first child or second child, does family history have any impact in terms of looking at whether immunisation for medical reasons would be appropriate for subsequent children?

**Dr Kidd:** Again I think that would be very rare. The anaphylactic reactions tend to be one-off, idiosyncratic things. They do not really run in families. There are things like penicillin allergies that are more common within a family, but again it is not definite. Just because one sibling has a penicillin allergy it does not mean the next one will definitely have one. It again comes back to really careful documentation about what has happened. Children can get a variety of illnesses, as Anne touched on, that are not actually related to immunisations. There can be a natural inclination, when a child is diagnosed with something or is having an ongoing problem, to try to blame something. Sometimes we will see the vaccinations being blamed because there is a need to blame something.

**Senator MOORE:** Or fear.

**Prof. Gericke:** Very often the anaphylactic reactions are not against the vaccine per se but against a substance that is part of the vaccine that is injected. I think this gets mixed up a bit in the public domain—

**Senator MOORE:** But the end result would be the same.

**Prof. Gericke:** Sometimes there are alternative vaccines available that could be used. The classic example is the influenza vaccine, which gets produced in chicken eggs. So actually it is allergies against the chicken egg protein that is the cause and not anything to do with the influenza virus used.

**CHAIR:** Is there an alternative for people in those circumstances where there is an egg allergy and that is playing out?

**Prof. Gericke:** For some there are different forms of vaccinations. For example, for polio we have different forms of vaccination available, but obviously not for all of them. For the anti HPV vaccine there are two different brands that use different mechanisms.

**CHAIR:** What is the difference between those two?

**Prof. Gericke:** They are produced by different companies—

**CHAIR:** Are there different elements that are used in the delivery of the vaccine?

**Prof. Gericke:** That is what I am saying: the vaccine itself is relatively similar except that they do not attack exactly the same sub-types of human papilloma virus, so they differ in that respect, but obviously there are differences in the production of the vaccine. So there will be different substances in both vaccines. That will be the case with other vaccines produced by different companies.

**CHAIR:** On your question, Senator Moore, on the differing accounts we had on medical exemptions, I think the specifics were around whether it had to be an anaphylactic reaction or not. Is there a view on that—I think that was certainly put by one witness—

**Senator MOORE:** That was from the second witness.

**CHAIR:** whether that is the only way of getting a medical exemption, where there has been that type of reaction.

**Senator MOORE:** Dr Kidd, what we could do for the AMA is get the Hansard record and get the AMA and the college to have a look at it. I cannot remember the actual information that was given, but the first witness was talking about the anaphylactic process and referring to the handbook and saying that was the only one. The second witness talked about a wider range in terms of how medical exemptions could be considered. I think it is a fairly important point that could be useful.

**Dr Kynaston:** There would be disease conditions, such as an underlying immune deficiency which a baby might be diagnosed as having, which might contraindicate immunisation, so that would broaden the definition.

**Prof. Gericke:** Or other severe disease. Obviously, you are not going to vaccinate a child that already has an encephalitis. You are not going to vaccinate them.

**Dr Kynaston:** A child that has leukaemia would be—

**Senator MOORE:** The *Immunisation Handbook*—

**Dr Kynaston:** A child with leukaemia would have deferred vaccinations. So there is a list of disease conditions in which we would not vaccinate.

**CHAIR:** I think it might be a good idea for that to be formally taken on notice, and if there is additional information you are able to give that would be—

**Senator MOORE:** We will ask the department as well in terms of their realm. But I think you need to see exactly what the witness said. I said I would be asking. Dr Kynaston, in your evidence you talked about the majority of families who are not conscientious objectors but are living in poverty that could be affected by the process. Do you have data to refine the statistics around who is taking up vaccinations and who is not?

**Dr Kynaston:** I can get that data for you. If I read what I actually said it was, 'The majority of families who are incompletely vaccinated are not conscientious objectors.' I do have some statistics for that—

**Senator MOORE:** That would be great.

**Dr Kynaston:** They are prone to those access barriers. And I said, 'They are more likely to be experiencing poverty or social isolation as a reason for their difficulty accessing immunisations.'

**Senator MOORE:** Can you refer us to where the database is, because we have seen the graphs that show that the people who are defined conscientious objectors are a smaller percentage of the numbers of people who are not vaccinated. What we have not got, or have not seen, are the figures that show that the people who are not taking up vaccines are in the poorest percentile. I will be asking the department the same question, but obviously there are some stats somewhere that tell us that.

**Dr Kynaston:** We can get that for you.

**Senator MOORE:** That would be great. One last question: there seems to be a lot of discussion around whooping cough that has come up consistently about the whole issue of vaccination and whooping cough. I do not want to put either of your organisations to the test, but do you have any comment around the large amount of evidence—which I am sure you have seen in what we have got—that says that vaccinations are, in fact, useless for whooping cough? I am not verballing the witnesses. It is that serious: it is useless to talk about vaccinations and whooping cough. Do you have any comment on that?

**Dr Kidd:** The pertussis or whooping cough vaccine is far from useless. It gives a high level of protection but it is not 100 per cent by any means. We have seen a problem recently with adults who have become the focus of infection. Some babies, sadly, have died where grandparents or others have had whooping cough. It is a bit like the chickenpox vaccine. It greatly enhances the immune system but a person can still catch the disease. If I can use the chickenpox example, the child who then gets a chickenpox infection after they have been vaccinated has a much smaller number of blisters and does not get the complications like the encephalitis. I have to say, from personal experience, my younger sister had a chickenpox encephalitis and it is a really devastating thing. So children are protected considerably, but not 100 per cent, by some of the vaccines.

**Dr Kynaston:** Unfortunately, the vaccines are not lifelong—in particular, the whooping cough, which is why there is the targeted immunisation of babies as early as possible at six weeks and why family contacts—particularly parents and grandparents—are offered vaccination. The incidence of children developing whooping cough having been immunised means that, unfortunately, the vaccine coverage is not 100 per cent and it does

wane. We know that, which is why we institute the vaccinations for families where there is a newborn baby coming along.

**Senator MOORE:** Dr Kidd, do the GPs follow up with adults? We have heard different evidence about how long, particularly, the whooping cough vaccination lasts. Do GPs follow up with adults naturally?

**Dr Kidd:** They are encouraged to have the discussion. For adults it is obviously a private vaccination. For a little while I think the government did subsidise it for the immediate adults in the family—the grandparents and the parents. But now for adults—outside of the parents, at least—it is a private vaccine, so obviously there is a discussion around that. GPs are encouraged to have that discussion and to try to promote that vaccination. Even for adults who get it it is a thoroughly miserable thing. They have a hacking cough that goes on for months and months. So even for their own self-interest it is worth having it, but certainly in terms of protecting babies who have not yet got adequate immunity it is imperative.

**Senator LINDGREN:** I have a question about the flu injections. Is the flu injection enough or should you have, say, the pneumonia injection after that? I know you get sick with the flu and it can cause a major issue. Is it the flu that kills or is it the pneumonia that is associated with the flu that kills? Do you need both injections?

**Dr Kidd:** It is both. There are about 3,000 deaths a year in Australia associated with influenza. A lot of those are people who have other problems. The pneumonia vaccine is certainly there as part of the national program for people over the age of 65, but anyone who has any other sort of chronic problem that could affect their immune system should certainly consider having the pneumonia vaccine even though it is not part of the national program for people who are younger. It would be a good thing to do for anyone who is particularly at risk.

**Dr Kynaston:** The pneumonia vaccine is a pneumococcal vaccine. There are other bacterial infections which can co-exist having had a previous influenza A or influenza B infection. It means that, even if you have been immunised, if you are very sick with influenza you should see your doctor as you may need oral antibiotics or hospitalisation for intravenous antibiotics.

**Senator LINDGREN:** So you would not have the two together. You would have them separately. Is the pneumonia injection as long-lasting as the influenza injection?

**Dr Kidd:** The pneumonia vaccine generally only needs to be given twice, five years apart. It is thought to be lifelong. It is mainly being used in that older population.

**CHAIR:** I might just get you to respond to some other evidence that is on the record now. There was some evidence given in earlier in relation to Gardasil. I think the specific words used were 'hundreds of deaths overseas'. Do you have any response to that?

**Prof. Gericke:** I think the Gardasil vaccine is now routinely used throughout all Western countries. So there are millions and millions of adolescent girls who have been vaccinated without any major side effects. I was a sceptic to start with because I thought the underlying studies were actually not thorough enough. They were mostly done on adult women. Very few of the studies tested the target population of girls. But now we have, as I said, millions of girls who have been vaccinated. I am very happy to have my own daughters vaccinated. We now know that the vaccine is very safe and there are no concerns.

**Dr Kidd:** Both my sons have been vaccinated as well. They are not properly in a risk group but it has been demonstrated that it greatly lowers the risk of getting oral cancers in men, so it is worth boys having it as well.

**CHAIR:** I wonder if I could get you to comment on one of the aspects of the bill. At the moment in order to meet the requirements for the extra payments immunisation is up to the age of seven and now we are talking about it being up to the age of 20. Is there a view from either of your organisations in relation to that particular change?

**Dr Kidd:** Can you restate that?

**CHAIR:** Effectively there is now a requirement in order to have the penalties or the non-payment apply up to the age of 20. I am interested in whether you have any comments on that particular aspect of the legislation.

**Dr Kidd:** If that part of it goes through, as I said, the AMA really believes that these catch-up vaccinations must be funded by the government.

**Prof. Gericke:** I do not think we have a formal position on this, but I agree. I think all vaccines should be covered by Medicare. But that is a personal opinion.

**CHAIR:** I think the actual effect of this legislation goes further. One of the things that occurs to me is that when a child is 16 adults have less and less ability to tell them what to do from a medical perspective, as you well know. So there might be some complexities there.

**Senator MOORE:** The other area I wanted to ask about was the compensation scheme. It has been raised in a couple of the submissions that if there is an element of compulsion in the vaccine process there should also be consideration of a national compensation scheme for people who have had adverse impacts. We have seen extraordinarily serious impacts in some vaccine cases. Do either of your organisations have a comment on that? One of the witnesses said that we do not have it because we have Medicare and so we have an effective health system that could pick up the needed medical support of people. I am just wondering whether either of your organisations have thought about the need for compensation if there is a serious impact.

**Dr Kynaston:** I will quote from the RACP document on immunisation. Under the heading 'Advocacy for no-fault vaccine damage compensation from Australia' it says:

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.

**Dr Kidd:** I am not aware that the AMA has a position on that particular point. But I would say personally, particularly as a Kiwi, that the ACC in New Zealand has been a great safety net for any kind of accidental harm that happens to anyone. Even a burglar falling out of a window is covered in New Zealand, so it does have some rather odd outcomes. But in an area like this I think it would be very reasonable because, if someone did have a very rare but very severe reaction, such as encephalitis, Medicare is going to cover only the medical costs. There are a whole load of other things which the national disability scheme may pick up, but I think that is an area that needs to be looked at.

**Senator MOORE:** Thank you for your comments.

**CHAIR:** I do not think we will follow you when it comes to the burglar falling out of the window, Dr Kidd! Thank you all very much for your evidence today. We appreciate it.

**Proceedings suspended from 11:47 to 13:02**

**HANSENSMITH, Ms Rebecca, Private capacity**

**HARRISON, Mr Maxwell Dulumunmun, Elder of Yuin Nation**

**HUTTON, Anthony Leigh, Private capacity**

**LAHN, Mrs Allona Arlene, Private capacity**

**PRINS, Joy, Private capacity**

**TRAFFORD, Mr Michael William, Private capacity**

**CHAIR:** Welcome. We now have another opportunity for people to give a short statement to the committee. This session will run for 25 minutes, with a strict two-minute time limit. The secretariat will signal when two minutes is up. I will then ask people to finish their sentences and then I will invite the next speaker to take the microphone.

I remind everyone that, in giving evidence to the committee, witnesses are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to the committee, and such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to the committee. I now invite Allona Lahn to address the committee.

**Mrs Lahn:** Two months after the hepatitis B vaccination, my mild eczema was out of control. I now have severe food allergies, chronic fatigue, anaphylaxis to dairy and an unknown autoimmune disease. I will not vaccinate and risk the health of my child, who has my genetic make-up, when there is no genetic or allergy testing prior to vaccination. Vaccines are not 100 per cent safe and effective; therefore the choice should be 100 per cent mine—without coercion and financial blackmail.

The government is mandating unnecessary vaccination and overvaccination of our children. There is no limit on the number or doses injected into our children. Vaccines are a one-size-fits-all disease injection, regardless of gestation period, weight, family history and health. This is bad pharmacology. No Jab, No Pay is coercion, blackmail and bullying. If you do not fully vaccinate your child, the government will bully and financially punish you, intimidate and coerce you, to vaccinate against your wishes. What a disgrace.

I want the government to: research and administer alternative, safer, non-toxic chemical- and injection-free vaccines; review whether all vaccinations in the schedule are really necessary; review whether the number of times a vaccine is administered is really necessary; give parents the options of genetic and allergy testing prior to vaccination; give parents the option of titer testing prior to booster shots to stop unnecessary vaccinations; review whether all vaccines should be mandated in this policy. Tetanus is a non-transferable disease, so why is this being mandated? I question the legalities of the policy and the financial discrimination it imposes on families. Leave conscientious objections as an exemption. Educate those with no exemption. Australia needs a vaccination court, like other countries, as a safety net for those that are injured or die from vaccines. I also want the government to assess social and personal issues from this policy such as mental health, stress, depression and anger issues. I say—and you should say—no to No Jab, No Pay. Just because we have done something one way does not mean it is the right way or the best way.

**CHAIR:** Thank you. I now invite Anthony Leigh Hutton to address the committee.

**Mr Hutton:** I believe this is compulsory vaccination by gradualism. It is coercion and threats. I know a couple who are vaccinating their child, and who would not normally get it done, because they need the money. They say a medical exemption is okay. I guess Saba Button would have a medical exemption, and maybe Kathy Watson-Jones in Melbourne with GBS after her flu shot. Both of those were flu shots, by the way—but everyone would know that. How would the parents of Saba Button know that the flu shot would cause her severe brain damage before it happened? Dr Richard Kidd mentioned the myths and realities book. Here it is here. Page 4: 'Vaccines are unsafe'. It says that it is a myth. Tell it to Saba Button's parents, Ashley Epapara, Kathy Watson-Jones in Melbourne with GBS. Page 5: 'Vaccines are not adequately tested'. I understand that they double-blind test them with adjuvants as the placebo. Not science. They talk about science. Page 10, toxic additives: formaldehyde, mercury, aluminium. Alzheimer's is increasing massively. Page 34—a myth—vaccines are linked to GBS. Talk to Kathy Watson-Jones about that being a myth. Definitely I believe those fit the definition of harm and injury in your Therapeutic Goods Act. The AMA lady earlier said that they are safe and effective. Tell that to those people who have been severely injured. Who would volunteer to have someone knowingly severely injured? I would like to know the vaccination status of all the people proposing and who are in favour of this legislation and vaccines and compulsory vaccination. I would hope that all their vaccinations are up to date. I do not agree with it.

**CHAIR:** Thank you. Just before we proceed, earlier I mentioned that we have a photographer from the *Courier Mail* and I said she would be free to take photos of senators and witnesses, unless there are objections. Are there objections from witnesses at the table in relation to photographs? There being none, I now invite Rebecca Hansensmith to address the committee.

**Ms Hansensmith:** I just want to make a couple of quick points about whether this bill will be effective. The goal of this bill is to increase vaccination rates. Obviously the Senate's job is to work out if this legislation will increase those rates. Concern has been raised about clusters of conscientious objectors like the Northern Rivers area. Have we mentioned Mr Abbott's electorate? The vaccination rate is only 85 per cent, which is a high-income group. That is lower than the Sunshine Coast rate here in Queensland. This measure is particularly punitive against lower income families. There is this idea out there that there are people receiving benefits and not vaccinating due to their disadvantageous family circumstances or forgetfulness. Where are these people? People cannot receive benefits without taking an action. Complacency is not an option. You either have to vaccinate or you actually have to take the action of submitting a conscientious objection. It was mentioned previously that the conscientious objectors are unlikely to vaccinate. It has been stated that there will be substantial cost savings from this policy. How is there going to be an increase in vaccination rates and a cost saving?

It appears that from the onset of this legislation it has been known that it will not significantly increase vaccination rates.

It is worth noting that the 95 per cent vaccination rate for effective coverage has been a moving goalpost over the years. In the 1990s, the goal was to raise it above 80 per cent. This moved to 85 per cent and then 90 per cent. Now we need 95 per cent. Where does this end? Is it worth giving up our rights as a community for something that is unlikely to improve rates? Thank you.

**CHAIR:** Thank you. I now invite Uncle Maxwell Dulumunmun Harrison to address the committee.

**Mr Harrison:** I am a Yuin man from the Yuin nation, on the far South Coast of New South Wales. I just want to thank Professor Christian Gericke for giving us all a good lead instead of pushing this way and that way, you know? He said that some of the vaccines might have just one thing in them that is causing a lot of the problems, and I know they are causing problems. I have 22 grandchildren and 24 great-grandchildren, and some of those little fellas are affected. My grandfather died at 104. My mum died at 99. Through that genealogy, through that four generations of living now, we only seem to have had this kind of thing since these jab things started happening. I do not know what you call them, but they are not right. I could remember my sister's three children that were vaccinated. The two girls passed over and the boy is now a mute. So what is in them? This is something we have to look at. This is something we have to take into consideration and look at what is in these vaccinations and whatever.

So we need good legislation on this. We need a good independent study and investigation on the vaccines, and it is a matter of looking at what is in them. That is the most important thing. I just want to thank you for allowing me to get my voice back and to be able to speak again. Cheese caused this—cheese! That can just show you that people can be so damaged by stuff going into their bodies.

**CHAIR:** You have done very well to recover, sir.

**Mr Harrison:** If cheese can do this to me, vaccines can do more damage to a little child.

**CHAIR:** Thank you. I now invite Michael Trafford to address the committee.

**Mr Trafford:** The debate about statistics is irrelevant to me. Our infant son nearly died a few hours after receiving his measles, mumps and rubella vaccination in 1994, and we now wonder what other risks and lingering effects ensued from the other vaccinations that our children received. The overwhelming public input to this committee, as I understand it from media reporting, has been against compelling vaccination due to concerns about freedom and bad health outcomes. This should not be dismissed as an unrepresentative sample or merely anecdotal evidence in favour of studies sponsored by drug companies. Families have no reason to invent or exaggerate the chronic illnesses and deaths that have followed from vaccinations.

I would like this committee to apply three principles when considering its findings. The first is that it is up to the pharmaceutical companies to demonstrate that vaccines are safe, and a good start would be by publishing what is in them. Try asking a doctor before he administers one. They do not know.

Secondly, the medical profession must show that it is necessary to give these vaccines and that they are effective. Without criticising witnesses to this committee, I note that both pharmaceutical companies and doctors have a financial interest in promoting and administering vaccines.

Thirdly, the government must not coerce people into accepting invasive medical procedures. That is the road to tyranny. Rather than forcing children to have invasive medical procedures and compensating those who have bad health outcomes, it would be better to allow people, including parents, to have freedom of choice concerning their children, and compensate or treat those who have negative health outcomes. Thank you.

**CHAIR:** I now invite Joy Prins to address the committee.

**Joy Prins:** Thank you. If vaccination worked, then those who are not vaccinated should not be an issue. Prior to having children, I saw a medical practitioner to find out if there were any possibilities of vaccinations giving my boys, now 33 and 31, epilepsy, which was raging in my family. My brother and my father had epilepsy. I have seen these fits. The answer of the practitioner was: 'Just don't give them triple antigen.' I said, 'What is that?' I had no idea. I have since looked up triple antigen. Both my boys are as healthy as anything; they never get sick. We have participated in measles parties so that they would have it and get it over and done with and create their own immune systems without being jabbed. Both my boys were not vaccinated, and I hope to hell they do not vaccinate their children. I have, in the meantime, read books on what is in these vaccinations and how many people and their babies are affected. I personally know of six babies who were born and now have epilepsy as a result of their vaccination of triple antigen. I thought we lived in a democracy. To force people into having their children poisoned—it should be a choice for each person on their own. Today, if we look at the world, it is a sicker world than ever before. We have autism at an all-time high. We have outbreaks of diabetes. Personally, I am not a medical practitioner, but the writing is on the wall that we are not getting any better with all the science available. Instead of finding out these diseases, maybe it is good to go back to the causes of disease.

**CHAIR:** I now invite Greg Beattie to address the committee.

**Mr Beattie:** Thank you once again. I will be quite brief. Before, the chair asked a very important question about the rates of severe reaction. It was a very important question for the consideration of the committee. You did not get a very good answer, but I do not blame the witnesses at the time for that. It is because there is no good data about severe reaction rates. However, I will point you to one of your submissions from a PhD immunologist, Tetyana Obukhanych. I think it is submission No. 287. In reference No. 7, she refers to a recent study on this exact question, and it found that the 12-month vaccination visit alone—there are many visits that children go for vaccination—leads to an emergency room visit for one in 168 recipients. That is quite different to the one in a million that you hear regularly.

The second point I would like to make is that our ex-PM, Tony Abbott, said that children in child care have a right to be surrounded by others who are vaccinated. That seems to be the underlying rationale of this bill. However, I would like to point out to you that there is no right. There is no human right that says you have the right to be surrounded by vaccinated people. Human rights are things like the right to education, the right to employment and the right to social security. They never involve dispensing with the rights of others. There is no human right that says you have the right to interfere with others' rights. That rationale needs to be examined very closely. Thank you.

**CHAIR:** I now invite Debbie Kemp to address the committee.

**Mrs Kemp:** Thank you. I have a vaccine-triggered autoimmune disorder which caused me suffering in the true sense for over a decade. My young, unvaccinated kids have already experienced eczema and food sensitivities. Despite the fact that good science says that autoimmune disease has a genetic component and is a contra-indication for vaccine, I cannot get a medical exemption for my kids. I am willing to forgo the \$12,000 that this legislation will cost me. My concern is the way that this legislation is spilling over into society. Enrolment in both child care and some recreational activities are demanding vaccination status.

My kids have never contracted a communicable disease and have never taken a dose of medicine, except for a little Panadol for babies, for teething pain. They are healthy. I ask: what about kids like mine, who suffer from allergies, autoimmune disorders or genetic susceptibility to vaccine injury? What about the children who have suffered a delayed vaccine reaction that was not reported? What about the children who are siblings of a child who suffered a severe and immediate reaction to a vaccine? What about the parents who have lost babies to vaccine injury; are they actually expected to have their other children vaccinated at risk watching them die too? What about women like Tanya Hammond, whose healthy husband was encouraged to be vaccinated to visit their newborn baby in the neonatal intensive care unit and who then became paralysed, and she has been caring for him full-time for the past three years? The system has deserted them.

I would also like to address the issue of harassment. I own a childcare centre which is fully compliant with legislation and regulations. At this stage, most staff and parents are unaware of my involvement in this space. Recently, I have had formal complaints filed against me to the regulatory body, I have had letters about me sent to

the judges of business awards that I was in and I have had public reviews made on my business Facebook page. These have all come from people who belong to a group that is known as the skeptics.

When I am involved with the group of people I have worked with and visited Canberra, people have been asking us, 'Where are the doctors?' I am telling you where they are: they do not want that sort of attention. Thank you.

**CHAIR:** Thank you. That concludes this part of the proceedings.

**AVENALL, Ms Katchia, Scheme Manager and Pedogical Leader, Inspired Family Day Care**

**BARKER, Dr Ruth, Parent Member, The Parenthood**

**BRIDGE, Ms Gwynn, President, Australian Childcare Alliance**

**BRISKEY, Ms Jo, Executive Director, The Parenthood**

**MINSON, Ms Anna, Executive Officer, Australian Childcare Alliance**

[13:22]

**CHAIR:** I welcome representatives from the Australian Childcare Alliance, The Parenthood, and Inspired Family Day Care. Could you please confirm that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you? Yes—I am getting nods. Thank you. The committee has received your submissions. I now invite you, if you would like to, to make short opening statements, and then we will move to questions.

**Ms Bridge:** The Australian Childcare Alliance, known as ACA, are pleased to appear before the committee today to discuss our concerns about the proposed reforms. Today I am joined by our national executive officer, Anna Minson, from our Canberra office. ACA is the national peak body representing members in the long day care, early childhood education and care—we refer to it as the ECEC—sector throughout Australia. We represent around 3,000 long day care centres across Australia. ACA has offices in Victoria, New South Wales, Queensland, South Australia and Western Australia, and representation in all states and territories.

From the outset, it is important to state our position of broad support for the intention of the reforms. I want to be very clear that we are not here to debate philosophy and values but, rather, to protect the thousands of childcare workers that we represent and stand up for the most vulnerable children in our community. It is critical to ensure that measures are put in place to protect those at the coalface of the immunisation debate.

As we have seen in the media, there is both vocal opposition to and support for increasing vaccination rates in Queensland. ACA questions whether the big stick approach by government is what is needed to encourage the parents who fail to commence the immunisation process or fail to complete the immunisation schedule for their children. ACA supports an educational program to encourage parents to immunise rather than the punitive approach outlined in this legislation. We are pleased that our colleagues from The Parenthood also support the urgent need for an educational campaign.

The common concern expressed in the inquiry submissions is that vulnerable and disadvantaged children will miss out on crucial early education and care. This is a view held almost across the board by stakeholders. Today I call on the federal government to implement a rapid awareness campaign to ensure all of those affected understand the changes and have an accessible point of contact where they can find out more. We simply cannot allow children to be excluded from an early education and care program so vital to their early years development, and our childcare centres to become a flashpoint of community dissent.

Our members have voiced their concerns over unintended consequences brought about by the simultaneous introduction of both state and federal changes from 1 January 2016. In Victoria children will be excluded from child care and early education centres if they are not immunised or granted a medical exemption. The Queensland parliament passed legislation last week that gave ECEC centres the power to refuse enrolment based on immunisation status, but we in Queensland can also accept children who are not immunised. What we are seeing with New South Wales and the other states is that there is no consistency across the states.

I note the submission from the New South Wales government highlights the additional administrative burden to be placed on childcare providers and families to ensure their records are accurately reflected on the register. Therefore, in all states except Victoria, from January 2016, unimmunised children can attend an ECEC service, but the federal government legislation is going to override all of the state legislation in that subsidies will not be offered to children who are not immunised. Conscientious objection will not be an approval for subsidy.

High-income parents may be able to afford to put their children into childcare and not receive a subsidy. In the low-income and disadvantaged communities, their children are going to be penalised, be without subsidy and without parents who can pay to put them in. Are we building another problem, where the children of more wealthy families can attend whilst children of lower income families will be penalised?

Senators, should this legislation be passed in its current form, I want to reiterate that we need a rapid and effective information strategy to ensure that parents are well informed that it is the federal government implementing the No Jab, No Pay policy and therefore no subsidy for the children, not the childcare services. We need to ensure that childcare educators on the front line are not faced with angry parents, upset community

members and vocal activists from those with an opposing view. And then there are the children—confused and not understanding why they cannot participate in an early education and care program. The federal government must lead reform and accountability.

Furthermore, I hope today the committee can provide assurance for the sector that, if childcare subsidies are removed if a child falls behind in their vaccination schedule, these small businesses are not financially penalised. I understand that there is a grace period for families to update immunisation, but my question is: if parents fail to complete the immunisation schedule, who will pay for this grace period when the subsidies are cut off, and how will this process be managed? Australian state and federal governments must protect our childcare providers financially, professionally and politically. Again, thank you for the opportunity to appear here today, and I welcome your questions.

**Ms Briskey:** Thank you, committee chair and fellow committee members, for affording The Parenthood the opportunity to come before you today and assist you in your inquiry into the Social Services Legislation Amendment (No Jab, No Pay) Bill 2015. With a national membership of over 35,000 parents, The Parenthood is Australia's leading parent advocacy and campaign organisation. We strive to give parents the opportunity to campaign and have a voice on issues that matter most to them and their kids. Several thousand Australian parents, including 1,000 from here in Queensland, have campaigned with The Parenthood to successive federal health ministers to take tough and vital action to help boost childhood immunisation rates across Australia.

That is why we were pleased to see the federal government announce its No Jab, No Pay policy earlier this year. It is great to be able to show our support here today. But this cannot be done in isolation of the education and awareness programs that are needed to support this tough and vital legislation. Immunisation has long been recognised as one of the most successful public health measures in Australia and across the world, keeping our communities healthy and protected by the reduction, and in some cases eradication, of vaccine preventable diseases. Vaccines not only help to protect us as individuals but when we are all vaccinated it helps keep contagious, life-threatening illnesses at bay.

Yet right now there are pockets of Australia, many here in Queensland, where the rates of full immunisation among children are below that which is considered safe. These rates fall short of the 95 per cent required to achieve herd immunity. What we are seeing also is an increasing trend in the number of parents who are choosing not to vaccinate their children, deciding to call themselves and identify as conscientious objectors. Unfortunately, the decision these parents make not only affects themselves and their children but affects others. It places the lives of others at risk.

In WA last year the number of measles cases was greater than in the previous three years combined. Australia has experienced one of the highest rates of whooping cough in all developed nations. Both of these are vaccine preventable illnesses. It is clear that, when herd immunity is compromised by people who do not immunise, it impacts the whole community, and this is simply not good enough in the year 2015. The people who are most at risk are children, in particular young children who are too young to be protected or those children who for medical reasons cannot be vaccinated. They depend on the rest of us. It is those children we are here today to advocate on behalf of. Any child losing their life to an illness is a tragedy; any child losing their life to a vaccine preventable illness is utterly devastating.

Catherine and Greg Hughes are the mum and dad of Riley Hughes, who just six months ago died after having contracted whooping cough. He was too young to be vaccinated. Catherine and Greg have been working with The Parenthood to increase awareness of the importance of vaccinations and the fact childhood immunisation starts before children are born, through pregnant mothers receiving the whooping cough vaccination in their third trimester. Catherine and Greg would have liked to have been here today to share their story in person but were unable to make it. They asked me to read out this statement on their behalf:

Put simply, we believe that a child's right to a life of good health, without the threat of serious preventable diseases, is more important than a parent's right to claim childcare benefits. We think this is a good policy that will benefit the majority of Australian families and, most importantly, reduce the chance of other babies and children contracting or dying from vaccine preventable diseases.

No-one knows better than Catherine and Greg, or any parent who has lost a child to a vaccine preventable disease, the devastating impact of vaccine preventable illnesses. What is heart-wrenching is the fact that Riley's death was preventable. Whooping cough can be prevented. It can be stopped.

My sincere admiration goes out to Catherine and Greg, who, despite losing their son Riley just six months ago, have not stopped campaigning to raise awareness of the importance of immunisation. Their strength and courage to help ensure no other family has to go through the pain that they have experienced is simply incredible. On behalf of thousands of Australian parents, I wish to thank them for the incredible work that they are doing in their

son's name. For Riley, for all children who have either lived through or lost a life to a preventable illness—that is why we are here, and that is why we must take tough action to help boost immunisation rates.

For us this policy simply makes sense. It demonstrates to all parents the requirement that, as members of our community, if they want their children to benefit from government support, they have to do what is right by their fellow human beings. They have to get their children fully vaccinated, like the rest of us do, in order to access taxpayer funded support payments.

As children progress through their rounds of childhood vaccinations in the years before they turn five, it is vital that we help make sure children in childcare centres are kept up to date with their vaccinations. Whilst it is important to help ensure no child is denied their right to access high-quality early education and care, we must equally ensure all children are safe whilst in child care.

That is why it is so important that an education and awareness program is rapidly introduced. As Gwynn Bridge has noted, it is vitally important that that comes with this tough and vital legislation. Parents need to have ready access to education and understanding, and access to vaccinations, to ensure that all of our children can receive the vaccinations they require and are not denied access to high-quality early learning and care. We believe that this policy will help boost immunisation rates across Australia to protect our children and the broader community against vaccine preventable diseases. Thank you for your time.

**CHAIR:** Thank you. Would you like to make an opening statement?

**Dr Barker:** No, thank you.

**Ms Avenell:** I am representing Inspired Family Day Care service. We are a private national scheme. We represent between 80 to 100 family day care educators plus their families and their children, but we are associated with a number of collegiate schemes and services that have supported my attendance today.

We strongly object to the proposal for the social services legislation amendment. We believe it is a breach of the International Covenant on Civil and Political Rights, the Convention on the Rights of the Child, and the International Covenant on Economic, Cultural and Social Rights, and that it violates informed consent by financial coercion. We believe there are alternative ways to make budget savings and to increase vaccination rates.

This policy has the very real possibility of placing families in extreme financial hardship. It has the real possibility of placing children in situations of risk. It has the very real possibility of resulting in the breakdown of families and businesses, and I have had those business owners on my telephone and at my doorstep crying because of the changes that this will bring. It has the very real possibility of creating a cycle of poverty and disadvantage among the many that it affects.

Our government acknowledges the importance of early childhood education through its generous support of education and health services to underdeveloped countries because it understands the importance of the role education plays in the economy, in socioeconomic status and in breaking the poverty cycle. So it perplexes us as to why it would withhold similar services to children in its own country. Research has shown us that the first zero to five years of life are incredibly important. This is when major synapse development occurs and key developmental skills take place as well as language development, social skills and school readiness. The government has written about just how important early years education is within the Early Years Learning Framework, the National Quality Framework and the National Quality Standard. The government also recognises this when releasing its kindergarten and early childhood packages.

Access to quality education and care services is a fundamental right of any child, regardless of personal, philosophical or religious beliefs. By refusing childcare assistance to non-vaccinated, partially vaccinated and conscientious objectors, the Commonwealth is determining who may or may not attend child care. In particular, it is further marginalising at-risk and low-socioeconomic families and creating a cycle of nonaccess to educational engagement.

There are a number of issues that we have as representatives of business owners and families, and if I may I will take a moment to reiterate them. Families that cannot afford to pay full childcare fees will leave the services, creating economic issues for the services. We have experienced a large degree of concern from both our clientele and clientele within neighbouring service schemes, which is forcing educators out of business and into financial hardship, because their client base will no longer be able to afford that service without government assistance.

Families will leave the workforce. Our service has already been advised by families in our service areas and neighbouring service areas within all of the eastern and western seaboard that they are preparing to leave the workforce in order to care for their children at home, because they will no longer be able to pay for child care. I find this in direct contradiction to the government's push and funding packages to increase parental uptake in the

workforce—so you are losing some and not gaining any others. Those that cannot afford to leave the workforce are pressuring their elderly relatives and extended family to pick up the burden, and they are often leaving the elderly, the sick or the disabled to provide care, and that really could endanger the lives of infants and children.

It is our belief—and we have begun to see it already—that there will be a rise in underground services, where 20 to 30 children may be cared for by one person at one venue in order to provide child care for working parents and an income for the carer, and this places children in danger. It places them at risk of abuse and neglect because there are no fail-safes or blue card checks and no child protection. It also ensures that pockets of the unvaccinated will routinely gather, driving down herd immunity and increasing the risk of disease outbreak. This legislation will only serve to decrease education and create a cycle of disadvantage, which in the long run will negatively affect our country's bottom budget and bottom line.

Our additional concern is for the ability for the schedule to be changed and that it can increase over time. So families that are currently within the schedule may inadvertently become objectors because a new vaccine may be added that they do not feel the need for. For example, who is to say that HPV will not become a zero to five vaccine in the future? I know it may sound a bit silly, but we do have to do think of that in the long term. I think linking social benefits to a changing schedule is dangerously unethical.

We urge you to reconsider the impact of this policy on its ability to provide all children with education and care as well as ensuring that we do not further marginalise communities and families from seeking quality education and medical services, and that means retaining the right to family benefits and assistance packages regardless of vaccination status.

**Senator MOORE:** Ms Bridge, who keeps the records of the vaccinations in child care now? Is it something that childcare providers keep?

**Ms Bridge:** We do keep them and that is mainly so that we know who is immunised and who is not. So if there is an outbreak, we know who to exclude for that period of time, and that includes our staff as well. Overall, it is down by the Child Care Management System, CCMS. We enter the child, the birth date and the CRN, and it will come back saying 'unimmunised', or they will cut the fees off and then the parent has to determine what it is.

**Senator MOORE:** Data has been mentioned a number of times this morning. You keep your records for the children who are in your centres—that is the expectation. Do you send that data off to the national people or do they have the register some other way?

**Ms Bridge:** The registers go from the doctors to the register. We are not involved in that, generally.

**Senator MOORE:** The data you are keeping now is not an element of the national register.

**Ms Bridge:** No.

**Senator MOORE:** Are you concerned that, should this legislation go through, there will be greater compliance requirements?

**Ms Bridge:** We certainly do not need more work to do.

**Senator MOORE:** Do you think you will get it?

**Ms Bridge:** No doubt there will be something. I can already see that we will have to write two weeks or four weeks before the injection is due to advise parents. We are educators of children.

**Senator MOORE:** Has the department discussed this bureaucratic responsibility with you?

**Ms Bridge:** No. There has been very little education for the services anywhere around Australia.

**Senator MOORE:** I will be asking these questions to the department later today. I just wanted to the current system clear. It is my understanding that childcare centres do keep records, but it is not the major element of your work at the moment.

**Ms Bridge:** No.

**Ms Minson:** Can I add to that. My understanding is that it is a rather complex system nationally. Child care, in the federal branch, sits under both social services and education. In the state areas, it could be health, education or social services. So there are a number of different departments operating at several layers of government, and that adds a complexity to the administration of the records.

**Senator MOORE:** Some of that is just the Constitution—the way it works. I do take the point. It has just bounced from DSS to education at the national level. It has been backwards and forwards a few times. We will be asking the department about these processes.

**Ms Minson:** Yes, not a criticism just an opportunity for streamlining.

**Senator MOORE:** It is a real element. As your submission pointed out, having different systems now and their own responsibilities for child care puts another layer of complexity onto it. I am sure they are all different.

**Dr Barker:** I believe that the immunisation histories are all held with the National Immunisation Registry, centrally.

**Ms Avenell:** Parents have to provide that enrolment at the childcare centre. They have to provide printouts of the immunisation status, their birth certificate and the enrolment documents, and the service must hold those and keep a copy.

**Senator MOORE:** Once again, it is something you do as part of your job now. But should it change, it could add another level of complexity.

**Ms Avenell:** It would. At the moment, we just need to keep the hard copies or a copy of that document. We do not have to monitor it besides in the event of an outbreak. In which case, we would have those who were immunised and not immunised and correspondence would go out to everyone.

**Senator MOORE:** That correspondence is generated by the service provider and that is part of the job now.

**Ms Avenell:** Yes, should there be an outbreak.

**Senator MOORE:** That is mainly whooping cough or flu; it is not diphtheria or polio.

**Ms Avenell:** They are also reportable items, though there have not been any reported ones.

**Senator MOORE:** That is good. Ms Avenell, you were raising serious concerns about the impact on your providers, and the same were raised by Ms Bridge. How many of your current clientele are not immunised?

**Ms Avenell:** A very large portion, depending on the state. Within pockets in, say, Mackay there is a large immunisation ratio—about 70 per cent of them are immunised. Within the broader South-East Queensland area it is much lower—I would say 40 to 50 per cent. That is of our clientele—so, a particular branch or a specified clientele in nature-based kindergartens, as well as river kinders and normal family day cares.

**Senator MOORE:** So if 40 to 50 per cent are not immunised that would have an immediate impact on each of the businesses in your area.

**Ms Avenell:** Definitely. Especially in Victoria.

**Senator MOORE:** Especially Victoria?

**Ms Avenell:** Especially in Victoria and in New South Wales. Those legislation changes are closing people down. They have started already.

**Senator MOORE:** Without compensation?

**Ms Avenell:** With no compensation, because nobody is allowed to enrol for next year, or nobody wants to enrol or continue their care program.

**Senator MOORE:** Ms Bridge, that was the same industrial or commercial issue that you had in terms of the process.

**Ms Bridge:** Yes. I think on the Sunshine Coast 85 or 86 per cent immunise there. That will have an impact on that area. Then we have areas like Cairns and up north, where there are more Indigenous children. A lot of those children are not immunised. We just think it is so wrong for them to be excluded from an early education and care setting as well. Children can go to the state schools without immunisation, but not in these early years, which the government is recognising as being so important. They are going to exclude children who need it probably more than a lot of the other children there. Everyone is sort of looking at the big argument, but the children are basically the losers in this. I agree with that.

**Senator MOORE:** Your submission talked about the fact that we are now extending the age under this legislation to 20 years, so there will be the schools' engagement as well as the childcare engagement.

**Ms Bridge:** I think that was the Family Tax Benefit Part B, if I am not wrong. Up to 19 years.

**Senator MOORE:** So it has never gone that far before?

**Ms Bridge:** No.

**Ms Avenell:** It stopped at seven previously. Now it has been increased to include the HPV. Theoretically, someone who chooses not to have the HPV when they are 14 or 12 may not be subject to the Family Tax Benefit Part B.

**Senator MOORE:** It was your submission, Ms Bridge, that talked about the need for the providers to work together in this area. Schools and childcare should be looking at this issue together rather than separately.

**Ms Bridge:** Yes.

**Senator MOORE:** You raised a concern that they could be not working as one voice.

**Ms Bridge:** That is right, but in some states I think the—

**Senator MOORE:** You are not 'presenting a united front'. Those were the words in your submission.

**Ms Bridge:** I think some of the OSHCs in some states can be included in the long day care if they are not immunised, and some cannot in others. I still need to check that out with Queensland.

**Senator MOORE:** This legislation was originally introduced into the House several months ago, and there has not been this kind of interaction with the department and your area to work this through.

**Ms Bridge:** This is why we are concerned. It is going to come in on 1 January. People are already booking children in for next year—and I notice that enrolments are not going to count; it has to be children in care. It just seems like it is going to be rushed legislation, and the children will just be spat out in the meantime. We have children now and we are going to have to stand beside their parents and say, 'Sorry, darling, you can't come anymore because you're not immunised.' Then in another 12 months we are going to have to say, 'Sorry, you can't come now because your mummy doesn't work.' We have these double whammies hitting children.

**Senator MOORE:** There is so much changing in the childcare space anyway.

**Ms Minson:** I could answer that. I think across the table—in fact, across all stakeholders—there really needs to be an education campaign and an awareness campaign around this. As Gwynn said, we are not here to debate the big issues or have a debate on philosophy. We are here to ensure that children do not slip through the cracks, that our childcare workers are protected and that our centres do not become flashpoints of community dissent, because we need to protect the children and our childcare workers. This sort of robust dialogue is absolutely critical to understand the intention of the legislation and an effective implementation, if that is the path it goes down.

**Ms Briskey:** The intention of the legislation should not be denying children access to child care but giving all children the same. So it is about ensuring that parents are aware of that and understand their obligation. Hopefully the intention of this is that children do not miss out, that their parents make the decision to vaccinate their kids and to keep all children safe.

**Senator MOORE:** A previous witness talked about personal harassment because of her position. Are any of you aware in your networks of—Ms Minson, you just used the term 'flash point of community dissent'. Are any of you aware of that occurring in the situation now? Can you tell us about it?

**Ms Avenell:** Absolutely. We have had Facebook pages updated with information that specific careers or educators have non-vaccinated children within their service. It seems to be very one-sided and we believe the medical records of the children should be private. We have had Facebook pages, we have had people pulled out or refused access because of the immunisation service and then quite some firey debates within other Facebook pages or online or cancelling advertisements based on that.

**Senator MOORE:** And you are aware of that across your network?

**Ms Avenell:** Yes, Family Day Car.

**Senator MOORE:** Ms Briskey, have you heard through your networks about the wider debate—which is a very passionate debate and we acknowledge that—being played out within the community?

**Ms Briskey:** No, I think we see the opposite side. Potentially it is firey on both sides. Those who are very passionate about being anti vaccination can say some very harsh things and can do some harsh things. So it is possibly on both sides and that is something to be mindful of, absolutely.

**Senator MOORE:** It is really one-sided.

**Ms Briskey:** No, that is right.

**Senator MOORE:** Ms Bridge, have you heard across your network?

**Ms Bridge:** Yes, we have. We have a lot of parents who, when they come to enrol, ask if there are any unimmunised children but then those parents usually ask, 'What's the process?' and we go through the exclusion process and how we monitor and so on. I imagine around Australia there would be some who would try to find a place where there are not any children immunised. But the thing that is worrying me with this debate is that, as it rolls out, if it passes in its current form, it is going to cause more angst, it is going to cause more division in the community and children are going to be separated from their peers—birthday parties and all of that. It is just not looking good for bringing our children together.

**Senator MOORE:** Do you believe this is a media-generated process? It could only be if you believe it is—

**Ms Bridge:** We do, yes.

**Ms Avenell:** I personally do. Both on and off the record, I certainly do believe that it started from that. The 'No jab, no play' media campaign has exacerbated the fear mongering, I think, on both sides—fear of damage from those who are pro choice, not necessarily anti vaccine, and those who are also pro choice or pro immunisation.

**Senator MOORE:** Ms Bridge, in your submission you talked about the issue of workforce and in terms of having a standard process about immunisation for workforce. You pointed out that in New South Wales they have a process for encouraging people working in the industry to be immunised but there is no subsidy for the staff members. I know there is a whole list of what is paid for and what is not paid for, at what agent and all those things, but you make the comment that there is no standard process for the workforce.

**Ms Bridge:** No, there is not, and likewise with children we keep a record of adult immunisation. But this is where I think we are singling out a certain group, naught to fives, because a lot of our educators and a lot of us probably do not know what immunisation we have had.

**Senator MOORE:** Not until you go overseas. It is a flash point when you go overseas, a moment when you ask those questions. I think there is an ignorance in the community.

**Ms Bridge:** There is—so that we do not know who is and who is not, but, suddenly, we are going to know who under five is not.

**Ms Avenell:** People are more fearful of going to an early childhood centre, in terms of disease outbreak, than the shopping centre. I can, pretty much, guarantee you there are probably more unvaccinated and unhealthy individuals in a shopping centre than there are in an early childhood centre, because there are very strict health policies in place. *Staying healthy* in child care, version 5, is very strict on who can and cannot come in, in terms of what they are portraying. They do not have that at a shopping centre, but nobody has that same opinion when they walk through the doors of Coles, Woolies or Myer.

**Senator MOORE:** It would be interesting to see if we tried to bring in legislation about that.

**Ms Avenell:** Yes, exactly. The very real issue we are facing is that we see children not as individuals and family members but as products, and we are seeing them without a voice. That is concerning. If this were happening in the older age group, the rollover of how we would be treating our children would be much different. I find it very disconcerting that we are looking at these children as objects and for financial gain rather than as individuals in need of an education.

**Senator MOORE:** I am not sure whether I agree with that, in terms of the motivation of the legislation. I think there is a genuine intent, with this legislation, to promote vaccination.

**Ms Avenell:** If they were really serious about this being not a budget issue but a health issue we would have nurses on staff who would be able to come into the early childhood centres and provide vaccinations or health information within those services. We are not against that. If people choose to immunise their children and if it is guaranteed because they cannot get there or they have economic issues where they cannot take a bus or book in a time, because they are working 12- or 15-hour shifts, if this were truly a legislation on increasing vaccination rates we would be looking at having nurses or doctors or people available within those service settings at a specific time to administer those shots and provide health-care packages. They are not offering that. They are just offering a budget cut.

**Senator MOORE:** It is my understanding that wrapped up in this legislation are other things, in terms of education campaigns and services. This is, again, a question, this afternoon, for the department to see where it is. As of yet, that detail is not clear but, in terms of the evidence we have, there needs to be more understanding. A lot of the submissions, today, have focused on the element of savings in the legislation and why it is savings when we should be looking at it. We will be asking the department about the other services that will be provided. It is definitely in the promotion stuff that there will be other services. We will take up that point.

**Dr Barker:** I would add one point. It is important, also, to consider the kids who do not have a voice if they have a different view from their parent to the vaccination question. There is that flip side as well.

**Ms Avenell:** I totally agree. If we are not allowing them to get education and care, they are not going to be outside of a community that is pro-choice. They are only going to be in that community and they are only going to know not to vaccinate. If we take that education and care away, it is creating a cycle. If we take the possibility of education and care away from them, they are not going to be exposed to that wider gamut of the environment.

**Dr Barker:** The other issue is that the targeting of under-fives is not because they are—as far as I see it, with the intent of the legislation—a target audience that is easy to pick on and you have them over a barrel, financially.

That is the window for starting a vaccination process, where they are more vulnerable than adults. The vaccine will take at certain points. Some of the diseases we vaccinate against carry a mortality rate. We are lucky enough not to see it, so much, in Australia because we do have vaccination processes.

In the last 20 years working as a paediatrician I have seen a big difference in the rate of serious invasive meningococcal Haemophilus disease. We do not see epiglottitis anymore. These are things that used to kill children, so it is important to—I understand it is a complex issue. I understand all the economic arguments. I understand the child-safety issues, the underground education and childcare systems. It is a complex issue. People need to realise that we vaccinate against these diseases for a reason, because some of them are lethal. I have certainly seen that in my career.

**Senator MOORE:** The highest level of vaccination is in that early range.

**Dr Barker:** You start a certain age partly because—the immunology of it is quite complex—they are susceptible and partly because you know the vaccine will take at a certain age. For example, for measles we normally vaccinate at 12 months because they have some maternal protection that lasts up until about nine months and the vaccine does not seem to be effective if you administer it very early. In an epidemic situation you can give it to kids at nine months because it gives them some protection. That is one of the illnesses that carries a mortality rate.

**Senator MOORE:** There has been a lot of concern today about the one-size-fits-all model. Please tell me if you do not want to answer this, but it has come out that our system seems to be focused on doing everything at once while the evidence says we should be looking at each vaccination separately, rather than the bucket. It really is a bucket and it is growing all the time. Is that something that you as a paediatrician have come across—how many are there?

**Dr Barker:** I have parents who say to me things like, 'I haven't vaccinated my two-year-old because I don't think their body can take it.' I have seen the very real impact of kids with pneumococcal disease and so for me, when new vaccines have come onto the market, I pay for them before they are part of the vaccination schedule because that is part of what I do for a living. I see the real diseases; I believe in the science behind it; I understand that certain people have adverse side-effects from vaccines—again it is a complex area. I hear what people say, 'I have had this experience' or 'I have had one child who has had this experience what is going to happen to the rest of the family?' There are certain unanswered questions in medicine that make it very difficult to give a blanket rule that everybody is happy with. I have not looked at what sort of guidance there is for doctors to write health exemptions, but I think that is an area that needs to be looked into.

The reason we vaccinate for so many things from such a young age is that is when those kids die from those things. There is no point in giving them the vaccine when they are 15, if they died at two. Even though it seems very overwhelming, and parents have concerns about the number of vaccines that the kids are getting, personally I believe that it is giving them really important protection. That is why I say that you can also argue that those kids with parents who have certain concerns or beliefs are not getting protection they should have been afforded. It is a very complex issue.

**Ms Minson:** Perhaps greater scrutiny through PBAC and the TGA could be one of the avenues we could pursue to give these sorts of assurances to the community: that our federal health bodies are in fact examining the individual vaccines with greater scrutiny and reacting to this sort of community comment.

**Dr Barker:** A lot of the vaccines are composite vaccines, and again the immunology of that is really complex. So, when you start talking about individual vaccines, straight up that is not possible because they are not individual vaccines—they are composite vaccines.

**Senator MOORE:** The community assurance that Ms Minson mentioned is so critical.

**Dr Barker:** Those composite vaccines are tested—they have to go through a very long process in order to demonstrate the efficacy and the relative safety. Anything that you take has a potential side-effect—anything—whether it is the baby Panadol that you take, the herbal oils you get, whatever you take.

**Ms Avenell:** But your benefits are not tied to that. I can choose to take some Panadol and my benefits are not tied to that. That is what I am debating here—not whether vaccines work or do not work. I am debating access to child care and the ability for children to access child care and that there will be real financial hardship and risks of these kids.

**CHAIR:** Thank you that has been a useful discussion.

**LEASK, Associate Professor Julie, Private capacity**

**NEWBOUND, Mrs Angela Marie, Co Convenor, Immunisation Special Interest Group, Public Health Association of Australia**

[14:05]

**CHAIR:** Welcome. Do you have any additional information about the capacity in which you appear?

**Prof. Leask:** I am representing Dr Kerrie Wiley and myself. We are both academics in the School of Public Health at the University of Sydney.

**CHAIR:** Thank you. Could you please confirm that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you.

**Prof. Leask:** Yes.

**Mrs Newbound:** Yes.

**CHAIR:** It has—thank you very much. The committee has received your submissions. Starting with Mrs Newbound, would you like to make an opening statement and then we will move to questions.

**Mrs Newbound:** Thank you. The Public Health Association of Australia is a national organisation recognised as the principal non-government organisation for public health in Australia. The Public Health Association of Australia, or PHAA, strongly supports the benefits immunisation has given to public health not only within Australia but around the world; and are advocates for appropriate policy change that strengthens Australia's vaccination program and shares the same goals as the Senate increasing immunisation rates.

The PHAA is keen to see a policy that addresses the structural and practical barriers to increasing immunisation coverage but does not support the No Jab, No Pay policy in its current form. The PHAA has a number of concerns relating to the No Jab No Pay policy and the adverse effect it will have on children. Since the family tax benefit is a payment to help with the cost of raising children using family tax benefits as the vehicle to increase immunisation rates, it is not just financially depriving parents; it will in fact deprive children. Whilst the policy is aimed at encouraging parents to immunise their children, the PHAA questions if policymakers have fully considered either the basis for or the implications of the policy.

The PHAA believes that parental concerns about vaccines should be dealt with by engaging parents with the system, not alienating them further through a measure that will be seen as coercive by them. Many parents of the undervaccinated face social, financial, psychological, physical and geographical disadvantage. The majority are not vaccine objectors. The new requirements simply stop capacity to claim objection and they do not address this group who have neither objected or fully vaccinated.

There is also a concern about the accuracy and the quality of the data upon which the requirements are enforced. The policy has used the Australian Childhood Immunisation Register, or the ACIR, data as the prime data source. The PHAA has concerns around flaws in this current system that was developed in the 1990s and is in urgent need of an upgrade.

Targeted data cleaning activities undertaken by divisions of general practice, Medicare Locals and, more recently, the primary health networks have revealed the reporting of incorrect vaccines, incorrect dose numbers, incomplete encounters and duplicate records. An example of this recently occurred in South Australia: 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.

Having an accurate data source will ensure providers identify underimmunised children quickly and manage extensive catch-up schedules efficiently and effectively. If immunisation data is not accurate and providers are under-resourced to undertake extensive history checking, there is a risk children will receive unnecessary vaccines. Although overvaccination is in most cases not harmful, the additional painful experience for the child and the taxpayer-borne cost of the vaccines are undesirable.

The policy risks contravening the Consent to Medical Treatment and Palliative Care Act, which states that valid consent should be given freely without coercion or duress, which in turn will place providers in a challenging position when confronted with aggressive parents. Part of the government's \$26 million campaign to increase immunisation rates is to develop resources and a promotional campaign. However, these resources have not yet been articulated, and the department is still preparing its communication activities. The delay in releasing resources and communication will result in an inadequate information time frame for community and providers to access and comprehend the impact of this policy. The PHAA requests that providers and parents receive adequate lead-up time before the implementation of any policy as significant as this.

Whilst the policy will persuade some parents to immunise their children, the PHAA is concerned it will drive many more vaccine-refusing parents to become more vocal and disengage from health providers and the health system. This is particularly the case as the amendment now removes the previous incentive for vaccine refusers to attend an appointment and be counselled by an immunisation provider for their objection form to be signed. The PHAA is concerned the amendment will prohibit the monitoring of conscientious objector numbers, which are important statistics for policymakers to consider when planning communication strategies. Supporting providers to assist parents to make vaccination choices through effective, non-confrontational communication is an effective strategy in increasing immunisation rates.

The PHAA hopes the committee will see an opportunity to recommend both incremental change and the addition of other approaches such as ACIR data cleaning, workforce training, addressing service delivery and access issues, and improving support measures to increase provider and consumer relationships, all of which will lead to increased immunisation rates. Thank you for your time.

**CHAIR:** Thank you.

**Prof. Leask:** Thank you very much for the opportunity to address the committee. I want to say at the outset that I share with you a desire to see high immunisation rates and protection of our nation, children and communities. With that in mind, first, before I go on, I do want to acknowledge that we sit today on Turrbal land and acknowledge any Aboriginal and Torres Strait Islander people here today.

This bill is designed to improve immunisation rates, but to understand the complexities around it it is important to understand how the current system works. I think this is missed by many people. We already have an incentive scheme for vaccination. Already childcare rebate benefit and family tax benefit part A supplement are linked to full vaccination. What we have now is an exemption for people who refuse vaccination, and to acquire that exemption they must take a form to an immunisation provider or a doctor, have a discussion about the risks of their decision, have that form signed and submit it to the Department of Social Services. That is what we have had in place since 1998 in various forms, and it has worked well. We did have immunisation rates at around 52 per cent in the nineties, when I first started studying this area, and we now have immunisation rates nationally at 92 per cent. It does vary in some regions, as you know. So, along with other measures, we have seen an improvement in vaccination rates, and we believe that the incentive scheme has made a real difference.

So what do you do when you get to a point where incentives are not working for a certain group?

What the existing scheme has taught us is that there are eight per cent who are not fully vaccinated nationally and, at the moment, 1.52 per cent register conscientious objection. That is the group who are targeted with this amendment bill. The remaining 6.5 per cent need other measures. They are already not being affected by the requirements. The measures that they need revolve around having supportive systems, reducing barriers to access, improving the reliability of our register, and strategies that are specific to Aboriginal and Torres Strait Islander communities. Reminder and recall has been shown in national and overseas studies to work to improve vaccination rates. We could be better utilising our existing register to enable reminders and recalls. Home visiting works to improve vaccination rates in that six per cent.

There are parts of this bill that are good. One of the positive flow-ons from this particular amendment, which has already passed both houses, is the expansion of the Australian vaccination register to a whole-of-life register. That will make a difference to protection of our entire community, through enabling adults and their providers to know whether they are up to date with their vaccines and, as you mentioned earlier, travel vaccines. Health will be implementing a \$6 catch-up incentive for providers to get children who are late up to date with their vaccines. That will make a difference. Expanding the requirements up to age 19 will make a difference.

The issue that I and many others close to vaccination programs and policy are concerned about is the removal of the capacity to register objection to vaccination. There will always be a group of people who refuse vaccination. You have got that idea today from people here. There will be some people who will end up vaccinating as a result of the removal of this exemption. The question is: of those eligible who are motivated by the policy, is that marginal difference worth all the negative unintended consequences that also come from this policy that you have heard highlighted today?

I believe that shutting out the exemption process is not the best way to go about this complex and very challenging problem with that under two per cent and that we need strategies that are multicomponent, that target the people at the margins of vaccine acceptance—the hesitant parents, the fence-sitters—with community-based interventions, provider-based interventions, which we are working on at the moment, incentivising the interaction between those parents and the healthcare system, which currently happens by that obligation to get their forms

signed by a provider, and looking at the prenatal environment, where parents are making decisions about vaccination, and raising awareness of the existence of adverse events clinics in the major capital cities.

If this bill goes ahead in its current form, there are a number of things that this committee should consider very carefully. First of all is a delayed start to the bill to enable the register and all the systems to be put in place before the implementation begins, because it is a very complex and very challenging change to the system. The second is to implement the findings of an audit into our register, particularly the problems with data entry and transfer of data from practice management software to the register. Because we are going to eliminate the capacity to monitor national objection to vaccination, we need to find other ways to monitor that so that we can detect early warnings of a dip in confidence and address that at local levels. A yearly monitoring of vaccine opinion among parents would be ideal, and it is not happening now. A no-fault vaccine injury compensation system, such as they have in place in 19 other countries, including the UK, the USA and New Zealand, would enable us to compensate the families where there is the extremely rare instance of long-term vaccine injury. That system has been implemented successfully in a number of other countries. Compensation happens very rarely, because vaccines are overwhelmingly safe, but there are instances where it is accepted that a vaccine is likely to have caused a very serious injury to an individual. Governments need to meet that reciprocal obligation to ensure that those citizens are looked after. I welcome any questions.

**CHAIR:** I might start where you have finished off, Professor Leask. In relation to those instances—and you address this in your submission—you talk about how rare it is and you reject claims in relation to things such as autism and diabetes and SIDS. You talk about a very limited number of adverse reactions. Are you able to talk us through what your best assessment is of the rate, either here in Australia or around the world, of serious adverse reactions?

**Prof. Leask:** I discussed this with my colleague who is a vaccinologist the other day. She specialises in vaccine safety issues. I am a behavioural researcher, so I will just qualify that. She said that the number of instances that would require compensation for serious injury each year would be between zero and less than five. That is where an independent panel has made an expert assessment of the link between the vaccine and the injury.

**CHAIR:** Are you able to talk us through the types of serious injuries we are talking about?

**Prof. Leask:** I will give you one example. Idiopathic thrombocytopenic purpura is a very rare bleeding disorder where there is an acknowledged link between vaccines and that particular outcome. Normally it resolves, but, if somebody had a head injury while they had that disorder and they developed a long-term brain injury from that, then they could be compensated. Another instance would be the new varicella zoster vaccine—the shingles vaccine—which will be implemented for older adults at the end of next year. Because it is a live vaccine, if someone were immunocompromised and accidentally given that vaccine and they acquired disseminated disease, then they would need to be compensated.

**CHAIR:** One other aspect of your submission—and we have dealt with this a couple of times today—is in relation to medical exemptions. We have heard from different experts and understand you have a particular expertise. Are you able to give your understanding of the breadth of medical exemptions? You say in your submission it is only a very narrow subset of children. We were trying to get to the bottom of this with some other witnesses, and it was not 100 per cent clear as to where the medical exemptions would start and finish at the moment.

**Prof. Leask:** It is my understanding that egg allergy has to be carefully reviewed before it is classed as a true medical exemption. Some children with an egg allergy can still have a vaccine that contains components using eggs. The other exemption that would be considered is immunocompromised children—so a child on chemotherapy—who cannot have live vaccines. But Angela is probably able to add to that.

**Mrs Newbound:** Julie is correct. It would be the cases of immunocompromised individuals not receiving live virus vaccines, for example. The medical contraindication would be for a certain period of time, so, once that individual was over their immune-suppressed disorder and assessed as well enough to receive the vaccine, they could go ahead and receive it. But certainly particular allergies to components of immunisation, if they have been known to exist and have been recorded, would also claim a medical exemption.

**Senator MOORE:** On that medical exemption: one of the things we have talked about is that your first batch of vaccines is when you are a couple of days old. How do you determine a medical exemption for a child? I do not know the answer to that question. I do not know whether you know the answer to that question. That child has no pre-existing—unless they have been diagnosed at birth with some serious condition, which does happen. How would you have a medical exemption for the first round of vaccines?

**Mrs Newbound:** In that particular vaccine we are talking about the birth dose of hepatitis B vaccine that is given within the first seven days of life. That vaccine is certainly recommended for babies that are physiologically stable to receive the vaccine in the first seven days. If this is a very premature little baby, certainly that vaccine is not going to be offered to a baby that is physiologically unstable.

**Senator MOORE:** That is a written limitation to that process?

**Mrs Newbound:** Sorry?

**Senator MOORE:** That is a written guideline for the practitioner?

**Mrs Newbound:** Yes, absolutely.

**CHAIR:** Senator Di Natale, do we have you on the line?

**Senator DI NATALE:** You do, thank you, Senator Seselja. I am just interested in a couple of things. A vaccine compensation scheme: if somebody is unlucky and experiences a serious vaccine related side effect and it is permanent, are they eligible for any sort of compensation at the moment under any scheme?

**Prof. Leask:** The question, I guess, begs the question of whether the National Disability Insurance Scheme could cover some of these instances. It is my understanding that it would not cover all instances, so that needs to be looked into further. At the moment we do not have any scheme that compensates these families, and they are left to fight it out in the courts in an adversarial system where they have to prove somebody is at fault.

**Senator DI NATALE:** Has there been any movement that you are aware of here in Australia to have such a scheme established?

**Prof. Leask:** The National Immunisation Conference run by the Public Health Association of Australia has for many years put on its resolutions the request for Australia to implement a national no-fault vaccine compensation scheme.

**Senator DI NATALE:** Is it just cost that is the barrier? I am just interested in what the potential barriers to that are, apart from cost.

**Prof. Leask:** I am not sure what the barriers are. The Department of Health might be able to better answer that. It is certainly fundable. The US have a system where they levy a certain percentage of each vaccine that is provided in the national program, and they have a surplus of money. They have compensated a number of individuals, but they have money left over from that levy. So there are different options to fund it that are highly feasible. The public health community and the immunisation research community for some years have been calling for such a scheme.

**Senator DI NATALE:** You are saying the scheme in the US is funded by a levy on vaccines, and it effectively funds the entire scheme?

**Prof. Leask:** That is correct. It more than funds the entire scheme.

**Senator DI NATALE:** Could I just ask one more question, which is, I think, directed at your objection. I take it that your specific objection is around the conscientious objector scheme provision. I think you said that that makes up about two per cent of people who do not vaccinate. Have I got the proportions correct?

**Prof. Leask:** It is 1.5 per cent who currently register vaccine objection. It reached a high of 1.79 per cent about a year ago.

**Senator DI NATALE:** I suppose the question I have—and I am not sure if you have any insight into this—

**CHAIR:** I am sorry to interrupt. Can I just clarify that number before you go ahead, Senator Di Natale. That is not of those who do not vaccinate; that is of the total cohort, is it?

**Prof. Leask:** It is of the total cohort of two-year-old children—well, of all children under seven, of all those children, 1.52 per cent have an objection registered against their name.

**CHAIR:** Proceed, Senator Di Natale.

**Senator DI NATALE:** I will just explore that further. Of that number, would you be able to hazard a guess—and I am not sure if you have done any work in this area—as to how many would be very active in their objection? There are obviously people who have a strong view that vaccination is harmful, and they would not do it under any circumstances. But, within that group that you have described, would that make up a small proportion of that number? What would you imagine the proportions to be, within that group, of people who are persuadable or open to changing their minds?

**Prof. Leask:** It is a really important question. The best proxy we have for the group who are persuadable versus the group who are not would be that, of that 1.52 per cent, about half have no vaccines recorded, so they

have refused vaccination from the start. They would be pretty hard to change. Then the remainder would be possibly amenable to having more vaccines or completing the schedule, and studies have shown that that can happen with skilled communication from a provider, particularly a GP, as you may have experienced.

That is one of our concerns about the policy, because currently, to get that exemption, they are incentivised to go to a vaccine provider and get the form signed. We know that occasionally that discussion results in a child ending up being fully vaccinated. Some parents will not do it at all, and it is a very challenging discussion for providers, but some parents end up deciding to consider some vaccines then all vaccines. We believe that positive engagement with the healthcare system is a much safer and more ethical way to address this problem than just completely alienating this 1.52 per cent.

**Senator DI NATALE:** Thank you. That is very helpful. I just want to go back to the evidence that we heard this morning. I cannot remember the name of the person, but I think they were from the Friends of Science in Medicine. One of those witnesses suggested that part of the problem is that, when you look at the outbreaks that have occurred, they are concentrated amongst people who are conscientious objectors. What do you suggest the most appropriate way of reaching out to that group and at least reaching those people who are persuadable, based on a conversation, would be, apart from those opportunistic events that occur within a general-practice setting? Can you see any other way of addressing that group?

**Prof. Leask:** Yes. First of all, I want to say that outbreaks are caused by the children of vaccine refusers but also adults who are not up to date with their vaccines who are returning from overseas. That is primarily where we get measles outbreaks—travellers who are not up to date and come back. In those communities where there is a lot of vaccine refusal, we do worry about what those outbreaks do. So, just to qualify: the outbreaks are caused by a number of factors, where adults and children are not up to date for various reasons.

In terms of swaying the people who now object to vaccination, as I said, there is always going to be a group who will not vaccinate, no matter what, but, for the people who are possibly on the fence and considering vaccination, we know from the evidence that strategies that focus at the immunisation provider level are very important. In fact, we are working on a program of support and resources to assist that process right now in our research at the University of Sydney, along with the National Centre for Immunisation Research and Surveillance.

The other strategies that could be looked at are community based interventions. Vaccine refusal is a community based phenomenon. People tend to cluster in these communities who do not vaccinate, and they share values and share beliefs about vaccines and about prevention and health. We think that it is important to prevent the parents of tomorrow becoming vaccine refusers and also to support positive advocacy within those communities for vaccination. You have heard today from some of those community groups, like the Northern Rivers Vaccination Supporters.

The other area that could be addressed is even going back to the school curriculum, reaching the parents of tomorrow with better education about vaccination within our high school curriculum. But this is a very challenging area because it is hard to unscare people, so we need to have a number of different strategies. We also need to make sure that we address the small number of health professionals who themselves are vaccine hesitant with good education, good support and good ongoing continuing education. To do that, we need to make sure that the Primary Health Networks are both incentivised and scrutinised—that they are indeed supporting that process in their regions.

So the answer is that no one thing is going to work on its own. We need multicomponent interventions that are realistic and that focus on the professional, the community level, schools and any areas where parents are shaping their decisions about vaccination.

**Senator DI NATALE:** I suppose implicit in that is accepting that, despite all of that, there will always be a small group—but, your suggestion is, much smaller than it is right now—of people who would continue to choose not to vaccinate, and we should accept that that group could be much smaller, and we would not then penalise that specific group?

**Prof. Leask:** Yes.

**Senator DI NATALE:** Thanks.

**Senator MOORE:** Thank you to both organisations for your submissions and the work you do in this field. We had a graph in earlier evidence that showed immunisation coverage for the year ending 2014. In the cohort from three to 63 months, 92.8 per cent vaccinated per schedule; 1.77 were conscientious objectors; and 6.15 were unvaccinated for other reasons. That seems to be right. My understanding is that this legislation impacts on all those who are not vaccinated. The particular impact for people who are conscientious objectors is that that

conscientious objection element has been removed in the legislation, but the change to childcare payments and family tax benefit B applies to everyone who is not vaccinated.

**Prof. Leask:** We already have links to childcare payments and family tax benefit part A supplement—linked to full vaccination or exemption. The proposed change with this legislation is removing the capacity to claim exemption—

**Senator MOORE:** Or a conscientious objection.

**Prof. Leask:** and still get the payments.

**Senator MOORE:** But the inability to have access to childcare payments relates to everybody who is not vaccinated. That is my understanding.

**Prof. Leask:** Yes, that is right.

**Mrs Newbound:** That is correct.

**Senator MOORE:** The process is still that it is that whole group, and the kinds of issues that you have been talking about from both your organisations about intensive awareness campaigns and more workforce being engaged in a very proactive way in the system would relate to all of those groups. Is that not right?

**Prof. Leask:** Yes.

**Mrs Newbound:** Yes.

**Prof. Leask:** Education and awareness are important up to a point, but what really changes vaccination rates is reminders, recalls—

**Senator MOORE:** The proactive elements.

**Prof. Leask:** and good registers that work well—we need to improve our register—so fixing up the system to make it as easy as possible to get your kids vaccinated on time.

**Senator MOORE:** And understand the process.

**Prof. Leask:** Yes.

**Senator MOORE:** We had evidence from the childcare providers earlier about some regions. Particularly they identified Aboriginal communities where people are not immunised—and I will take your point soon, Mrs Newbound, about the data accuracy. I would not imagine that all those families in the Cairns region to which the previous witness related would have formal conscientious objection documentation. I would think there would be a lot that are just not in the system.

**Prof. Leask:** That is correct. We have ascertained that you could probably add one per cent to the rate of conscientious objectors. In reality it is probably between two and three per cent, but some of them are silent objectors and they are not registering, for whatever reason.

**Senator MOORE:** They are somehow lost in the system.

**Prof. Leask:** They are not up to date, according to the register. They are within that six—

**Senator MOORE:** Mrs Newbound, a couple of the submissions mentioned the register—and I will certainly be asking the department about that, particularly in view of the recent audit that was done in that area. The way it works now is dependent on medical advice. Is that right? So the way the data is collected by the register is through the GPs or whoever is giving the immunisation—the childcare nurse or whatever. That is where it is supposed to happen.

**Mrs Newbound:** Yes, that is correct. The provider does the report to the register—

**Senator MOORE:** Case by case?

**Mrs Newbound:** Yes, case by case. And unfortunately it is just an error in data reporting, quite often. The duplication of records is often a big problem as well, particularly with children changing their names, et cetera. We have found the same child with four different immunisation records and, once we have navigated our way through that and found the right child with the record, the child was fully up to date.

**Senator MOORE:** Is that exacerbated by movement, with children moving between the different elements of their vaccination program? It is quite a big period of time—six months, 12 months, 18 months.

**Mrs Newbound:** Not necessarily, because we are dealing with a national register. States and territories report to this register, so movement is not so much of the issue—

**Senator MOORE:** I am trying to find an excuse.

**Mrs Newbound:** Yes, I know. It is very much a data entry issue, but it is also, as Julie was saying, the transfer between medical software to the register. There have certainly been hiccups along the way, where data has been submitted by the provider but it just did not make it through cyberspace to get to the register, for some reason. Those children were all identified as being not fully immunised when, in fact, they were.

**Senator MOORE:** That is going to be a threshold issue for receiving payment.

**Mrs Newbound:** Correct.

**Senator MOORE:** The detail is still unknown about how this is going to operate. People are lost in how it is going to work but there does not seem to be any clarity about appeal rights, how you are going to get it right—all of those things, all of which we will be asking the department. Whilst we cannot be certain of any register, this one is particularly questionable, I believe.

**Mrs Newbound:** I believe that, yes, there are a lot of questions to be raised about the accuracy of this particular register as it stands.

**Prof. Leask:** We have done some work looking at the accuracy of the register and we looked at the range of audits that have been done. There are very variable figures. It is estimated that between 18 per cent and about 50 per cent of those who are shown as not up to date on the register might actually be up to date. But again we urgently need a national study of children not up to date on the register to find out exactly what is going on with those children and, if they are not up to date, exactly why. The last one was done more than a decade ago.

**Senator MOORE:** Do you believe that is a resources issue, Professor?

**Prof. Leask:** There are a lot of barriers to privacy with accessing register data for the purposes of research.

**Senator MOORE:** And that is something you would be struggling with all the time in your work—

**Prof. Leask:** Yes.

**Senator MOORE:** because the data is so important to your work. But making the register accurate would seem to be a threshold statement in any of this kind of research, it would seem to me.

**Prof. Leask:** It is absolutely important, because families may be not getting their payments, even though they are actually up to date. The 1.5 per cent is going to contain people who are not affected by the loss of payments, but we do not know what proportion are. We know that that 1.5 per cent is more likely to be families on a higher income. The small group in that 1.5 per cent on lower incomes are the ones who are going to be hardest hit by the removal of payments. I would be interested to hear if the Department of Social Services has those figures available, because we have heard highly variable figures.

**Senator MOORE:** That question is on the list. We had evidence from a previous submitter who talked about the number of people on low incomes who are going to be affected. We have not been able to quantify that, so that is a question for the department.

**Prof. Leask:** If they are the ones it is going to affect, what proportion will be motivated by the potential loss of payments? Is that it going to be big enough? Is it going to be 0.1 per cent of children? Are we going to see a rise in vaccination rates of 0.1 per cent or 0.3 per cent? We do not know. That is a really crucial bit of information to judge the effectiveness of this policy in reaching our common goal, which is to improve vaccination rates.

**Senator MOORE:** And there are questions about the evaluation strategy. Is it going to be evaluated over the process? I have two more areas I want to cover. One is whether either of your organisations were involved in discussions with the department or the minister in the development of this policy.

**Prof. Leask:** Which department?

**Senator MOORE:** Any department. DSS, Health and Human Services are the main ones.

**Prof. Leask:** I have been involved in providing general advice to the Department of Health in relation to strategies to improve vaccination uptake—

**Senator MOORE:** That would be a lot of your job.

**Prof. Leask:** in my capacity as a visiting research fellow at the National Centre for Immunisation Research and Surveillance. That was in September of last year.

**Senator MOORE:** Are you aware of whether NCRIS was formally involved in any discussions with the department about this particular policy change?

**Prof. Leask:** They were asked to answer some questions in the lead-up to the announcement.

**Mrs Newbound:** I have had no communication personally. Michael Moore, the CEO of the Public Health Association, may have, but I am not aware of it.

**Senator MOORE:** My last question is about the extension of this program to young people up to 20. Do you think there would be any particular impact from that? That is a considerable extension of the ownership of records. There is also the issue of access to payments and access to out-of-school care for the adolescent group. Have you got any particular comments about that particular element of the change?

**Prof. Leask:** NSW Health have put in a submission with concerns about the transfer of data from their register of vaccines given to adolescents which could be included as potential catch-ups under the requirement within this policy which relate to vaccines for the under-fives. That is an important point. Adolescents given vaccines such as HPV are not audited under this policy. It relates to vaccines for the under-fives. But sometimes the catch-up vaccines are given in adolescence. So the recording of that vaccination status is a concern for NSW Health and they have put in a written submission in relation to that. The idea of catching up children who are undervaccinated in older childhood is a good one. There are parents who have come from overseas with kids who are on a different schedule or unvaccinated. To remind them to catch their children up is a good thing to do. It is an important thing which will help reduce disease spread, particularly with outbreaks.

But, again, you can have that catch-up program along with an exemption for people who are vaccine refusers and are not going to change. The exemption should be difficult enough to get so that it sorts out the people who are entrenched from those who are just on the fence or hesitant.

**Senator MOORE:** What does the Public Health Association think about the extension to the age of 20?

**Mrs Newbound:** We believe that it will have quite a significant impact on parents. We are unsure about the functionality of the extension to the register because that information has not really been articulated to us. If a parent comes forward and has some vaccine records that were never put onto the register when the child was much younger, is there going to be a capacity to backdate the register and add in those history statements? We are unsure of that. As I have alluded to, our fear is that parents will be coming to providers in a degree of panic saying, 'I thought they were up to date. Are they up to date?' Providers will then have to do extensive history checking to either reassure the parent or plan a catch-up program for the child. It certainly has wider implications.

Going back to your earlier point, Senator, about the transient population, the one element I could comment on there, as Julie alluded to, is the power of recall reminder systems. But unfortunately somewhere along the way permission for providers to change the address details of parents has been removed. The parents must contact the Department of Human Services—

**Senator MOORE:** Just when I think I cannot be surprised anymore! So the provider who has the record cannot change the record?

**Mrs Newbound:** That is correct.

**Senator MOORE:** The parents themselves have to change—

**Mrs Newbound:** They have to change their address details.

**Senator MOORE:** That would be under the Privacy Act.

**Mrs Newbound:** Perhaps it is. This is really problematic for a lot of families that no longer have a home telephone line. When they phone the Department of Human Services on a mobile phone they can be on hold for an hour before they actually get to speak with anybody. So a really big problem for providers of immunisation services is not being able to update that information on behalf of their clients.

**Senator MOORE:** That comes back to the possible multiple records under one name—

**Mrs Newbound:** That is correct.

**Senator MOORE:** and whether they are in New South Wales or Queensland or in a military capacity travelling around Australia.

**Mrs Newbound:** That is correct.

**CHAIR:** Thank you very much for that.

**Proceedings suspended from 14:52 to 15:07**

**HALBERT, Ms Catherine, Group Manager, Payments Policy Group, Department of Social Services**

**McNEILL, Ms Felicity, First Assistant Secretary, Department of Health**

**CHAIR:** We will recommence. I welcome the witnesses. I remind witnesses that the Senate has resolved that an officer of a department of the Commonwealth or of a state shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude questions asking for explanations of policies or factual questions about when and how policies were adopted. Knowing both of you, I am sure you are familiar with parliamentary privilege and information on the protection of witnesses and evidence. The committee has received the Department of Social Services submission. I now invite each of you to make a short opening statement and then I will move to questions.

**Ms Halbert:** The Social Services Legislation Amendment (No Jab, No Pay) Bill 2015 reinforces the Australian government's position that immunisation is an important public health measure for children, their families and the community. The aim of this policy is to further increase immunisation rates in the Australian community and, therefore, protect others' right to health by providing immunisation against infectious diseases. This new policy will tighten up the rules and reinforce the importance of immunisation and the protection of public health by providing a level of encouragement and incentive for families to more thoroughly inform themselves about the importance of immunising their children.

The government has determined that, whilst parents have the right to decide not to vaccinate their children, if they are doing so as an objector to vaccinations, their decision will mean they are no longer eligible for some government financial assistance. Importantly, an individual is not prohibited from maintaining their vaccination objection, although they will not receive some of their family assistance and will lose access to childcare benefit and childcare rebate.

The overwhelming body of medical and scientific evidence supports the promotion of vaccination for the prevention of potentially crippling, debilitating and deadly diseases. By allowing the continuation and exemption from immunisation as a vaccination objector, the government would contradict its position that immunisation is an important public health policy. The choice not to vaccinate on the grounds of vaccination objection is supported by neither public health policy nor medical research. The bill is compatible with human rights. It advances the protection of the right to physical health. To the extent that it may also limit human rights, those limitations are reasonable, necessary and proportionate.

**CHAIR:** Ms McNeill, would you like to make an opening statement?

**Ms McNeill:** We have nothing to add from the Department of Health.

**Senator MOORE:** I have a number of questions that have come up from the submissions and the evidence that we have heard today, and I thought I would start with those. One of the questions I have, generally, regards the database in terms of the numbers of families that you have modelled to be affected by this and, also, whether you have done the work by income.

**Ms Halbert:** Around 10,000 families with recorded vaccination objections are expected to lose an average of \$7,000 in childcare payments in 2016-17. Around 75,000 with around 146,000 children will not receive the FTB part A supplement in 2016-17, which is currently \$726.35 per year per child.

**Senator MOORE:** But also under potential change as well—that particular payment—under another piece of legislation.

**Ms Halbert:** A different measure? I understand, Senator Moore, that you asked earlier today what the number of conscientious objectors would be by income ranges.

**Senator MOORE:** Yes, by income.

**Ms Halbert:** We cannot actually tell you that, and I can tell you why. The ACIR system collects information on the different reasons that people might not be meeting—

**Senator MOORE:** So that is the Australian—

**Ms McNeill:** Children's Immunisation Register.

**Senator MOORE:** So the register collects on what basis?

**Ms Halbert:** It has information on the different reasons why someone might not be meeting the immunisation requirement. When it sends the message to the family payment system—it is all within DHS—all that it sends is 'met' or 'not met' the immunisation requirements. So we cannot actually tell you the conscientious objector group by income range. We could, however, give you a breakdown of all of those who have not met by age of child—

one, two and five—because that is the current arrangement. We could get the incomes for all families that have not met the immunisation requirement. We would have to do a data run—and, so, I was not able to have that for you today.

**Senator MOORE:** That would be useful. Can we also get the range of reasons? Does it give you the reason as to why they have not met?

**Ms Halbert:** You can get that from ACIR. We will not be able to line that up with the incomes.

**Senator MOORE:** If I can get what I can get, that would be really good. There have been specific questions raised about the veracity and usefulness of ACIR in terms of the data that is there, the process for collection and the interaction between the person who is supposed to be putting the record on and its interactability with the current system. Some of that was in the audit that was done on ACIR recently which raised some particular issues. Can you run as through the process with ACIR and the credibility of ACIR from the department's point of view?

**Ms Halbert:** It is probably a question for the Department of Human Services. I can really only give you information on the audit.

**Senator MOORE:** So we can actually go to human services for information on—

**Ms Halbert:** I do not know whether health can add anything to that, but I could only tell you—

**Senator MOORE:** Which department owns ACIR?

**Ms McNeill:** Human services.

**Senator MOORE:** Okay. We will put that on notice to human services. A number of witnesses have talked about that. It is, really, the basic tool for looking at a snapshot of immunisation in Australia.

**Ms McNeill:** It is. Some of the work that is going to be done as a result of the whole-of-life register work that is being funded and has been approved by the parliament to proceed next year is actually going to contribute to that. The government has heard that people have raised some concerns about the veracity of the data at times and the checking of that data. One of the measure that we will be undertaking as part of the rollout of the whole-of-life register is to provide those support officers in the states and territories to assist with that data cleansing—I guess that is the best term to use for it. As you know from my previous time in the PBS, data in is what allows for the information out. I think the previous speakers talked about this. One of things that we are looking at is the interaction between the GP software and the types of information, and some of the areas that occur there—which we have heard through the National Immunisation Committee, which ACIR has attended as well—to look at how those things can be worked not just from ACIR's perspective but also from the perspective of the software vendor sector in GPs and hospitals.

**Senator MOORE:** Is that being linked in with the e-health stuff as well?

**Ms McNeill:** The longer term vision is to ensure that it will be compatible with the e-health records in the future, yes. One of the challenges we do have at the moment is, of course, that we want the whole-of-life register, which is a really great initiative. It is something that many people have been looking at for a number of years and, with the ability to look from the time someone is born to the time that, unfortunately, they pass on, we will have that record of information. That work has to commence now, but it is all being done in full allowance for the fact that it has to be able to link into and be available through e-health records in the longer term.

**Senator MOORE:** So the work on cleansing the records and the whole-of-life process is with Human Services. The work on e-health is with Health.

**Ms McNeill:** Regarding the work that is being done on the ACIR and actually moving that to be the Australian immunisation register, it is currently 'ACIR' because it is for children. Because we are expanding the age—and allowing for the varicella vaccine for shingles also to be recorded when it comes on next year, because that is in people 70 and above—that work is being led by Health through our service provider, which is ACIR, the Department of Human Services. Some work will be done on the register that is used within schools, the HPV register, which we will need to expand to be the schools register. That work is being oversighted by Health through—we expect, shortly—tendering arrangements.

**Senator MOORE:** And that will be linked in to the states because of the link with education.

**Ms McNeill:** Yes, and that is the reason for the two registers. At the moment there are two. One of the things we find in the health system, as we know, is that you have multiple touch points as to where you access your services. With children under seven that is predominantly in the community and GP setting, and the current ACIR is targeted there. The HPV vaccine register is already targeted at the school setting, and the fact is that we will then be able to capture all the vaccinations that are occurring in the school setting. Because they are often

delivered by local government and at a different access point, we will ensure that is ready to go and then we will bring the two together.

**Senator MOORE:** So we actually have an idea. Literally, this piece of legislation is going for the childcare component, which is the one that has actually received the greatest discussion today. It is looking at 10,000 families. Is that right?

**Ms Halbert:** That is right.

**Senator MOORE:** The childcare providers who gave evidence today raised quite significant concerns about their own industry and the impact this would have, particularly for the childcare payments. What interaction has the department had with the childcare industry and the childcare providers, particularly now that child care is no longer DSS and it has now gone back to Education. What is the interaction there, Ms Halbert?

**Ms Halbert:** You will need to direct that question to the childcare area in Education. My area of the department has not had any—

**Senator MOORE:** Did it start before child care moved, a couple of weeks ago? Was it actually within DSS?

**Ms Halbert:** There are functions in the department.

**Senator MOORE:** The discussion would have been in DSS, then, before the machinery-of-government change.

**Ms Halbert:** You would have to direct that question to that area.

**Senator MOORE:** We will have to get that to child care, because there were significant concerns by childcare providers about how this legislation will impact on them. So we have done the register. We cannot do the child care. Regarding whooping cough, considerable discussions were raised this morning about the effectiveness of the whooping cough vaccine and also credibility issues around the process there, and whooping cough was used as an example. The evidence provided was that this was a useless vaccine because of the nature of the illness and the nature of the community. Where does the department of Health have the information about this whooping cough issue, because it has come up consistently in this debate? Where would I get information about the effectiveness of whooping cough vaccine?

**Ms McNeill:** There is some information that is available from the Pharmaceutical Benefits Advisory Committee. To place a vaccine on the National Immunisation Program it must be assessed for clinical effectiveness and cost effectiveness by the PBAC. They have considered the whooping cough vaccine in a number of submissions over the past three or four years during my time there with respect to looking at herd immunity and with respect to looking at the frequency of dosing, and I think, as you will recall, at the moment the government has announced that we will be adding the 18-month booster to the immunisation program. So there is a lot of information that is available on the public websites with respect to the efficacy and long-term impact of the whooping cough vaccine.

**Senator MOORE:** Right. I will go to the public website for that. It may have been useful, considering the amount of discussion on this part issue, if that had been provided to the committee, rather than referring us to a website.

**Ms McNeill:** I am very happy to provide that information.

**Senator MOORE:** We see the amount of effort that the submitters have made and when this has come up consistently it may have been useful in the department's response to go 'and on that point on whooping cough'. I will find the public website. Hep B, in terms of the process: we had this morning some direct evidence from one of our submitters about the hep B in particular in terms of the impact. It went on to talk about the adverse reactions which could be linked to the hep B vaccine. In terms of the process, the information provided by the witness was that provided in the documentation from the provider of this vaccine and it was horrific reading to see what that provider said could be possible impacts of hep B but in terms of where that links. What information does the department give back to the people who are looking at getting that vaccine to assure them that this is a straightforward and straight process?

**Ms McNeill:** Vaccine adverse events are recorded by the TGA and are reported. With respect to the hep B vaccine, in 2014-15, administered under the National Immunisation Program, we had no serious adverse events reported for the paediatric use of the hepatitis B vaccine and that was for 339,426 doses.

**Senator MOORE:** So basically when the immunisation provider is working with a parent about taking on that vaccination it would be on the basis that there has not been an adverse effect and that would counteract the concern that is in the notice by the maker of the hep B that these things could happen. When you check the

*Hansard* you will see the things on that list, according to the witness, which are quite horrific. So the doctor or the nurse would have to see—

**Ms McNeill:** Consistent with all medications, whether they be a vaccination or other form of medication, they come with consumer information which is to explain the benefits and risks of the medication being proposed to be used and we expect clinicians to explain that information to their patients or to the patients in respect of their children.

**Senator MOORE:** So the argument would be the volume base, that on that very large number of people who received a vaccine there were no adverse effects.

**Ms McNeill:** There were no significant adverse events.

**Senator MOORE:** What constitutes 'significant'.

**Ms McNeill:** Let me get the definition for you.

**Senator MOORE:** You are reading my mind, Ms McNeill.

**Ms McNeill:** Too many years together, Senator.

**Senator MOORE:** That is probably quite true.

**Ms McNeill:** Yes. I did not mean that.

**Senator MOORE:** No. I understand totally.

**Ms McNeill:** I want to make sure I get the correct medical version. I am using the one reported in Eurosurveillance:

Adverse events were categorised according to predefined criteria which include any untoward medical event that results in death, was life threatening or required hospitalisation. It also includes seizures requiring medical attendance or hospitalisation as medically important events.

**Senator MOORE:** One of the witnesses this morning was saying that from their records one in—I forget the number—

**CHAIR:** 137 attended—

**Senator MOORE:** ER after having a vaccine. It was one of the three-minute statements. The gentleman put on record that it was one in a relatively small number required an ER visit, not hospitalisation necessarily but an ER visit. It was obviously a condition that caused a parent concern enough to take their child to a hospital. That would not necessarily be captured by that definition, because that definition looks at hospitalisation.

**Ms McNeill:** No, it would be. Just to clarify, the report says, 'Emergency department and/or hospitalisation.'

**Senator MOORE:** There does not seem to be an alignment between the data that we were given on record this morning about concerns about how many people—and we will get that on *Hansard*, of course, to find the actual quote and that process there. Hep B was mentioned a number of times this morning in evidence.

**Ms McNeill:** I am very happy to look at that and get back to you on notice and correlate that.

**Senator MOORE:** I understand; that would be good.

**Ms McNeill:** It might also depend on the time period that is being reported on. As I said, I have come in with 2014-15 data. If they were talking about a previous financial year then we could have a different set of information.

**Senator MOORE:** We can follow up with the witness as well if we need more data, but it was a statement on record about ER presentations. That was true.

**CHAIR:** Just on that generally, on the severe adverse reactions you talked about for hep B, I think there were none in Australia in the last year. More broadly, with the immunisation program generally, what are the rates in Australia?

**Ms McNeill:** It is less than 0.002 per cent each year. So, in the 10.8 million doses that were administered under the National Immunisation Program in 2014-15, there were 243 serious adverse events reported.

**CHAIR:** Are you able to give us an indication of the type of events that are represented by those 243?

**Ms McNeill:** No. I can give you a breakdown by vaccine, but I cannot tell you the specificity of the type. I can happily take that for you on notice, though.

**CHAIR:** All right, that would be good. Thank you.

**Senator MOORE:** And with the breakdown of the vaccine as well to see which ones caused that from 2014.

**Ms McNeill:** I can read that out to you now if you would like.

**Senator MOORE:** In terms of this information—I know this is more looking at the data—does it vary much from year to year in terms of the numbers? That was the number in 2014, 243, but I am really interested, in view of the information we received this morning, in the number over a period of time. I would just like to get a sense of what constituted a serious adverse effect over a period of time. Can that data be given for 10 years? Could you just see whether that is available.

**Ms McNeill:** Yes, I can see how far I can do. Five years is usually achievable.

**Senator MOORE:** That would just be useful to have a picture of something that caused the circumstance you describe as a serious impact, because the evidence we have received, both in the submission and in evidence today, indicated a much wider concern about the numbers that could have this kind of reaction. If you are one of those 243, it is outrageous and one is too many. But I just want to get a sense of the numbers over 10 years—you think that is a fair snapshot. That would be good. What you can give us, that would be good, and by the process.

**Ms McNeill:** I will do my best in what I can get for you.

**Senator MOORE:** RACP actually was concerned that, under the new proposal, we are not going to be able to find out about conscientious objectors. There will be no reason, in the new system, for conscientious objectors to interact—people who actually are called conscientious objectors, rather than just labelling them as conscientious objectors—with the system, because they will not be engaged with the system because of their circumstance. The issue raised by the RACP and also by some of the researchers was that we will not know why someone has made that decision, because they will not be talking to us anymore. Ms Halbert, in the research around the process, has that been raised with the department, just in terms of getting a snapshot of the reasons that people immunise or do not immunise in our community?

**Ms Halbert:** From our perspective, with the new measure, it will not be necessary to find out if someone is a conscientious objector, because that is no longer a criterion. The other reasons that you can be exempt, the medical et cetera, I assume will still be collected by ACIR because they are required in order for people to receive their payments. In terms of your broader question about the interactions with the health system, I think that is a question for Health. But I would note that we already have a larger group of families who do not receive their FTB part A supplement or their childcare payments who have no reason recorded and are therefore also not, presumably, interacting with the health system about immunisation.

**Senator MOORE:** The evidence we have received raised concerns as to why such a detailed and, I would imagine, costly process is being focused on 10,000 objectors. Has the department done any modelling on how many of those 10,000 families they think may change their position as a result of this legislation?

**Ms Halbert:** I would note that it is not just the 10,000 families. There are 75,000 families—

**Senator MOORE:** Under the FTBA.

**Ms Halbert:** That is right.

**Senator MOORE:** I am really looking at the childcare component.

**Ms Halbert:** I understand that we have made some assumptions around whether this would change. I would have to take on notice to get the exact information.

**Senator MOORE:** That would be very useful. If you have that data on the 75,000 as well, even though that is a larger number—

**Ms Halbert:** Whatever we have we will—

**Senator MOORE:** it has a low impact, really, in terms of financial impost. The childcare payment is the big one. I would like any figures we can get. A number of submitters—in particular, the Public Health Association and some of the childcare groups—had the view that it is possible that people who are on lower incomes will be most directly impacted by this change. Within that group of people who have identified as having an objection and will lose their exclusion, the greater impact is going to be on people with lower incomes. They could not tell me where they got that data from and you cannot give that data, so I am just wondering where that comes from.

**Ms Halbert:** Of course, anybody in the full income range for FTB part A supplements will be affected by this. It is not just low-income families. I note that an estimated 3,900 FTB part A families are expected to lose their payments altogether. Mr Whitecross may have given you a complicated answer about the fact that it is rolled into the rate. So it is only the higher income earners who would lose, via losing the supplement, entitlement for FTB part A altogether.

**Senator MOORE:** The department's modelling took a few assumptions on that. If we do get that information on notice, that would be useful. Ms McNeill, one of the issues around the vaccination process that came up this morning was around one-size-fits-all. It was a term used by numerous submitters. There was concern about the

fact that increasingly, particularly for young children, there are multiple vaccinations. There was a concern that it is very hard to identify the impact and the safety of individual components because of the fact that we are now receiving vaccinations that include three or four at one time. From the Department of Health's point of view, how is safety actually assessed? They have to go through rigorous TGA process. Is the safety assessed for the multiple process or is it assessed single option by single option?

**Ms McNeill:** I would probably have to take that on notice for you, Senator, so that I do not misquote my TGA colleagues.

**Senator MOORE:** Sure—absolutely.

**Ms McNeill:** My understanding is that the entire vaccine is tested for its safety. Individual components and the vaccine are given as an entirety and often they are compared to the individual components as well. I would like to check with my TGA colleagues so that I am not misrepresenting them.

**Senator MOORE:** It was a significant issue raised by a number of people that it is all in or all out. You do not have an opportunity to say, 'I am happy for that, but I am not happy for the other.' On the register, you are either fully immunised and all the boxes are ticked or you are not. I just wanted to see, from the TGA's point of view, what the issues are. I am sure they have had how that safety is assessed raised with them before. There were some very scary figures this morning about how many individual streams of vaccination are in very young children.

**Ms McNeill:** There are, but, like I said, the serious adverse events information that we have—

**Senator MOORE:** Is on the group—

**Ms Halbert:** is on the group vaccine—the combination vaccine. I can give that to you.

**Senator MOORE:** This is quite a detailed question. You will have to take it on notice. There were particular issues raised about Gardasil. This committee has a long history of looking at the Gardasil process. It was raised by one of the submitters that Gardasil, now, is not being used in Japan and that, generally, in Japan the age of immunisations for children is not until two, so we are not in the Japanese system—we are not immunising kids at six, 12 and 18 months. The first one is at two. I just wanted to get an international snapshot, which I know your group would have.

**Ms McNeill:** We do, and I will take that one on notice because the question with respect to Japan has been asked. I think it was about two years ago. We will be able to provide that.

**CHAIR:** There was also a claim made—in relation to Gardasil—about death and whether the EU was looking at it, again, I think with the suggestion.

**Senator MOORE:** It was just a snapshot on Gardasil. Ms Halbert, we will come back to you. The component of the bill that extends the register to 20-year-olds, can you tell us what the background to that is and how that will work?

**Ms Halbert:** It relates to the eligibility of criteria for FTB part A which, from 16 years old, they are required to be in secondary education to be eligible. But you can be paid in respect of a child to the end of the year in which they turn 18, I think, in the calendar year. It just relates to the FTB part A, the eligibility criteria.

**Senator MOORE:** So there is no element of out-of-school care for adolescents; that is for the child-care component.

**Ms Halbert:** It is best directed to child care, but there is a narrow group of people who may access child care up to older age groups, such as children with disabilities, but it would be best directed to child care.

**Senator MOORE:** In terms of your department, it would be the FTB part A. Can we get the data for how many—to refine those figures, to show the impact for each age and whether it goes up or not?

**Ms Halbert:** We would have that, yes.

**Senator MOORE:** In terms of this particular process and maybe, generally, the immunisation process across the board, what is the consultation mechanism that departments use? Is there an advisory group on immunisation, generally? I know there is a national immunisation committee. How does the department—I imagine this is health—get advised about immunisation, generally, in our system?

**Ms McNeill:** There are multiple committees that provide advice in that space.

**Senator MOORE:** I imagine there would be.

**Ms McNeill:** We have ATAGI, which is the Australian Technical Advisory Group on Immunisation, which is our pre-eminent expert, in respect to immunisation. It provides advice on immunisations for consideration by the PBAC for inclusion on the National Immunisation Program.

**Senator MOORE:** Is that on the website?

**Ms McNeill:** It is.

**Senator MOORE:** Are they mainly immunologists and people of that kind?

**Ms McNeill:** Yes—paediatrics and a variety of areas.

**Senator MOORE:** Are there any consumers on that group?

**Ms McNeill:** Yes, there are. There is a longstanding consumer representation on that one as well. There are also the ones that design and modify the national *Immunisation Handbook*, the pre-eminent advice we use in advising how to use vaccines and what the schedule should be, for the administration and vaccines, and for what kind of advice needs to be provided on safety and other concerns. We then have the Pharmaceutical Benefits Advisory Committee who look at the cost effectiveness and clinical effectiveness, from the system perspective. We do have the National Immunisation Committee, which includes representations from the state and territory governments with respect to their public health immunisation areas. It includes representation from local government. It also includes representation from some peak bodies, such as the RACGP, the AMA, local government, midwives and nurse practitioner advisory representations as well.

**Senator MOORE:** Is the Public Health Association of Australia on that one?

**Ms McNeill:** Let me just check for you.

**Senator MOORE:** That is fine. I was just wondering because of their long-term interests.

**Ms McNeill:** No, they are not.

**Senator MOORE:** They run the national conferences on immunisation, which, I would imagine, would be of relevance to this area. How does the National Immunisation Committee link into ATAGI? Do they have any cross-referencing?

**Ms McNeill:** No, they do not. In respect to the advice on the immunisation schedule, ATAGI provides advice on the medical use of these immunisations and the MRC is what operationalises those recommendations on the NIP, noting that the National Immunisation Program is not just a Commonwealth program it is a states and territories program as well.

**Senator MOORE:** The National Immunisation Committee would be, hopefully, deeply involved with the review of the register and the work that is happening with all of—

**Ms McNeill:** Yes, and at their meetings they regularly invite the ACIR administrators from DHS to present and provide updates.

**Senator MOORE:** Are they the only two? The ATAGI, the National Immunisation Committee and PBAC, which is over here looking at costs. They are the two.

**Ms McNeill:** That is the technical side—the medical side—yes. And then there is the implementation side.

**Senator MOORE:** They are the people who play in the field. The focus of today's evidence has clearly been on the concerns about the impact on families and childcare centres, which we will take up with child care. But one of the other things is the expectation that the bill will have education components linked in with the funding and other elements—that the bill is wider than just this particular childcare impact it will have. My understanding was that they had an education campaign linked in with this bill in the funding as well. Am I wrong?

**Ms Halbert:** For affected families?

**Senator MOORE:** Yes.

**Ms Halbert:** That is correct, but I do not have the figure for you here. We could give you that—

**Senator MOORE:** Who is actually working on the detail of that, Ms Halbert—about how the education component will work?

**Ms Halbert:** Social Services is the lead agency, but our communications area is, of course, working closely with Health and DHS on that.

**Senator MOORE:** Where do we get detail on that? There has been a great deal of concern around education. In fact, some of the people who oppose the bill are saying that with better education and better awareness we would not need the bill—that is a wider issue and I would never ask your opinion on that—in terms of the education for the people who are involved in this process?

**Ms Halbert:** I can provide that information for you on notice.

**Senator MOORE:** It would just be good to get some detail because no-one seems to know. Certainly there have been concerns raised by people in the community and by the childcare people who are supposed to

implement this to a large extent, that they have not been engaged at all. I am very concerned about a 1 January implementation date.

**Ms Halbert:** Certainly, and of course the legislation is still before the parliament so that has been some constraint, but I can give you details around the communications.

**Senator MOORE:** That would be good—as much as we can get, because I want to put on record my concern about 1 January, particularly as over the Christmas period the last thing anyone thinks of is actually doing enrolments and getting their child care worked out. We have a dead period, for all intensive purposes, in December. We are in November now. Within that process, I would really like to have any information you can give me, some type of timeline.

**Ms Halbert:** We are certain that DHS can provide that.

**Senator MOORE:** That would be very, very useful. In terms of general information—this is a wider question about information into the community, about the importance of immunisation and how it operates—can we get some information about what is out there already? Is that you, McNeill—in terms of what we are doing now to tell people about immunisation?

**Ms McNeill:** Yes, we do have a range of communication materials already available.

**Senator MOORE:** If I put that on notice—

**Ms McNeill:** Yes, I can do that for you, and there is some additional information that is going out to accompany so that if the bill passes the parliament, it can actually go out in support of DSS's initiative with us with respect to talking to general practitioners.

**Senator MOORE:** Are you doing one and DSS is doing one as well, or is it the same education component?

**Ms McNeill:** There are different aspects. Obviously, DSS is educating with respect to this initiative, how it works and the process for undertaking that. Our focus is on the public health aspects, which is why immunisation is important if you are a general practitioner and a patient shows up and says, 'I need to check if my vaccines are up-to-date for my children'—how that will work. We will be communicating, and we are responsible for ensuring, that sufficient vaccines are available for parents who want to undertake the catch-up program, not just in the under 10s, but importantly the 10- to 19-year-olds. We are also funded to look at broader education with respect to immunisation and promoting that. As I mentioned earlier, we have the whole-of-life register, which is a fantastic opportunity in Australia from cradle to grave to look at this. There is some education that we are going on in that space, which includes research with respect to hesitant parents and what the conversations might need to be, what concerns they might have in respect of vaccination and how we can support providers in having that conversation with parents who want more information but are nervous.

**Senator MOORE:** If we can get as much detail on that on notice, and also the costing—what the budget is for that—that would be really useful.

**Ms McNeill:** Certainly. Could I also just take the brief moment: I missed one committee—you thought it was too good to be true. It is actually a very important one, particularly for this committee. The Advisory Committee on the Safety of Vaccines through the TGA. I cannot believe I forgot them, given I was going to ask them a question on notice.

**Senator MOORE:** That is a complementary committee, through another agency—the TGA?

**Ms McNeill:** It is through the TGA, which is through the department.

**Senator MOORE:** So the TGA have their own committee, which is focused on safety?

**Ms McNeill:** Safety of the vaccines, yes.

**Senator MOORE:** That would also be made up of medical practitioners?

**Ms McNeill:** Yes, they are medical practitioners.

**Senator MOORE:** Okay. Fair enough. I know there is something I have missed, but I just cannot find it.

**CHAIR:** I have some questions while you look.

**Senator MOORE:** Please, yes.

**CHAIR:** This was probably covered in Senator Moore's questioning, but I think it is important that it is crystal clear one way or another, so I might ask it again and maybe in a slightly different way—if indeed it was asked. I know there were questions around who is covered and what will change. We discussed in earlier evidence if this is just changing things for conscientious objectors, is this actually changing things for a bunch of people at the moment or are things going to be the same? Could you tell us, as clearly as possible: if this legislation passes,

does it change the situation for someone who at the moment is not immunising their children but is not a conscientious objector; they are simply not in the system and obviously may be accessing benefits like FTB and childcare benefits?

**Ms Halbert:** Families who have not lodged an objection or who will not be lodging an objection in the future but who have not met the immunisation requirement will now be affected for every year that their child does not meet those requirements. Currently, for FTB part A, the ages of immunisation—and Health can back me up or not on this—are one, two and five. For childcare benefit, they are somewhat different; it is under the age of seven, I think. In the years in between and in the years beyond that, you do not need to have met the immunisation requirement. Once the new measure comes in, until the age of 19, every year we will be—or DHS will be—checking whether you have fully met the immunisation requirement, and therefore families could lose the supplement or childcare benefits for longer periods of time.

**CHAIR:** Until they are 19?

**Ms Halbert:** That is right.

**CHAIR:** One thing we were talking earlier was the age of medical consent. When you are talking about up until the age of 19, there is a disconnect, potentially, between the decision of an individual who is not a child anymore and the effects for a family and adults. But I will not get you to go into that.

On the issue of medical exemptions, which we have dealt with a fair bit, perhaps, Ms McNeill, you could give us your understanding of how they apply at the moment.

**Ms McNeill:** Certainly. Obviously, we have the two major medical exemptions, which are, first, where it is contraindicated. I think you had witnesses talk earlier about this—for those who are immunosuppressed, who have anaphylaxis to the actual vaccine or who have an acute medical illness which prevents the vaccine being administered at that particular time. The second is where there is natural immunity, for five of the vaccines: hepatitis B, measles, mumps, rubella and varicella. So those are already in place. What we are looking to do in the changes here is to make stronger and make it clearer to medical practitioners what is an acceptable medical exemption and what is not an acceptable medical exemption. For example, egg allergy is something that people are talking a lot about, as in, 'If I have anaphylaxis, am I medically exempt,' or, 'If I just have an allergy and a rash, am I allowed to be medically exempt?' That is something that we are working through. We are consulting with the GP Roundtable, with the NIC and with DHS to finalise the medical exemption form so that it is available for next year, and a lot of that effort is very much about clarifying what is not covered as a medical exemption versus what is actually covered.

**CHAIR:** Can I just throw a couple of questions at you that I think I know the answers to but I want to get on the record, in terms of your response to some of the submissions that have been made. Some submitters have sought clarification of whether vaccines for non-communicable diseases such as tetanus will be included in the new measures.

**Ms McNeill:** No, only the vaccines that are currently on the national immunisation register. Tetanus is currently in a combination vaccine.

**CHAIR:** There were also concerns raised by some submitters about why Gardasil is on the schedule for children under the age of consent and whether this impacts on FTB part A.

**Ms Halbert:** Is the question: 'Why is Gardasil on the list?'

**CHAIR:** I think it was twofold in their submission as to why, for those under the age of consent, but, probably, more importantly in terms of this bill, does it impact on FTB part A payments, in terms of Gardasil?

**Ms McNeill:** I can answer the NIP. It is on the NIP at the age that it is recommended for, based on the advice of ATAGI and the PBAC, as the optimal time to provide that particular vaccine. Importantly, the aim of that is to give it to 12- to 14-year-olds because it is highly reliant on ensuring that it is given before sexual activity is undertaken.

**CHAIR:** Sure—and, then, in terms of clarifying the impact on FTB part A payments?

**Ms Halbert:** We take advice as to what is on the schedule and what constitutes fully meeting that requirement.

**Ms McNeill:** That is not in scope for this measure.

**CHAIR:** It is not in scope, you say?

**Ms McNeill:** No, because it is for childhood vaccinations.

**CHAIR:** Thank you for clarifying that. I do appreciate that.

**Senator MOORE:** Ms Halbert, it is my understanding that, in terms of the current process, once people have a discussion, they have a 63-day period to catch up and do what they have to do. Under the new act, how does that work?

**Ms Halbert:** That is, again, a question that should be directed to child care, but my understanding is that that continues in the new measure.

**Senator MOORE:** We will give it to child care. The catch-up schedule—is that a childcare issue as well?

**Ms Halbert:** It is a broader—because once you commence a catch-up schedule you are considered to be meeting the requirements.

**Senator MOORE:** So once you start, you make a commitment to do it. Can you tell me about the costs? That could be a health thing; it will be a health thing—how much each one costs—because it was my understanding that all the things on schedule, particularly for kids, were free.

**Ms Halbert:** So it is the older children catch-up schedule, and the younger children—and the question is, 'What do they cost?'

**Senator MOORE:** Because people talked about the costs. What are the costs?

**Ms McNeill:** Yes, I can answer that for you. If you currently get your child immunised and you follow the schedule, that is for free. If, as part of this measure, you need to undertake the catch-up program, the government will be funding those catch-up vaccinations from 1 January 2016 to 31 December 2017, and they will be made available free of charge.

**Senator MOORE:** So if you are actually in the system and catching up, because you want to be in the system, you can get that free as well—all the ones on the schedule.

**Ms McNeill:** You can. Importantly, that is one of the reasons we have been undertaking a procurement; vaccines for children under 10 in a catch-up program are the same as those already available on the National Immunisation Program. If we need to catch you up between the ages of, basically, 11 and 19 that requires a different vaccine, and we are procuring those so that those are available, again, with no additional cost to the parent.

**Senator MOORE:** Is that extra cost covered in the budget?

**Ms McNeill:** Yes.

**Senator MOORE:** There were some concerns in the submissions about the human rights compatibility. Certainly, there was one human rights statement attached to the information we got from the department, and that particular human rights committee said the bill was compatible with human rights. There were other elements about the human rights subcommittee that were mentioned in a number of the submissions, which said that the committee had concerns about the bill, and that was quoted at length in some of the submissions. Can you give us a clarification—and I am on this committee, so I should know the answer—on what the human rights committee's opinion is of this bill?

**Ms Halbert:** I have cleverly managed to leave my submission and the human rights' view on that in Canberra!

**Senator MOORE:** You can have my meditative one, Ms Halbert!

**Ms Halbert:** I just do not have my briefing on it. My understanding is that, yes, there were concerns about some of the limitations—

**Senator MOORE:** That went back to the minister.

**Ms Halbert:** That is right, and he has responded. The minister's view is, and the department's view is, that those limitations are reasonable and that the bill is compatible with human rights.

**Senator MOORE:** Basically, the original human rights subcommittee raised concerns, which were quoted in public. Those concerns went back to the minister, and the minister provided more information—the augmented ministerial response—on the basis that the human rights committee had said that the bill had passed muster.

**Ms Halbert:** That should all be on the public record, I think.

**Senator MOORE:** I wanted to get that on record, because a number of submitters had seen the first report—

**Ms Halbert:** Understood.

**Senator MOORE:** where we had raised the concerns but not the final one. The one that is attached to your submission is the final human rights committee assessment of the bill.

**Ms Halbert:** Yes.

**Senator MOORE:** Good.

**CHAIR:** That concludes our hearing. Before we finish, though—we are on a very tight time schedule and that is going to be one of the challenges. I know it will be a challenge for all witnesses, and for the department, in particular, who have taken a few things on notice. We are due to report, effectively, next Monday. As soon as you can get those answers to questions on notice—if that is able to be done in the next few days that would certainly assist the committee greatly. We understand the difficulty of that, but we are all on a very tight schedule. Thank you for that. Thank you to our departmental officials and to all other witnesses who appeared, and to the conference centre for hosting us here.

**Committee adjourned at 15:55**