



Public Health (Childcare Vaccination) and Other Legislation Amendment Bill 2015

Report No. 5, 55th Parliament
Health and Ambulance Services Committee
October 2015

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Abbreviations

ACIR	Australian Childhood Immunisation Register
ACSOV	Advisory Committee on the Safety of Vaccines
AHPPC	Australian Health Protection Principal Committee
AIH	Australian Immunisation Handbook
ATAGI	Australian Technical Advisory Group on Immunisation
Bill	Public Health (Childcare Vaccination) and Other Legislation Amendment Bill 2015
CCB	Child Care Benefit
CCR	Child Care Rebate
Committee	Health and Ambulance Services Committee
CDNA	Communicable Diseases Network Australia
Explanatory Note	Explanatory Note for the Public Health (Childcare Vaccination) and Other Legislation Amendment Bill 2015
FTB	Family Tax Benefit
GP	General Practitioner
Health Ombudsman Act	<i>Health Ombudsman Act 2013</i>
Public Health Act	<i>Public Health Act 2005</i>
Public Hearing Transcript	Public Hearing – Inquiry into the Public Health (Childcare Vaccination) and Other Legislation Amendment Bill 2015, Transcript of Proceedings, Thursday 10 September 2015
NCIRS	National Centre for Immunisation Research and Surveillance
NIC	National Immunisation Committee
NIP	National Immunisation Program
NIP Schedule	National Immunisation Program Schedule
TGA	Therapeutic Goods Administration

Chair's foreword

This report presents a summary of the Health and Ambulance Services Committee's examination of the Public Health (Childcare Vaccination) and Other Legislation Amendment Bill 2015.

The Committee's task was to consider the policy outcomes to be achieved by the legislation, as well as the application of fundamental legislative principles – that is, to consider whether the Bill had sufficient regard to the rights and liberties of individuals, and to the institution of Parliament.

The Committee received forty-five written submissions and held a public hearing, where the Committee heard further evidence from invited witnesses.

The Committee made one recommendation, that the Public Health (Childcare Vaccination) and Other Legislation Amendment Bill 2015 be passed.

On behalf of the Committee, I thank those individuals and organisations who lodged written submissions on the Bill and those who appeared at the Hearing. I also thank the Committee's Secretariat, and the Department of Health.

I commend this Report to the House.



Leanne Linard MP

Chair

Recommendations

Recommendation 1

9

The Committee recommends the Public Health (Childcare Vaccination) and Other Legislation Amendment Bill 2015 be passed.

1. Introduction

1.1 Role of the Committee

The Health and Ambulance Services Committee (the Committee) is a portfolio committee of the Legislative Assembly which commenced on 27 March 2015 under the *Parliament of Queensland Act 2001* and the Standing Rules and Orders of the Legislative Assembly.¹

The Committee's primary areas of responsibility include health and ambulance services.

Under section 93(1) of the *Parliament of Queensland Act 2001* a portfolio committee is responsible for examining each Bill and item of subordinate legislation within its portfolio areas to consider:

- the policy to be given effect by the legislation,
- the application of fundamental legislative principles, and
- for subordinate legislation – its lawfulness.

1.2 Referral

On 15 July 2015, the Minister for Health and Minister for Ambulance Services introduced the Public Health (Childcare Vaccination) and Other Legislation Amendment Bill 2015 (the Bill) into the Legislative Assembly and it was referred to the Committee for detailed consideration.

In accordance with a resolution of the Legislative Assembly on 17 July 2015, the Committee was required to report to the Legislative Assembly by 2 October 2015.

1.3 Inquiry process

On 24 July 2015, the Committee wrote to the Department of Health (the Department) seeking advice on the Bill. The Committee received written advice from the Department, dated 10 August 2015.

On 27 July 2015, the Committee wrote to stakeholders and subscribers to inform them of the inquiry and invite written submissions. Forty five submissions were received and published on the Committee's webpage. A list of submitters is at **Appendix A** to this report.

A public hearing was held on 10 September 2015, where the Committee heard further evidence from invited witnesses. The transcript of the hearing is also available on the Committee's webpage.

The Committee received further written advice from the Department, dated 16 September 2015, in response to matters raised during the hearing.

1.4 Policy objectives of the Bill

The primary objective of the Bill is to amend the *Public Health Act 2005* (the Public Health Act) to '... give the person in charge of an approved education and care service the option to refuse, cancel or place a condition on the enrolment or attendance of a child who is not vaccinated, or not up to date with their scheduled immunisations.'²

¹ *Parliament of Queensland Act 2001*, section 88 and Standing Order 194.

² Explanatory Note, page 1

Amendments to the Public Health Act are proposed to commence on 1 January 2016, to ‘... enable staff at approved services sufficient time to be appropriately informed on the requirements.’³

The Bill also contains amendments to the *Health Ombudsman Act 2013* (the Health Ombudsman Act) to provide an authorised person with the power to require a person to attend and answer questions and produce documents in relation to investigations into serious healthcare complaints and offenses under the Health Ombudsman Act.⁴

Amendments to the Health Ombudsman Act are proposed to commence on assent.⁵

1.5 Consultation on the Bill

The Explanatory Note states targeted consultation on the proposed amendments to the Public Health Act was undertaken with external industry stakeholders. The note lists the stakeholders consulted and states stakeholders ‘generally supported the amendments.’⁶

The Explanatory Note also refers to consultation with, and support from, the Health Ombudsman in relation to the proposed amendments to the Health Ombudsman Act.⁷

1.6 Should the Bill be passed?

Standing Order 132(1) requires the Committee to determine whether or not to recommend the Bill be passed.

After examination of the Bill, including the policy objectives which it will achieve and consideration of the information provided by the Department and submitters, the Committee recommends that the Bill be passed.

Recommendation 1

The Committee recommends the Public Health (Childcare Vaccination) and Other Legislation Amendment Bill 2015 be passed.

³ Department of Health, Correspondence, 10 August 2015

⁴ Explanatory Note, page 1

⁵ Department of Health, Correspondence, 10 August 2015

⁶ Explanatory Note, page 9

⁷ Explanatory Note, page 9

2. Immunisation in Australia

2.1 What do vaccination and immunisation mean?

While the terms immunisation and vaccination are often used interchangeably, they do not have the same meaning. The World Health Organisation describes vaccination as the process by which a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine. Immunisation means both being administered a vaccine, and becoming immune to a disease as a result of being vaccinated.⁸

2.2 Why do we vaccinate?

Vaccination is a key health priority of government and is generally recognised as a simple, safe and effective way of protecting people by reducing the incidence of vaccine-preventable diseases. The more people who are vaccinated against a disease, the greater the level of immunity in the community, and the fewer the opportunities the disease has to spread.⁹

The importance of vaccination was acknowledged by many submitters and was discussed at length with the Committee at the public hearing. Queensland's Chief Health Officer, Dr Jeanette Young, stated:

Immunisation has long been recognised as one of the most successful public health interventions introduced in Australia, enabling community health to be maintained and protected by reducing and eradicating vaccine preventable diseases.¹⁰

This was supported by Ms Beth Mohle, Secretary of the Queensland Nurses Union, who expressed the following similar view:

Other than clean water, vaccinations had the most significant impact on public health during the 20th century and remains one of the most important activities involving health professionals.¹¹

Dr Lee-Anne Perry of the Queensland Catholic Education Commission was equally supportive, describing vaccination as a 'critically important health measure'.¹² Beth Mohle noted that immunisation has been so successful that most people in developed countries have never seen the diseases vaccines prevent:

In many ways immunisation programs have become the victims of their own success. In industrialised countries the vast majority of the population has never witnessed the diseases that vaccines protect against. Consequently, in recent times there has been a growing resistance to such interventions. However, we know that routine childhood

⁸ <http://www.who.int/topics/immunization/en/>

⁹ <http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/about-the-program>

¹⁰ Public Hearing Transcript, page 2

¹¹ Public Hearing Transcript, page 9

¹² Public Hearing Transcript, page 28

*immunisations protect babies and children from potentially serious diseases such as measles, polio, tetanus and whooping cough.*¹³

2.3 What is conscientious objection?

While the majority of people support immunisation, some individuals hold a personal, philosophical, religious or medical belief that immunisation should not occur. This is often referred to as conscientious objection.

Currently, parents with these beliefs are able to record their objection on an approved form, which must be signed by a doctor or immunisation provider and sent to the Australian Childhood Immunisation Register (ACIR). Recording an objection in this way allows parents of an un-immunised child to meet the immunisation requirements for family assistance payments, however a child with a conscientious objection recorded on the ACIR is still considered not up to date for immunisation according to the requirements of the National Immunisation Program (NIP) Schedule.¹⁴

The Australian Government recently announced changes to these arrangements, which are to commence in January 2016 (see Part 2.6).

2.4 The Immunise Australia Program

The Immunise Australia Program implements the NIP Schedule, which currently includes vaccines against 16 diseases. The NIP Schedule lists the diseases for which immunisation is available and the ages at which the vaccines currently funded under the NIP should be given.

The Australian Government provides funding to:

- State and Territory governments – to obtain vaccines listed on the NIP Schedule, in accordance with the list of designated vaccines, as defined under the National Health (Immunisation Program – Designated Vaccines) Determination 2014 (No 1),¹⁵
- the Department of Human Services – to administer the ACIR, which records all vaccinations given to children under seven years of age, and subsidies for private consultations that involve immunisation through the Medicare Benefits Schedule, and
- the Victorian Cytology Service – to administer the National HPV Vaccination Program Register.¹⁶

The National Immunisation Committee (NIC) is responsible for overseeing the development, implementation and delivery of the Immunise Australia Program. The NIC reports to the Australian Health Protection Principal Committee (AHPPC) through the Communicable Diseases Network Australia. The AHPPC is chaired by the Chief Medical Officer and reports to the Australian Health Ministers' Advisory Council.

¹³ Public Hearing Transcript, page 9

¹⁴ <http://www.humanservices.gov.au/health-professionals/forms/immu12>

¹⁵ <https://www.comlaw.gov.au/Details/F2014L01255/Download>

¹⁶ <http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/about-the-program>

The Australian Technical Advisory Group on Immunisation provides advice to the Minister for Health on the Immunise Australia Program and other issues related to immunisation and vaccination.¹⁷

The Advisory Committee on the Safety of Vaccines advises and makes recommendations to the Commonwealth Minister for Health, and the Therapeutic Goods Administration, on the safety, risk assessment and risk management of vaccines.¹⁸

Vaccine safety and the adequacy of current arrangements was a concern for a number of submitters. This matter is discussed in further detail at Part 5.1.

2.5 Herd immunity and immunisation data

In his introductory speech, the Minister for Health and Minister for Ambulance Services touched on the concept of herd immunity, where he stated:

*Queenslanders support immunisation. This is validated by high childhood immunisation rates in Queensland of approximately 92 per cent. However, over 15,000 Queensland children aged under five are not fully immunised, which falls short of the 95 per cent target required to achieve herd immunity for diseases such as measles. Herd immunity prevents the transmission of highly contagious conditions, such as measles, and protects those who are not immunised, such as babies who are too young to be immunised and people who are immunosuppressed.*¹⁹

The term ‘herd immunity’ (or community immunity) applies when a critical portion of a community is immunized against a contagious disease, thereby protecting most members of the community against that disease because there is lesser opportunity for an outbreak. Even those who are not able to have certain vaccines (such as infants, pregnant women, or immunocompromised individuals) receive some protection because the spread of contagious disease is contained. The principle of herd immunity is applied to control of a variety of contagious diseases, including influenza, measles, mumps, rotavirus, and pneumococcal disease.²⁰

Data from the Immunise Australia Program supports the Minister’s assertion that Queensland is falling short of the 95 per cent target required to achieve herd immunity.

Childhood immunization coverage in Queensland: 1999 to 2014

Currently, 91 to 92 per cent of Queensland children in each age cohort are fully immunised. Historical data also shows that the percentage of fully immunized children in each age cohort has increased over time. For example, the immunisation rate for Queensland children aged:

- 12 to 15 months has risen from 88.19% in 1999 to a 91.53% in 2014,
- 24 to 27 months has risen from 79.58 % in 1999 to 92.36% in 2014, and

¹⁷ <http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/immunisation-advisory-bodies>

¹⁸ <http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/immunisation-advisory-bodies>

¹⁹ Minister Dick, *Hansard*, 15 July 2015, page 1349

²⁰ <http://www.vaccines.gov/basics/protection/index.html>

- 60 to 63 months has risen from 76.93% in 2005 to a high of 92.41% in 2014.²¹

Immunisation coverage of Aboriginal and Torres Strait Islander Children in Queensland: 2003-2014

The percentage of fully immunised Aboriginal and Torres Strait Islander children is lower than that of the general child population, both nationally, and in Queensland. At March 2015, the percentage of fully immunised Aboriginal and Torres Strait Islander children in Queensland was:

- 86.28% in the 12 to 15 month age cohort,
- 89.19% in the 24 to 27 month age cohort, and
- 93.23% in the 60 to 63 month age cohort.²²

Reassuringly, data for the period 2003 to 2014 shows a steady increase in coverage rates for Aboriginal and Torres Strait Islander children, both nationally, and in Queensland, among all age cohorts.²³

Conscientious objection data

The national rate of conscientious objection to immunisation has risen slightly over time, from a low of 0.23% in 1999 to a high of 1.77% in 2014.²⁴ Conscientious objection data has also been reported, on a quarterly basis, by state and territory since 31 March 2012. This data shows:

- Queensland has consistently had the highest rate of conscientious objection of all states and territories, with the rate of conscientious objection in Queensland rising from 1.92% in March 2012 to 2.17% in March 2015.
- Currently, there are 9,747 Queensland children recorded as not immunised, or fully immunised, due to conscientious objection.²⁵

2.6 Changes to Commonwealth immunisation requirements

The Australian Government has implemented a new policy which will strengthen the immunisation requirements for the following benefits and allowances – Child Care Benefit (CCB), Child Care Rebate (CCR) and the Family Tax Benefit (FTB) Part A end of year supplement.

From 1 January 2016, families with children who are not immunised (and do not have an approved exemption) will not be eligible to receive the FTB Part A end of year supplement, the CCB or the CCR. While exemptions for approved medical reasons (medical contraindication or natural immunity certified by an immunisation provider) will continue to apply, vaccine objection (conscientious objection) will no longer be an exemption category.

²¹ <http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/acir-ann-cov-hist-data.htm>

²² <http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/acir-curr-data-atsi-child.htm>

²³ <http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/acir-ann-hist-data-ATSI-child.htm>

²⁴ <http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/acir-cons-object-hist.htm>

²⁵ <http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/acir-s-t-cons-objection-data.htm>

Under the reforms, families need to have their children immunised in order to receive the FTB Part A supplement for that child. This means, for any year a child is not up to date with their immunisation, the end of year FTB Part A supplement will not be paid for that child. The supplement, which is worth up to \$726 per child, is payable at the end of the financial year.²⁶

The Australian Government will also provide \$26.4 million over four years to increase national immunisation coverage rates. While over 92 per cent of five year olds in Australia are fully vaccinated, pockets of low coverage remain, putting those communities at risk.

This initiative will:

- provide an incentive payment to immunisation providers each time they identify a child in their practice who is overdue for vaccination and call them in for catch-up vaccines,
- promote community understanding of the importance of vaccinating through a communication campaign focused on increasing awareness and understanding of the NIP and addressing parents' concerns about immunisation, including dispelling common myths, and
- include tools for doctors and nurses to help them support parents to make an informed decision about immunisation.²⁷

2.7 National Law for Education and Care Services

Australian jurisdictions have a National Quality Framework for most long day care, family day care, outside school hours' care and preschools/kindergartens which has been enacted through national scheme legislation. The system comprises the *Education and Care Services National Law* and Education and Care Services National Regulations. In effect, it is one law with some varied provisions in each state or territory.²⁸

In Queensland, the vast majority of education and care services are regulated by the *Education and Care Services National Law (Queensland)* and the Education and Care Services National Regulations 2011.

The remaining services are regulated through the *Education and Care Services Act 2013* and Education and Care Services Regulation 2013. All services approved under the National Law (Queensland) and the *Education and Care Services Act 2013* are known as 'approved education and care services' and are within the scope of the Bill.²⁹

2.8 Immunisation status under the National Law

Section 162 of the Education and Care Services National Regulations 2011 sets out the health information to be kept in the enrolment record for each child enrolled in an approved education and care service. This includes the immunisation status of the child and in New South Wales, certificates for

²⁶ <https://www.dss.gov.au/our-responsibilities/families-and-children/benefits-payments/strengthening-immunisation-for-young-children>

²⁷ [http://docs2.health.vic.gov.au/docs/doc/5D3FD1A4BA5BB2D2CA257E830023C92D/\\$FILE/1506005_August%202015%20Immunisation_news_web.pdf](http://docs2.health.vic.gov.au/docs/doc/5D3FD1A4BA5BB2D2CA257E830023C92D/$FILE/1506005_August%202015%20Immunisation_news_web.pdf)

²⁸ <http://www.acecqa.gov.au/Article.aspx?pid=51&gcpid=2&acpid=372>

²⁹ Correspondence, Department of Education and Training, 3 August 2015

immunisation or exemption, as required under the New South Wales *Public Health Act 2010*.³⁰ Tasmania has similar exemption provisions, under the Tasmanian *Public Health Act 1997* (see below).

The Education and Care Services National Regulations 2011 do not specify the type of record to be kept to prove immunisation status, nor do they provide for the exclusion of a child from enrolment if they are not immunised.

2.9 Immunisation status under Public Health legislation

A number of jurisdictions include provisions in public health legislation which require parents to provide childcare facilities and primary schools with particular information about their child's immunisation status at enrolment. In the case of Western Australia, similar provisions are included in the *School Education Act 1999*. As indicated above, some states also have exemptions to these requirements. A summary of provisions, by state and territory, is set out below.

Legislation	Immunisation status	Exemption/s
<i>Public Health Act 2010</i> (NSW)	Section 87 provides principals of childcare facilities must not permit a child to enrol unless the parent has provided a vaccination certificate. Section 86 requires principals of primary schools to ask parents to provide an immunisation certificate at enrolment.	Section 87(2) provides an exemption where an authorised practitioner has certified, in the approved form, that the child has a medical contraindication to vaccination, or their parents have a conscientious objection to vaccination. ³¹
<i>Public Health and Wellbeing Act 2008</i> (VIC)	Section 145 provides the parent of a child must give an immunisation status certificate to the person in charge of each primary school that the child is to attend. ³²	-
Public Health Regulation 2000 (ACT)	Section 8 (1) requires the person in charge of a kindergarten or primary school to require a parent or guardian to provide an immunisation record which states the immunisation status of their child for each vaccine preventable disease on enrolment to a kindergarten or primary school, or a statutory declaration which states that their child has or has not been immunized, or that they do not know, prior to their child's attendance at a kindergarten or primary school. Section 8(2) requires the person in charge	-

³⁰ Education and Care Services National Regulations 2011, s.162 (f); *Public Health Act 2010*, s. 87(1)-(3)

³¹ <http://www.legislation.nsw.gov.au/maintop/view/inforce/act+127+2010+cd+0+N>

³² <http://www.legislation.vic.gov.au/>

	of a preschool or childcare centre to provide for inspection, and give a copy of, an immunisation record setting out the immunisation status of the child for each vaccine preventable disease. ³³	
<i>Public Health Act 1997 (TAS)</i>	Section 58 (1) (a) requires a person in charge of a school or child care facility to require a parent or guardian of a child to produce an immunisation certificate prior to attendance.	Section 58 (1) (b) and (c) provide exemptions where the parent or guardian of the child provides a statutory declaration stating that they have a conscientious objection to immunization or that they believe the child has been immunised against that disease but cannot produce any immunisation certificate or other proof. ³⁴
<i>School Education Act 1999 (WA)</i>	Section 16(1)(f) provides that a person who applies for enrolment at a school is to provide the vaccination status of the enrollee. Section 16(2) provides that the principal may require supporting, documentary evidence. ³⁵	-

The Committee is not aware of any legislative requirement in Queensland, Northern Territory or South Australia for persons in charge of childcare facilities and primary schools to require parents to provide information about their child's immunisation status at enrolment.

³³ <http://www.legislation.act.gov.au/sl/2000-1/current/pdf/2000-1.pdf>

³⁴ http://www.thelaw.tas.gov.au/tocview/content.w3p;cond=;doc_id=86%2B%2B1997%2BAT%40EN%2BSESSIONAL;histon=;prompt=;rec=0;term=

³⁵ http://www.slp.wa.gov.au/legislation/statutes.nsf/main_mrttitle_878_homepage.html

3. Former Committee Inquiry

In May 2013, Mrs Jo-Ann Miller MP, Member for Bundamba, introduced the Public Health (Exclusion of Unvaccinated Children from Child Care) Bill 2013 into the 54th Parliament as a Private Members' Bill. The Bill was referred to the former Health and Community Services Committee (the former committee) for examination and report.

While the 2013 Bill was not the same as the current Bill under consideration, it had the same primary objective as the current Bill, that is:

*... to amend the Public Health Act 2005 to give the person in charge of an approved education and care service the option to refuse, cancel or place a condition on the enrolment or attendance of a child who is not vaccinated, or not up to date with their scheduled immunisations.*³⁶

3.1 Former Committee report and recommendations

The former committee tabled its report on the 2013 Bill on 26 September 2013, recommending that Bill not be passed.³⁷ Despite this recommendation, the former committee made a number of substantive comments, in its report, about the future policy and legislative context of immunisation, including:

- any legislative mechanism to facilitate excluding an unvaccinated child from child care should be consistent with the range of age appropriate vaccination in the NIP Schedule and allow for exemption on the grounds of informed conscientious objection (philosophical, religious or medical) to immunisation,
- there would be value in the government reviewing the NIP Schedule and improving its accessibility,
- the right of parents to make a decision about immunisation must be balanced against the benefits of immunisation and the importance of protecting the community, and
- there were alternative approaches to increasing immunisation that could be taken which would have fewer unintended impacts on children and their rights to education and/or that would better mitigate the risk of unintended consequences.

These matters, and how they are addressed in the current Bill, are discussed further in Parts 4 and 5 of this Report.

Although the 2013 Bill was voted down at the end of the second reading debate on 12 February 2014, the former committee made two further recommendations in its report:

Recommendation 2: In light of the concerns about the current [2013] Bill, the committee recommends that the Legislative Assembly consider supporting any future Bill that would encourage parents to ensure that children are appropriately vaccinated on entry to child

³⁶ <http://www.parliament.qld.gov.au/documents/committees/H CSC/2013/PHunvaccinatedchildren/rpt-029-26Sep2013.pdf>

³⁷ <http://www.parliament.qld.gov.au/documents/committees/H CSC/2013/PHunvaccinatedchildren/rpt-029-26Sep2013.pdf>

care. Any such legislation should include provision for medical exemption and informed conscientious objection (philosophical, religious or medical), with an emphasis on ensuring that parents are provided with education and information on immunisation.

Recommendation 3: The committee recommends that the Minister for Health consider implementing a well-planned, multifaceted and ongoing public education campaign about the benefits of childhood immunisation, particularly in localities where immunisation rates are low.

3.2 How the 2013 Bill recommendations have been addressed

The Committee is confident from evidence received during the course of its inquiry that the concerns expressed about the 2013 Bill have been addressed. The current Bill will support parents to ensure their children are appropriately vaccinated before entering child care, and the Committee has therefore recommended the Bill be passed.

The Committee notes that while the Bill does not provide for informed conscientious objection, it does so on the basis that changing federal arrangements mean that there is no longer a status of conscientious objection, or a process to register and manage those children whose parents choose not to vaccinate them on such grounds (see earlier at Parts 2.3 and 2.6).³⁸

The then Minister for Health supported the third recommendation, to implement a well-planned, multifaceted and ongoing public education campaign about the benefits of childhood immunisation, particularly in localities where immunisation rates are low.

The current Minister for Health and Minister for Ambulance Services stated that prior to the [2015] Bill's introduction, Queensland Health had commenced a public education campaign, using social media, proactive and reactive print media, direct mail to parents of under-immunised children, print and online information and resources and local immunisation promotion.

The Minister advised the Department of Health was developing a strategy for Queensland's Immunisation Program, which would support families to make informed decisions about immunisation and be confident in the benefits it provides.

Key campaign messages include the risks of not immunising. Messaging was also to be targeted at vulnerable groups, including parents of under-immunised children, including Aboriginal and Torres Strait Islander children, whose vaccination coverage at 12 months of age is five per cent lower than the State average, and areas of low coverage.³⁹

³⁸ Public Hearing Transcript, page 4

³⁹ <http://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2013/5413T4190.pdf>

The 2015-16 Service Delivery Statement for Queensland Health indicates the communication strategy continues to be a priority of the current government:

... internally reallocating \$2.7 million over three years (including 1.1 million in 2015-16) to provide a comprehensive communication strategy to support amendments to vaccination legislation that would give the person in charge of an early childhood education and care service the option to refuse to allow children who are not fully immunised to enrol in the early childhood facility or to participate in activities or services provided by the facility.⁴⁰

The Committee heard extensive testimony from Queensland's Chief Health Officer, Dr Young, during the public hearing on the Bill, about work the Department is undertaking in this area.

Dr Young described the 'Drive to 95' initiative, which will commence on 1 October 2015, three months prior to the proposed commencement date of the vaccination provisions. Under that initiative, the Department will use the 13HEALTH line to contact the family of every child under 5 who is not fully immunised, to provide information on immunisation and encourage them to talk to their General Practitioner (GP). Dr Young noted there is a small group of families who do not have a GP, and that 'GPs have come forward and are willing to assist us in providing clinics to assist that group.'⁴¹

Dr Young spoke about the establishment of a specialist clinic at the Lady Cilento Hospital, to assist people who have a serious side effect to a vaccine '... because with a lot of vaccines you do need two or three doses for it to be efficacious or you need booster shots—so they can have that vaccine in a safe, protected environment.'⁴² The clinic will also support parents who think their child has a medical contraindication to a vaccine, by allowing them to see experts in the field and be vaccinated in a highly supported environment. Dr Young advised:

We are going through a lot of strategies at the moment to try to assist parents. We are not just putting this in as a single strategy. It is all about working together, and we think with all of these things working together we genuinely aim to get to a rate of 95 per cent.⁴³

Dr Young also spoke of encouraging vaccination among older communities, and advised the Committee that the department is currently evaluating a program which successfully trialled vaccinating adults in pharmacies.⁴⁴

⁴⁰ Service Delivery Statements, Queensland Health, 2015-16, page 7

⁴¹ Public Hearing Transcript, page 5

⁴² Public Hearing Transcript, page 7

⁴³ Public Hearing Transcript, page 3

⁴⁴ Public Hearing Transcript, page 5

4. Vaccination amendments to the *Public Health Act 2005*

Part 2 of Chapter 5 of the Public Health Act makes provisions about managing outbreaks of contagious conditions in schools and approved education and care services. These include:

- Requiring teachers and educators to advise the person in charge of the service if they suspect a child has a contagious condition, which other children may be at risk of contracting (s 162), and requiring the person in charge to advise the child's parent (s 163).
- Authorising the person in charge of the service to direct the parents of a child who has not been vaccinated for a vaccine-preventable condition to remove the child and not send them back for a prescribed period (ss 164-166).
- Authorizing the chief executive to arrange for a doctor to examine some or all of the children attending the service to decide whether the children have, or may have, the contagious condition (s 167-168) and to direct the person in charge of the service to direct the parent of a child who has, or may have a contagious condition, to remove the child and not send them back for a prescribed period (s 169).

The list of contagious conditions and prescribed periods is set out in Schedule 2A of the Public Health Regulation 2005. Part 2 of the Schedule lists vaccine preventable conditions. The only vaccine-preventable condition currently specified in Part 2 is measles. The Explanatory Note states amendments to the regulation are proposed to list all necessary vaccine-preventable conditions relevant to the Bill.⁴⁵

4.1 The effect of the Bill

The Public Health Act does not require parents to provide information about their child's immunisation status at enrolment, or empower those in charge of a service to refuse to enrol a child, or place conditions on their attendance or enrolment, if they are not immunised.

The Bill proposes to amend the Public Health Act to give the person in charge of an approved education and care service the option to refuse, cancel or place a condition on the enrolment or attendance of a child who is not vaccinated, or not up to date with their scheduled immunisations.⁴⁶

The Explanatory Note accompanying the Bill states that by empowering approved services in this way it will protect children, their families and those who work with children against vaccine-preventable conditions.⁴⁷

4.2 New division and definitions

Clause 5 of the Bill contains a new division: *Division 1AA Exclusion of unvaccinated children from particular services*, for insertion into chapter 5, part 2 of the Public Health Act. The new division includes definitions (s 160), exclusion actions that can be taken before enrolment (s 160B) and after enrolment (s 160C) and the status of children without an immunisation statement (s 160D).

⁴⁵ Explanatory Note, page 3

⁴⁶ Explanatory Note, page 1

⁴⁷ Explanatory Note, page 4

Clause 4 of the Bill proposes to amend section 158 of the Public Health Act to insert a range of new definitions for the new Division 1AA, each of which is defined by reference to the new section 160A.

4.3 Key terms

Key terms, and their definitions in section 160A of the Bill and related legislation (including the Public Health Act, the *Education and Care Services National Law (Queensland)* and the *Education and Care Services Act 2013*) are set out below:

- *Immunisation history statement* means an immunisation history statement as recorded on the Australian Childhood Immunisation register (ACIR), kept under section 46B of the *Health Insurance Act 2103* (Cwth), or a statement about a child's immunisation history given by a recognised immunisation provider (s 160A).
- *Immunisation status 'up to date'* means, for each vaccine-preventable condition, a child is age-appropriately immunised for the condition in accordance with the recommendations stated in the Australian Immunisation Handbook (AIH), or is following an approved immunisation catch-up schedule for the conditions developed by a recognised immunisation provider in accordance with the AIH, or has an exemption for a vaccine for the condition given by a recognised immunisation provider because of a medical contraindication to vaccination (s 160A).
- *Approved education and care service* means both an approved education and care service under the *Education and Care Services National Law (Queensland)* and a QEC approved service under the *Education and Care Services Act 2013* (see Part 4.8).
- *Parent* means a child's mother, father or someone else having or exercising parental responsibility for the child. Where a child is in the custody or guardianship of the chief executive (child safety) under the *Child Protection Act 1999*, the chief executive is considered to be the child's parent for the purposes of these provisions. A 'parent' also includes a person who under Aboriginal tradition or Torres Strait Island custom is regarded as a parent.⁴⁸
- *National Immunisation Program Schedule Queensland* means the schedule for age appropriate immunisation for vaccine-preventable conditions recommended by the Department of Health and published on the Department's website.⁴⁹
- *Vaccine-preventable condition* means a contagious condition that is prescribed under a regulation as a vaccine-preventable condition.⁵⁰

4.4 Exclusion actions that can be taken before enrolment

Proposed new section 160B of the Public Health Act (Clause 5 of the Bill) sets out the circumstances in which a person in charge of an approved education and care service may exclude a child who is not yet enrolled at the service.

⁴⁸ *Public Health Act 2005*, s 159

⁴⁹ Explanatory Note, page 15

⁵⁰ *Public Health Act 2005*, s 158

A person in charge of an approved education and care service may refuse to enrol a child, refuse to allow a child to attend the service, or impose a condition on the child's enrolment or attendance, if the person has not received an immunisation history statement which states that the child has an immunisation status of 'up to date'.

These decisions may only be taken if the person in charge has:

- requested that the child's parents provide the statement within a reasonable period, and
- advised the parents that not providing the statement within this period may result in the previously identified actions, and
- not received the statement within the period, or the parent refuses to comply with the request.

The request may be included in an enrolment form provided to a parent when they are applying to enrol their child. The Explanatory Note states the request does not need to state which of the prescribed decisions will be taken if the statement is not provided, rather it must note that any of those decisions may be taken.⁵¹

Any condition imposed on a child's enrolment or attendance must be relevant to the child's immunisation status and may include that the child's enrolment will be cancelled if the parent does not provide the statement.

The Explanatory Note states the person in charge may make a combination of these decisions and provides the following example:

*... enrol the child conditionally and also allow the child to attend conditionally, so that if the immunisation history statement is not provided within the stated period, both the enrolment is cancelled and the attendance refused...*⁵²

4.5 Exclusions actions that can be taken after enrolment

Proposed new Section 160C of the Public Health Act (clause 5 of the Bill) sets out the circumstances in which a person in charge of an approved education and care service may exclude an enrolled child.

A person in charge of an approved education and care service may cancel a child's enrolment at the service, refuse to allow a child to attend the service, or impose a condition on the child's enrolment or attendance, if the person has not received an immunisation history statement with an immunisation status of 'up to date'.

These decisions may only be taken if:

- the child has reached the age stated in the NIP Schedule Queensland at which they should be immunized against a vaccine-preventable condition, and

⁵¹ Explanatory Note, page 14

⁵² Explanatory Note, page 14

- the person in charge has requested the statement from the child's parents, allowed at least four weeks for it to be provided, advised the parents that not providing this statement may result in the previously identified actions, and does not receive the statement within the timeframe.

Any condition imposed on a child's enrolment or attendance must be relevant to the immunisation status of the child.

4.6 Immunisation status of children who attend without a statement

Proposed new section 160D of the Public Health Act (clause 5 of the Bill) provides where a person in charge of an approved education and care service enrolls or allows a child to attend the service without having received an immunisation history statement which states that the child's immunisation status is 'up to date', the child is taken to not be vaccinated.

The Explanatory note states this will enable the person in charge to direct the parent of an unvaccinated child not to send their child to the service when there is an outbreak of a vaccine-preventable condition because they may be at risk of contracting the condition.⁵³

4.7 Protection from liability

Clause 6 of the Bill contains a new subsection (1A) for insertion into section 179 of the Public Health Act.

Section 179 provides where a person in charge of a school or an approved education and care service takes action to temporarily exclude a child, or instruct a parent not to send a child to the service because the child is unvaccinated or at risk of contracting a contagious condition or vaccine-preventable condition, the person is not liable civilly, criminally, or under an administrative process for doing the thing, where the person acted honestly.

The new subsection 1A extends this protection from liability to prescribed decisions made by a person in charge of an approved education and care service under the new sections 160B, 160C and 160D contained in the Bill.

4.8 To what services will the amendments apply?

The amendments will apply to education and care services approved under the *Education and Care Services National Law (Queensland)* and the *Education and Care Services Act 2013*. The most common service types approved under this legislation are family day care services, standalone kindergarten services, long day care services, limited hour's services and outside school hour's services.⁵⁴ They will not apply to primary or secondary schools.

4.9 Implementation and review

The Department states the commencement date of 1 January 2016 for the Public Health Act amendments will '...give approved services sufficient time to be appropriately informed of the requirements of the proposed legislation.'

⁵³ Explanatory Note, page 16

⁵⁴ Explanatory Note, page 6

Responsibility for implementation is shared between the Department of Health and the Department of Education and Training, with the Department of Communities, Child Safety and Disability Services also involved where the legislation is applied to children in vulnerable situations.

An implementation Plan has been developed, which includes the development and distribution of resource materials to assist families and approved services to understand the changes to the Act and to promote immunisation. These materials will be available in multiple languages, can be accessed online, will be promoted through various social media platforms and will include advice on accessing ACIR documents.

The Department has advised it will also launch a hotline to assist families and approved services, particularly those located in rural and regional areas. Also an administrative review will be undertaken two years after commencement to determine whether further amendments are required to ‘... enhance the effectiveness of the legislation.’⁵⁵

⁵⁵ Department of Health, Correspondence, 10 August 2015

5. Issues raised about amendments to vaccination provisions

A number of issues were raised by submitters on the specific policy proposal contained in the Bill and also about vaccination more generally.

5.1 Efficacy and safety of vaccines

Submitters raised a number of concerns relating to the efficacy and safety of vaccines in general. Submitters opposed to vaccination alleged:

- Vaccines contain neurotoxins and harmful substances, such as aluminium, thimerosal, formaldehyde, methanol, borax and monosodium glutamate.⁵⁶
- The interactive and cumulative effects of all the vaccines on the NIP schedule are unknown.⁵⁷
- Legal action has been taken against companies for manipulating the efficacy of the mumps vaccine, and for the HPV vaccine Gardasil, which ‘has damaged thousands of girls worldwide.’⁵⁸
- Vaccines cause contraindications, such as allergies, genetic metabolic mutations, auto immune diseases and eczema, and can induce autism in children.⁵⁹
- Cochrane Reviews of vaccines for influenza, whooping cough (pertussis) and measles, mumps and rubella (MMR) have found that most vaccines have not been adequately studied for efficacy; the design and reporting of safety outcomes in MMR vaccine studies are largely inadequate and there is no research that assesses the effectiveness of the rubella component of the MMR vaccine; and influenza vaccines were associated with serious harms such as narcolepsy and febrile convulsions.⁶⁰

Queensland’s Chief Health Officer, Dr Jeanette Young, noted during the public hearing that the majority of submissions which opposed the Bill had been made by individual members of the public, and that many of these raised general concerns about vaccine efficacy and safety. In response, Dr Young provided strong evidence to assure the Committee that vaccines were both safe and effective.

Dr Young emphasised that immunisation has ‘long been recognised as one of the most successful public health interventions introduced in Australia’ and that the majority of Queenslanders support immunisation, as evidenced by Queensland immunisation rates sitting consistently around 92 per cent.⁶¹

⁵⁶ Submissions 8, 18, 22, 28 and 30

⁵⁷ Submission 18

⁵⁸ Submission 22

⁵⁹ Submissions 10, 21, 22 and 27

⁶⁰ Submissions 30 and 31

⁶¹ Public Hearing Transcript, page 2

With regard to efficacy, Dr Young stated:

I wish to assure the committee that government's worldwide support and implement immunisation programs because immunisation is highly effective at preventing serious and life-threatening vaccine preventable diseases.

*Worldwide it has been estimated that immunisation programs prevent approximately 2½ million deaths each year. Due to immunisation, diseases such as diphtheria, tetanus, haemophilus influenzae type B and poliomyelitis do not occur or are extremely rare in Australia.*⁶²

She also outlined the importance of aiming for 95 per cent coverage, to ensure that the small group of people who do not develop immunity are still protected.⁶³

Dr Young also testified as to the safety of vaccines.

*In terms of their safety, these vaccines are all trialled extensively and there is ongoing reporting about instances. Again, no pharmaceutical is 100 per cent safe. Every pharmaceutical will have side effects, and vaccines are no different. But the vast, vast majority of the side effects to vaccines are local ones—so they cause pain at the site of the injection, some redness, some swelling. Then far, far less commonly there are more serious effects, and that is one of the reasons that Lady Cilento clinic has been set up.*⁶⁴

The Immunise Australia Program website supports this statement. The website states that before being made available for use, vaccines are ‘... rigorously tested in thousands of people in progressively larger clinical trials which are strictly monitored for safety’ and evaluated by the Therapeutic Goods Administration (TGA) to ‘... ensure they are effective, comply with strict manufacturing and production standards, and have a strong safety record.’ Vaccines may take up to 10 years to be approved for use.⁶⁵

5.2 Case studies

A number of submitters provided information on whooping cough and rotavirus, to support their belief that there are diseases for which vaccination is inappropriate, ineffective or unfairly targeted at only one age group.⁶⁶

Whooping cough

Submitters argued the pertussis vaccine is ‘at most, only theoretically capable of reducing the severity of the disease, not the incidence of the disease’ and is incapable of producing a herd immunity effect. Submissions stated the disease is endemic to Australia, with cyclical epidemics, and stated notifications have been misrepresented. Examples of outbreaks were cited in fully immunised populations, and concerns were expressed about the impact of multiple booster shots on a child’s immune system.

⁶² Public Hearing Transcript, page 7

⁶³ Public Hearing Transcript, page 2

⁶⁴ Public Hearing Transcript, page 7

⁶⁵ <http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/safety-of-vaccines>

⁶⁶ Submissions 12, 13, 18, 21, 22, 27, 28, 30, 31, 34, 39 and 44

Submitters also emphasised that the disease can be spread by vaccinated individuals and argued that the burden of vaccination should not rest on children under the age of five.⁶⁷

Dr Young addressed these concerns during the public hearing on the Bill, where she outlined the reasons for focusing vaccination on under five year olds.

*The reason we are focusing on under-five-year-olds is for their own protection. We know that the deaths that occur as a result of whooping cough are in the youngest children so they are the group that has to be immunised. Although older people can get very sick from whooping cough, for instance, and from other diseases, they do not usually die. It is similarly so with measles. It is the younger ones who are the most vulnerable in our society. Particularly when we are gathering lots of children together, some who are too young to be immunised at all against some of the diseases—for instance, you cannot get immunised until 12 months against measles. Even in an epidemic we do not recommend it before nine months. That means you are vulnerable until that stage, and you are going to a childcare centre where you have a lot of other children, and children do rapidly pass diseases on from one to another.*⁶⁸

Dr Young also discussed the efficacy of the pertussis vaccine, following a question about whooping cough outbreaks in the adult population. Dr Young agreed that pertussis is not as efficacious a vaccine and that immunity wanes over time and concluded this is even more reason to vaccinate.

*... the most important thing is to protect those babies under two months of age because they cannot get vaccinated until they are six weeks old and they are the ones who will die if they get it. It is an awful disease when adults get it, but they do not usually die from it, but little babies do. We have now rolled out a program that has been quite successful for pregnant women. In their third trimester, we are vaccinating them and that is passing on that immunity to their unborn babies so that baby is protected for the first six weeks. The UK did a similar program, which is why we followed. They had a whole run of deaths of little babies—I cannot remember now but I think it was about 10 deaths, and of course their population is so much bigger—and they put in the program and they only had one death after that in the evaluation period and that was in a mother who had not been immunised against pertussis during pregnancy. So it is a very effective program.*⁶⁹

Rotavirus

A number of submissions argued the rotavirus vaccine should not be included on the NIP Schedule as the primary concern with the virus is gastroenteritis induced dehydration, which they consider can be managed 'if parents are taught simple methods to prevent dehydration and recognise the symptoms of

⁶⁷ Submissions 21, 28, 39 and 44

⁶⁸ Public Hearing Transcript, page 5

⁶⁹ Public Hearing Transcript, page 7

dehydration.⁷⁰ Submitters also stated that fully breastfeed babies rarely suffer serious effects from rotavirus.⁷¹

During the public hearing Mr Smith, from the Australian Vaccination-Skeptics Network, outlined the Network's concerns with the rotavirus vaccine:

If you actually look at how rotavirus got on the schedule in Australia and the Western World, it is a fine example of how a product like this should not be pseudo mandated. I do not know if anyone is really aware of rotavirus and how it became part of the schedule in the United States and then, de facto wise, in Australia, but it was developed and patented by Dr Paul Offit. He had the privilege of also sitting on the advisory board of the CDC to determine which vaccines would end up on the schedule. That vaccine ended up on the schedule in the United States and he made over \$40 million, and it is now on our schedule.⁷²

In response, the Committee Deputy Chair and Member for Mudgeeraba observed:

... rotavirus is the most common cause of severe diarrhoea in infants. Before that vaccination was put on the market in the US, rotavirus A caused 2.7 million cases of gastro in children with 60,000 hospitalisations and around 37 deaths each year. Rotavirus A is the most common cause of outbreak of severe diarrhoea in children attending day care centres. From a personal perspective, before that vaccine came along I almost lost my six-month-old son to rotavirus from severe dehydration. I understand your comment about vaccinations and people benefiting from them, whether it is financially or otherwise, but I think the population in general benefits at a greater level.⁷³

Ms Fleur Cross of Diabetes Queensland also spoke of research which has linked rotavirus with the development of type 1 diabetes in children who are predisposed to diabetes:

Rotavirus can potentially accelerate the development of type 1 diabetes in children predisposed to the condition, so there is a susceptibility and rotavirus can be a trigger. By allowing rogue immune cells to attack the pancreas, some research has discovered that it is a precursor to the development of type 1 diabetes. Some research has gone further to draw a direct link between rotavirus infection and the induction of type 1 diabetes. From our stance, encouraging vaccination through measures such as those provided in the bill could then have that additional benefit in that causational factor.⁷⁴

5.3 Adverse events and medical contraindications

Concerns about adverse reactions and medical contraindications to vaccines went hand in hand with claims that vaccines were unsafe, ineffective, inappropriate or unfairly targeted at only one age group. A

⁷⁰ Submission 30

⁷¹ Submission 39

⁷² Public Hearing Transcript, page 22

⁷³ Public Hearing Transcript, page 25

⁷⁴ Public Hearing Transcript, pages 26-27

number of submissions suggested these events are more common than expected, and that the current regulatory arrangements do not provide adequate oversight and reporting of such events.⁷⁵

The Australian Immunisation Handbook (AIH) defines an adverse event following immunisation as:

...any untoward medical occurrence that follows immunisation and does not necessarily have a causal relationship with the usage of the vaccine. The adverse event may be any unfavourable or unintended sign, abnormal laboratory finding, symptom or disease. Such an event may be caused by the vaccine(s) or may occur by chance (i.e. it would have occurred regardless of vaccination). Most vaccine adverse events are minor, such as low-grade fever, and pain or redness at the injection site; these should be anticipated.⁷⁶

The Handbook also includes an information sheet developed by the Australian Technical Advisory Group on Immunisation, which provides data for vaccine-preventable diseases on the NIP Schedule. The sheet compares the effects of the disease (mortality and/ or morbidity) in unvaccinated populations with the side effects of the vaccine (see **Appendix B**).⁷⁷

Responsibility for monitoring and reporting on the safety of vaccines rests with the Therapeutic Goods Administration (TGA). This includes collecting reports on adverse events to a vaccine⁷⁸ and supporting a publicly accessible database, which provides information about adverse events related to medicines and vaccines used in Australia.⁷⁹

The TGA also works in collaboration with the National Centre for Immunisation Research and Surveillance (NCIRS) to prepare annual reports on adverse events following immunisation. These reports contain information on the rate at which an adverse event following vaccination is reported and information about serious adverse events and deaths that are reported to have occurred following a vaccine.⁸⁰

Again, Dr Young responded to this issue during the public hearing, stating:

The vast, vast majority of the side effects to vaccines are local ones—so they cause pain at the site of the injection, some redness, some swelling. Then far, far less commonly there are more serious effects.

I assure you that all vaccines are thoroughly tested. They have to go through the Therapeutic Goods Administration — and the Commonwealth for assessment before they

⁷⁵ Submissions 2, 24, 27, 29, 34, 39, 42 and 44

⁷⁶ <http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home~handbook10part2~handbook10-2-3>

⁷⁷ Department of Health, Correspondence, 16 September 2015

⁷⁸ <https://www.tga.gov.au/reporting-problems-0#vaccine>

⁷⁹ <https://www.tga.gov.au/database-adverse-event-notifications-daen>

⁸⁰ <https://www.tga.gov.au/consumer-questions-and-answers-daen-medicines>

*are endorsed and are allowed to be used in Australia, and there is a very thorough process there. That process is well and truly tried and tested.*⁸¹

Dr Richard Kidd of the Australian Medical Association (Qld) also spoke to the matter. When asked by the Committee whether there was any evidence about potential immune system dysfunction or illness as a consequence of receiving a vaccination, Dr Kidd replied:

There have been a couple of studies but they have been flawed. At the end of the day, the real evidence is that immunisation activates the immune system in terms of developing meaningful immunity against diseases that in many cases kill 10 people out of every hundred who get them.

*That is the really important take-home message: for children who get meningitis, pneumococcus, pertussis, diphtheria, the mortality rate is about 10 per cent. Then you have the terrible disability—the kids who get meningococcus and end up losing limbs or having brain damage or heart damage. It goes on and on. At the end of the day, there is plenty of evidence that vaccination activates the immune system in a very useful way. I do not think there is any real evidence that it does anything to harm the immune system.*⁸²

Committee comment

The Committee considers vaccination is an effective, proven public health measure and strongly endorses the need for children to be immunised for the vaccine preventable diseases recommended by the National Immunisation Program.

The Committee acknowledges that a number of parents have deeply felt concerns about the safety and efficacy of vaccines however the Committee considers the arrangements in place to oversee the development, implementation and delivery of the National Immunisation Program are robust and provide appropriate avenues for concerns about vaccine safety and efficacy to be tested, reported, monitored and addressed.

The Committee notes the Department has prepared an implementation plan to support the Bill, which includes resource materials to promote immunisation.

The Committee commends the additional measures introduced by Queensland Health to further support parents who have concerns about vaccine safety. In particular, the establishment of the specialist clinic at the Lady Cilento Hospital, which will enable children who have a serious side effect to a vaccine to receive vaccines in a supportive, clinical environment.

5.4 Rights of parents to make an informed decision

Many submissions argued the vaccination provisions force parents to choose between accessing childcare and having a medical procedure they may wish to delay or avoid. Submitters argued this was a

⁸¹ Public Hearing Transcript, page 7

⁸² Public Hearing Transcript, page 32

coercive approach, and effectively removed the right of a parent to make an informed decision about whether or not to vaccinate their child.⁸³

Submitters stated this was contrary to various international declarations and codes, as well as information contained in the Australian Immunisation Handbook. A summary of some of key documents referenced by submitters is provided below:

The **Nuremberg Code** outlines ten standards to which physicians must conform in a code that is accepted worldwide. The first standard states voluntary consent is absolutely essential, and describes this as follows:

*This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision.*⁸⁴

Article 6 of the **Universal Declaration of Bioethics and Human Rights** relates to consent, and states:

*Any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information. The consent should, where appropriate, be express and may be withdrawn by the person concerned at any time and for any reason without disadvantage or prejudice.*⁸⁵

Section 2.1.3 of the **Australian Immunisation Handbook** states all four of the following elements must be present for legally valid consent:

- *It must be given by a person with legal capacity, and of sufficient intellectual capacity to understand the implications of being vaccinated.*
- *It must be given voluntarily in the absence of undue pressure, coercion or manipulation.*
- *It must cover the specific procedure that is to be performed.*
- *It can only be given after the potential risks and benefits of the relevant vaccine, risks of not having it, and any alternative options, have been explained to the individual.*⁸⁶

⁸³ Submissions 3, 6, 11, 12, 14, 15, 17, 18, 21, 22, 24, 26, 28, 30, 31, 32, 34 and 38

⁸⁴ <http://www.cirp.org/library/ethics/nuremberg/>

⁸⁵ http://portal.unesco.org/en/ev.php-URL_ID=31058&URL_DO=DO_TOPIC&URL_SECTION=201.html

⁸⁶ <http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home~handbook10part2~handbook10-2-1>

What constitutes informed consent, and whether the Bill contravenes a parent's right to make an informed decision about vaccination was discussed at length during the public hearing. Ms Rebecca Hansensmith appearing on her own behalf stated:

When it cannot be predicted who will be harmed by a vaccine and it cannot be guaranteed that those who have been vaccinated will not get infected or transmit infection, the ethical principle of informed consent becomes a civil, human and parental right that must be safeguarded in law. The current legislation puts pressure on parents to accept a risk that may not outweigh the benefits for their individual child. I do feel that it is a level of coercion.⁸⁷

When asked what her understanding of informed consent was, Dr Young replied:

Ultimately this is a decision for every single parent to make. We have an obligation to provide the best information to them so they can make those decisions. We have the obligation to provide the best information to the directors of all childcare services, kindergartens and so forth so they can make the best decision for those children. We do believe it is very important that children are vaccinated so we will assist everyone to accomplish that aim.⁸⁸

The Member for Thuringowa noted that Queensland Ambulance Service staff must be vaccinated for hepatitis B and other diseases, and suggested this was a sensible policy measure to protect vulnerable members of the public from disease, rather than a coercive action.⁸⁹

On a related issue, the Member for Moggill stated the '... availability of consistent, quality information related to vaccinations is critical' and suggested there may be a role for the Australian Commission on Safety and Quality in Health Care to develop a healthcare standard to guide health service providers on what information should be provided and in what format.⁹⁰

Committee comment

The Committee notes vaccination is not compulsory, and the provisions in the Bill which allow a person in charge of an approved education and care service to refuse, cancel or place a condition on the enrolment or attendance of a child who is not vaccinated are discretionary, and not mandatory.

While the Committee appreciates that some parents interpret this to mean that their child will not be accepted to childcare unless they are compliant with the NIP Schedule, the Committee does not consider this amounts to coercion where there is an unwillingness on the part of a parent to vaccinate a child.

⁸⁷ Public Hearing Transcript, page 23

⁸⁸ Public Hearing Transcript, page 4

⁸⁹ Public Hearing Transcript, page 23

⁹⁰ Public Hearing Transcript, page 18

Rather, it is the right of the person in charge of an approved education and care service to exercise discretion as to whether, and in what circumstances, they will enrol and or accept the attendance of an unvaccinated child.

The Committee considers that the right of a parent to make a decision about the immunisation of their child must be balanced against the benefits of immunisation, and the importance of protecting the whole community, particularly in childcare centres where the consequences of contracting a vaccine preventable disease are greater due to the vulnerable age group. In this regard, the rights of parents to have their children in an environment supportive of vaccination must also be considered.

The Committee notes there is a wealth of information on the NIP and encourages parents who have questions or concerns about vaccine safety or efficacy, or immunisation more broadly, to speak with their General Practitioner in the first instance.

The Committee also encourages parents who are concerned that their child may have a medical contraindication to a vaccine to use the services of the specialist clinic at Lady Cilento Hospital.

5.5 Unintended consequences

Associate Professor Julie Leask of Sydney University, a supporter of vaccination, considered there were a number of potential unintended consequences that would flow out of the Bill. Dr Leask opposed the Bill on the basis of the potential 'negative consequences that flow from enabling the exclusion of children who are incompletely vaccinated and the minimal impact such a measure would have on vaccination rates and disease control.'⁹¹

Dr Leask considered the vaccination provisions were '... based on only a partial understanding of the under-vaccination problem and as a policy, may do more harm than good'. Dr Leask set out number of concerns about the policy being implemented by the Bill, in that it would:

- Encourage the vaccination of children who are unwell.
- Result in a clustering of unvaccinated children in permissive centres, causing a critical mass of non-immune to more readily seed an outbreak. Dr Leask stated an outbreak in these centres would spread much more rapidly, and there was evidence this had already occurred in Steiner schools and religious communities in the Netherlands.
- Punish children for the decisions of their parents by restricting their access to educational opportunities afforded by childcare. Dr Leask considered this was contrary to the 2008 National Partnership Agreement on Universal Access to Early Childhood Education, and that the concern would be amplified for two groups of vulnerable children of vaccine refusers - those who are under the supervision of the Family and Community Services where childcare has been recommended for child welfare or those living with deprivation whose access to childcare exponentially improves their educational and social outcomes.

⁹¹ Submission 37

- Leave enforcement in the hands of childcare providers, which in turn leads to role conflict. Dr Leask argued the role of childcare providers was to provide early childhood education, not to enforce health related behaviours, and that pressure from parents to apply discretionary powers may lead to adversarial situations.

Ms Elaine MacDonald stated the Bill could also impact on family structure and economics, as it would result in vaccine hesitant parents debating ‘... whether two incomes override their children's health and safety.’ She stated the provisions may result in one parent being unable to return to the workplace because they choose to not vaccinate their child and are unable to find childcare. She stated the stay at home parent is more likely to be the mother.

*This will affect her ability to return to the workplace, her longevity in the workplace, her ability to afford education for her children, her future superannuation, her contribution to society etc. the list goes on.*⁹²

The Australian Vaccination-Skeptics Network expressed a similar concern, stating the Bill will impact negatively on women, by reducing their workforce participation or opportunities for self-development, their ability to provide essentials and luxuries for their children.⁹³

Ms MacDonald also argued single parent families are especially vulnerable.

*I haven't even touched on what would happen to single parent families if the parent is unable to have their unvaccinated children enrolled at a child care centre to return to work. The dependency upon the welfare system would be even greater for single and partnered families with child care aged children than it is now.*⁹⁴

Committee comment

The Committee notes the Department of Health has committed to an administrative review two years after commencement to determine whether further amendments are required to enhance the effectiveness of the legislation. The Committee strongly suggests the Department consider, as part of this review, whether the vaccination provisions have resulted in any potentially negative, unintended consequences.

5.6 Won't control disease

Associate Professor Leask also argued the policy implemented by the Bill would not control disease because others, such as parents, childcare workers, and particularly travellers, also spread disease and need vaccination. She referred to a review which found that up to 50 per cent of infants hospitalised with whooping cough contracted it from a parent or sibling and stated vaccination rates were much lower in adults than in children. Dr Leask also referred to a NSW study of 319 childcare centres, containing 3,574 workers, which found that only 29.4 per cent of workers were fully vaccinated.

⁹² Submission 15

⁹³ Submission 21

⁹⁴ Submission 15

Many submissions made similar statements about the time limited nature of vaccine induced immunity and the need to place an increased focus on vaccination in particular professions, and other age groups.

Committee comment

The Committee recognises the time limited nature of vaccine induced immunity and encourages individuals who have frequent contact with vulnerable populations, such as young children and the elderly, to speak with their GP about booster shots for vaccines they may have received some time ago.

Other initiatives such as the approach taken by the Queensland Ambulance Service in relation to mandatory vaccination of their staff can occur in parallel with the policy in the Bill. The Committee strongly encourages childcare providers to consider introducing a similar policy.

5.7 Won't increase vaccination rates

Associate Professor Leask also argued the vaccination provisions in the Bill will fail to convince the entrenched. Rather, she believed the policy would further alienate parents who have concerns about vaccine safety and efficacy from the system and that it would be preferable for 'vaccine refusers' to be required to obtain an exemption from a health care provider or doctor.

Dr Leask considered family doctors have the greatest chance of changing these parents' minds and that sometimes these encounters lead to partial then even full vaccination.⁹⁵

Committee comment

The Committee recognises the importance of actively engaging with those who have concerns about vaccine safety and efficacy, and appreciates this should involve more than the dissemination of public health information on immunisation.

The Committee considers the Drive for 95 initiative is an excellent start in this area and once again encourages individuals with concerns about vaccination to speak with their GP, in the first instance.

The Committee also encourages both the Department of Health and individual Health and Hospital Services to consider ways in which they can more actively engage with those in the community who have deep seated fears and concerns about vaccination.

5.8 Grounds for exemption

The Committee received a number of submissions which stated the Bill should allow for exemption on the grounds of conscientious objection to vaccination, including a detailed submission from an organisation which described itself as '... grass-roots network of about 1000 people who object to the Australian Childhood Immunisation Schedule (not necessarily objecting to vaccines) and /or the diminution of civil liberties to accomplish government vaccination targets.'⁹⁶

⁹⁵ Submission 37

⁹⁶ Submission 16

The Chief Health Officer, Dr Jeanette Young, addressed this matter during the public hearing, in part by reference to the proposed changes to federal arrangements, outlined at Part 2.6:

In April 2015, the Prime Minister announced federal budget measures that would mean that parents who fail to immunise their children would no longer have access to family tax and childcare benefits. In keeping with these national changes, the bill does not exempt children whose parents object to immunisation on the grounds of conscientious objection. However, the bill makes allowances for children who are unable to be immunised for medical reasons or children who are on a recognised catch-up schedule.⁹⁷

The family tax and childcare benefit changes announced in April 2015 will be accompanied by changes to the Australian Childhood Immunisation Register (ACIR), which records the details of all vaccinations given to children under seven years of age who live in Australia. The provision which allows parents to record a formal conscientious objection on the ACIR will cease to exist from 1 January 2016.⁹⁸

Dr Young also provided the following rationale as to why the Bill makes no reference to conscientious objection:

Given that conscientious objection was a process that was put in place and managed by the Commonwealth—it is not a scientific term; it is a social term—and given that has now been removed, people who do not want their children to be vaccinated will just be deemed as people who do not want their children to be vaccinated. So there is not that status around it and that ability to be exempted. That is why it has not been included in this bill.⁹⁹

Committee comment

The Committee considers the removal of the process to record a formal conscientious objection to a vaccine on the ACIR makes it infeasible to include provisions relating to conscientious objection in the Bill.

⁹⁷ Public hearing transcript, page 2

⁹⁸ <http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/vaccination-data>

⁹⁹ Public Hearing Transcript, page 4

6. Amendments to the *Health Ombudsman Act 2013*

The *Health Ombudsman Act 2013* (the Health Ombudsman Act) provides for the appointment of authorised persons to investigate healthcare complaints and to monitor and enforce compliance with the Act.¹⁰⁰

The powers available to an authorised person when conducting an investigation are set out in sections 186 to 228. They include the power to enter premises and seize items with a warrant and powers to require information. The Act also provides it is an offence to fail, without a reasonable excuse, to provide information to an authorised person.¹⁰¹

6.1 Amendment of to section 228 Power to require information

Section 228 provides where an authorised person reasonably believes that an offence against the Act has been committed and a person may be able to give information about it, or a matter being investigated by the Health Ombudsman, the authorised person may issue a notice which requires the person to give the authorised person ‘information related to the offence, or matter being investigated, at a stated reasonable time and place.’

Clause 9 of the Bill proposes to replace the existing section 228(3) of the Health Ombudsman Act with a new section 228(3) (a) and (b), which will provide that an authorised person may, by notice given to the person, require the person to:

- (a) give information related to an offence or matter being investigated, at a stated reasonable time and place. (This is an existing power); and
- (b) attend before the authorised person at a stated reasonable time and place to answer questions, or produce document, related to an offence or matter being investigated. (This is a new power).

The Explanatory Note states ‘... an authorised person may exercise the power to issue a notice under section 228(3)(b), even if the authorised person has issued a notice under section 228(3)(a).’¹⁰²

In his introductory speech, the Minister stated these amendments will ensure that the Health Ombudsman has the necessary powers to effectively investigate serious healthcare complaints and will give certainty to those persons who have been involved in matters before the Health Ombudsman.¹⁰³

The Minister stated the powers were consistent with the information-gathering powers of the former Health Quality and Complaints Commission and the provisions in the *Health Practitioner Regulation National Law Act 2009*, which regulates less serious disciplinary proceedings for registered health practitioners in Queensland.¹⁰⁴

¹⁰⁰ *Health Ombudsman Act 2013*, ss 186-188

¹⁰¹ *Health Ombudsman Act 2013*, s 229

¹⁰² Explanatory Note, page 17

¹⁰³ Hansard, 15 July 2015, page 1350

¹⁰⁴ Hansard, 15 July 2015, page 1350

On 29 September 2015 the Minister for Health and Minister for Ambulance Services tabled an erratum to the Explanatory Note, to provide additional detail on the consistency of the proposed changes with legislation in other jurisdictions. The Erratum noted that serious healthcare complaints, such as those dealt with by Queensland's Health Ombudsman, are dealt with under the Health Practitioner Regulation National Law in all states but Western Australia and New South Wales, and that the amendments will ensure the Health Ombudsman's powers consistent with those used in most other Australian jurisdictions.

The Erratum also included the following information on the NSW Health Care Complaints Commission

In New South Wales, healthcare complaints are considered by the Health Care Complaints Commission under the Health Care Complaints Act 1993 (NSW) or the relevant health profession council established under the Health Practitioner Regulation National Law (NSW). The equivalent provisions in the New South Wales legislation do not expressly state that a person may be compelled to answer questions, but enable the person to be compelled to appear at a specified reasonable time and place and give evidence, either orally or in writing, and produce documents.¹⁰⁵

6.2 Supreme Court ruling on section 228 Power to require information notice

The Explanatory Note states the amendment clarifies an existing power and is '... urgently required to ensure the Health Ombudsman has sufficient information-gathering powers to undertake investigations into healthcare complaints and possible offences under the Act.'¹⁰⁶ The note refers to the Supreme Court case of *Moosawi v Massey*,¹⁰⁷ which dealt with a challenge to a notice issued by an authorised person under section 228 of the Health Ombudsman Act.

In *Moosawi v Massey*, the section 228 notice required a person to appear and answer questions as part of an investigation. The Supreme Court ruled the existing power in the Act, to require a person to give information, did not extend to compelling a person to attend in person and answer questions and was insufficient to support such a notice.¹⁰⁸

6.3 Stakeholder views

The Committee received one submission on this aspect of the Bill from McInnes Wilson Lawyers. It was submitted the amendment to section 228 of the Health Ombudsman Act would not fully address the apparent defect as the amendments permit a person to refuse to answer a question or produce a document where to do so might incriminate the person.

¹⁰⁵ Erratum to Explanatory Note

¹⁰⁶ Explanatory Note, page 4

¹⁰⁷ [2015] QSC 169

¹⁰⁸ Explanatory Note, page 4

McInnes Wilson suggest, instead, that provisions similar to the NSW Health Care Complaints Commission should be considered to ensure that the Health Ombudsman's investigative powers are clear and operate in the public interest.¹⁰⁹

In response, the Department advised that the Supreme Court case on this matter considered whether the power in section 228 to compel a person to give information extended to compelling a person to attend and answer questions. The Court did not consider whether the applicant was entitled to refuse to answer questions of produce documents on the grounds of self-incrimination. The Department advised:

Queensland Health considers the amendment proposed would remedy the defect raised by the Court in Moosawi while retaining appropriate protections for persons appearing before authorised persons. It is a fundamental principle that legislation provides appropriate protection against self-incrimination (see section 4(3)(f) of the Legislative Standards Act 1992).

*The amendments to sections 228 and 229 mirror the information-gathering provisions in the Health Practitioner Regulation National Law, which also provide that an individual may refuse to answer a question or produce a document if to do so might tend to incriminate that individual.*¹¹⁰

In response to concerns raised by the Committee relating to the need for any additional natural justice provisions, the Department advised:

The amendments to the Health Ombudsman Act address the decision of the Supreme Court of Queensland in Moosawi and are intended to ensure that the relevant provisions apply as originally intended by Parliament. That is, to make it clear that the Ombudsman can require a person to attend and give evidence at a particular time and place. Provisions additional to those required to give effect to Parliament's original intent have not been considered.

*The Department understands that, through the application of the common law, the principles of natural justice will apply to legislation relating to administrative decision-making unless the legislation expressly states otherwise.*¹¹¹

Committee Comment

The Committee is satisfied that with the Department's response and considers the amendments to the Health Ombudsman Act are necessary and appropriate to rectify the defect identified with section 228 arising out of the decision in *Moosawi v Massey*.

¹⁰⁹ Submission 20

¹¹⁰ Department of Health, Correspondence, 16 September 2015, pages 2-3

¹¹¹ Department of Health, Correspondence, 16 September 2015, page 3

6.4 Amendment of section 229 Offence to contravene information requirement

Clause 11 of the Bill proposes to amend section 229 of the Health Ombudsman Act to clarify it is an offence for a person to fail, without reasonable excuse, to comply with a notice under section 228(3)(a), and inserts a new section 229A *Offence to contravene attendance requirement* into the Health Ombudsman Act, which makes it an offence for a person to fail, without reasonable excuse, to comply with a notice under section 228(3)(b).

6.5 Transitional provisions

Clause 16 of the Bill contains a new division 2 into part 21 of the Health Ombudsman Act to provide transitional arrangements for the substantive amendments.

The transitional provisions ensure that section 228, as amended, applies in relation to an offence or a matter being investigated by the Health Ombudsman, even if the offence was committed or the matter being investigated happened or arose before the amendments commence. This means that an authorised person may issue a notice under section 228, as amended, in relation to matters already on foot at the time the amendments commence.

Further, the transitional provisions ensure that a notice to a person under section 228, issued before the amendments commence (a pre-commencement notice) which requires the person to attend before the authorised person to answer questions at a stated time and place has effect, and is taken to have had effect since it was given.

However, a person is not taken to have committed an offence under section 229 or 229A if, before commencement, the person fails to attend or answer a question or produce a document as required by new section 229A(1)(a) to (d).

Also, information obtained as a result of the giving of a pre-commencement notice is taken to have been lawfully obtained by the authorised person as it would have been if it were obtained pursuant to a notice given under the amended provisions; and any decision made, or action taken by, the Health Ombudsman based on information obtained pursuant to a pre-commencement notice is taken to be lawful, as it would have been had it been issued under section 228, as amended.

7. Compliance with the *Legislative Standards Act 1992*

7.1 Fundamental Legislative Principles

Section 4 of the *Legislative Standards Act 1992* states that ‘fundamental legislative principles’ are the ‘principles relating to legislation that underlie a parliamentary democracy based on the rule of law’. The principles include that legislation has sufficient regard to:

- the rights and liberties of individuals, and
- the institution of Parliament.

The Committee has examined the application of the fundamental legislative principles to the Bill. The Committee brings the following to the attention of the House.

Rights and Liberties of Individuals

Section 4(2)(a) of the *Legislative Standards Act 1992* requires that legislation has sufficient regard to the rights and liberties of individuals.

Amendments to the *Public Health Act*

As outlined earlier, clause 5 of the Bill provides that a person in charge of an education and care service may take one of the following actions (exclusion actions) if a child’s immunisation status is not up to date:

- For a child who is not yet enrolled– refuse to enrol the child, refuse to allow the child to attend the service, or impose a condition on the child’s enrolment or attendance.¹¹²
- For a child who is enrolled - cancel the child’s enrolment, refuse to allow the child to attend, or impose a condition on the child’s enrolment or attendance.¹¹³

This matter was addressed in the Explanatory Note tabled with the Bill where it stated:

This power may be considered to impact on the rights and liberties of children and their parents, and particularly may be considered discriminatory in nature.

However, refusing to allow the enrolment or attendance of a child at an approved education and care service based solely on the child’s immunisation status could not be considered discriminatory. The Anti-Discrimination Act 1991 prohibits discrimination on the basis of a number of attributes, including disability or religious belief, however immunisation status is not a recognised attribute. The Anti-Discrimination Act 1991 also provides a broad exemption for actions which are reasonably necessary to protect public health, and the aim of the Bill is to protect children and people who work at approved education and care services from vaccine-preventable conditions. Accordingly, the Bill will not lead to unlawful discrimination.¹¹⁴

¹¹² Public Health (Childcare Vaccination) and Other Legislation Amendment Bill 2015, s 160B

¹¹³ Public Health (Childcare Vaccination) and Other Legislation Amendment Bill 2015, s 160C

¹¹⁴ Explanatory Note, page 7

Committee comment

The Committee notes only one recognised religion, the Church of Christ, Scientists (Christian Scientists), has been provided with an approved vaccination exemption by the federal government since 1998.

The former federal Minister for Social Services, the Hon. Scott Morrison, recently advised that after discussions with the Christian Scientists, the exemption was not necessary as they are no longer advising members to avoid vaccinating their children.

The Committee notes the principal objective of the Public Health Act is to protect and promote the health of the Queensland public and therefore considers there is sufficient justification for the Bill to proceed.

Amendments to the Health Ombudsman Act

The amendments in Clause 9 of the Bill relating to new section 228(3) in the Health Ombudsman Act also affect the rights and liberties of individuals.

The Explanatory Note provided justification for this amendment stating:

The existing complementary right of a person to refuse to answer a question or produce a document on the ground of self-incrimination will not change.

The new provisions are consistent with the Health Quality and Complaints Commission Act 2006, repealed by the Health Ombudsman Act, which provided a power to require a person to attend before an authorised person to answer questions or produce documents. The new provisions are also consistent with the information gathering provisions in the Health Practitioner Regulation National Law 2009 (Queensland) that apply to disciplinary proceedings for registered health practitioners. The new power goes no further than is reasonably necessary to enable the Health Ombudsman to conduct investigations and inquiries into the provision of health care services.¹¹⁵

Committee comment

The Committee notes there is, in the common law, a traditional objection to compulsory interrogations.¹¹⁶ However, it also notes from *Lee v R*,¹¹⁷ there is a long history of legislation, both at federal and State level (and not limited to Australia) providing for compulsory interrogation and production of documents in aid of investigation of criminal and other illegal activities.¹¹⁸

The amendment clause is consistent with the *Health Practitioner Regulation National Law 2009 (Queensland)* (see section 173) and also retains the right for an individual to refuse to answer a question on the grounds of self-incrimination. The Committee considers it does, on balance, have sufficient regard to the rights and liberties of individuals.

¹¹⁵ Explanatory Note, page 7

¹¹⁶ (1965) 114 CLR 81

¹¹⁷ [2013] NSWCCA 68

¹¹⁸ See *Lee v R* [2013] NSWCCA 68 at paragraph 20

The Committee considers that the greater powers afforded to the Health Ombudsman make it better equipped to carry out the main objectives of the Health Ombudsman Act (at section 3) which include protecting the health and safety of the public and to promote:

- professional, safe and competent practice by health practitioners,
- high standards of service delivery by health service organisations, and
- public confidence in the management of complaints and other matters relating to the provision of health services.

Retrospectivity

Section 4(3)(g) of the *Legislative Standards Act 1992* (the LSA) provides that legislation should not adversely affect rights and liberties, or impose obligations retrospectively.

The amendments to the Health Ombudsman Act in clause 16 of the Bill operate retrospectively to provide that a pre-commencement notice has effect, and is taken to have had effect since it was given, to the same extent it would have if the notice was given under section 228, as amended.

Strong argument is required to justify an adverse effect on rights and liberties, or imposition of obligations, retrospectively. In this instance, clause 16 provides that a notice issued before commencement is deemed valid by allowing the provisions to act retrospectively. The Explanatory Note provide the following justification for the new provisions and also acknowledge that they will affect the rights and liberties of individuals:

These provisions will affect the rights and liberties of individuals retrospectively. In issuing notices under section 228, the Health Ombudsman has acted on the belief the existing provisions in the Health Ombudsman Act provide sufficient powers to require a person to provide information by attending at a place and answering questions. However, the recent Supreme Court decision creates uncertainty as to, firstly, the validity of notices issued by authorised officers that required a person to attend at a place and answer questions and, secondly, reliance on information obtained pursuant to these notices.

The Health Ombudsman is responsible for investigating complaints about health services and health service providers, which may include, for example, allegations of inappropriate behaviour by a provider or concerns about the quality of treatment or care provided. Applying the amendments retrospectively will provide certainty for all parties, by validating notices issued under the current provisions. It will also provide clarity that decisions made and actions already taken by the Health Ombudsman are not invalidated because of defects relating to the issuing of notices under section 228. Accordingly, the retrospective application of the amendments is justified in the circumstances.¹¹⁹

¹¹⁹ Explanatory Note, page 8

Committee Comment

The Committee considers that it is appropriate in this instance that the provisions apply retrospectively in order to provide certainty to the investigation process and to allow the Health Ombudsman's office to continue to fully investigate the current serious matters under its care.

Immunity from proceedings

Section 4(3)(h) of the *Legislative Standards Act 1992* (the LSA) provides that legislation should not confer immunity without adequate justification.

At present, section 179(1) provides that if a person, who acts honestly, gives information or for example, directs a parent to remove a child from a school, education and care service, that person is not liable, civilly, criminally or under an administrative process by way of section 179(2).

Clause 6 inserts new sub-section 1A into section 179 of the Public Health Act by providing that a person in charge of an approved education and care service is not liable civilly, criminally, or under an administrative process, where they followed the prescribed process pursuant to section 160 and acted honestly.

Therefore, protection from liability is provided for a person in charge of a service for making the decision to refuse enrolment or attendance.

The OQPC Notebook states "a person who commits a wrong when acting without authority should not be granted immunity. Generally a provision attempting to protect an entity from liability should not extend to liability for dishonesty or negligence. The entity should remain liable for damage caused by the dishonesty or negligence of itself, its officers and employees. The preferred provision provides immunity for actions done honestly and without negligence ... and if liability is removed, it is usually shifted to the State".¹²⁰

Committee Comment

The Committee notes clause 6 only provides immunity for actions done honestly in regard to section 160 and does not extend to negligent acts. In light of this it is considered that, on balance, clause 6 has sufficient regard to this fundamental legislative principle.

New Penalty

The Committee also notes clause 11 of the Bill inserts new section 229A which provides for a maximum penalty of 100 penalty units for a failure to attend by notice, or answer a question from or produce a document to, an authorised person. The penalty of 100 penalty units is consistent with the current penalty at section 229 (Offence to contravene information requirement) of the Health Ombudsman Act.

¹²⁰ Office of the Queensland Parliamentary Counsel, Fundamental Legislative Principles: *The OQPC Notebook*, page 64

7.2 Explanatory Notes

Section 22 of the *Legislative Standards Act 1992* requires a Member, when introducing a Bill to circulate an Explanatory Note for the Bill.

The requirements for the Explanatory Note are contained in section 23 of the *Legislative Standards Act 1992* and state:

- (1) An explanatory note for a Bill must include the following information about the Bill in clear and precise language—
 - (a) the Bill's short title;
 - (b) a brief statement of the policy objectives of the Bill and the reasons for them;
 - (c) a brief statement of the way the policy objectives will be achieved by the Bill and why this way of achieving the objectives is reasonable and appropriate;
 - (d) if appropriate, a brief statement of any reasonable alternative way of achieving the policy objectives and why the alternative was not adopted;
 - (e) a brief assessment of the administrative cost to government of implementing the Bill, including staffing and program costs but not the cost of developing the Bill;
 - (f) a brief assessment of the consistency of the Bill with fundamental legislative principles and, if it is inconsistent with fundamental legislative principles, the reasons for the inconsistency;
 - (g) a brief statement of the extent to which consultation was carried out in relation to the Bill;
 - (h) a simple explanation of the purpose and intended operation of each clause of the Bill;
 - (i) if the Bill is substantially uniform or complementary with legislation of the Commonwealth or another State—
 - (i) a statement to that effect; and
 - (ii) a brief explanation of the legislative scheme.
- (2) If the explanatory note does not include the information mentioned in subsection (1), it must state the reason for non-inclusion.

Committee Comment

The Explanatory Note tabled with the Bill contained the information required by section 23 of the *Legislative Standards Act 1992* and a reasonable level of background information and commentary to facilitate understanding of the Bill's aims and origins.

The Committee considered it would have been helpful if the Explanatory Note identified the relevant clause(s) of the Bill, when identifying matters of compliance with the fundamental legislative principles.

Appendix A – List of Submissions

Sub #	Submitter
001	1 - Mrs G Osmak
002	Name suppressed
003	Name suppressed
004	Mr Lou Coppola
005	Louisa Kenzig
006	Mrs Hildegard Beinholz
007	Diabetes Queensland
008	Mr Greg Moeliker
009	Mr Michael Asher Browne
010	Mr John Babet
011	Samantha Van Resnburg-Malopito
012	Wendy Daniel
013	Kari Edwards
014	Sam McCullouch
015	Elain Macdonald
016	Name suppressed
017	Deanne Freeman
018	Lica Bienholz
019	Queensland Catholic Education Commission
020	McInnes Wilson Lawyers
021	Australian Vaccination-Skeptics Network Incorporated
022	Aneeta Hafemeister
023	Mr Ian Billman
024	Stacey O'Toole
025	Australian Medical Association
026	Judy Wilyman, School of Humanities and Social Inquiry, University of Woollongong, NSW
027	Dannielle Torrisi
028	Danielle Vicary

029	Brenda McManus
030	Name suppressed
031	Mrs Lara Warwick
032	Dr David Tulip
033	Hayley Rikihana
034	Jane Tulip
035	Queensland Nurses Union
036	Daniel Nolan
037	Associate Professor Julie Leask, School of Public Health, The University of Sydney, NSW
038	Dr Joseph Wayne Smith
039	Rebecca Hansensmith
040	Name suppressed
041	Elizabeth Gazeas
042	Name suppressed
043	Matthew Smith
044	Jason Woodforth
045	Laureate Professor Nicholas Talley and Dr Nicki Murdock, The Royal Australasian College of Physicians

Appendix B – Information Sheet – Comparison of the Effects of Vaccines and the Side Effects of NIP Vaccines

INFORMATION SHEET – COMPARISON OF THE EFFECTS OF DISEASES AND THE SIDE EFFECTS OF NIP VACCINES

From *The Australian Immunisation Handbook* 10th Edition (see *Handbook* contents for more details)

DISEASE	EFFECT OF DISEASE	SIDE EFFECT OF VACCINE
Diphtheria – bacteria spread by respiratory droplets; causes severe throat and breathing difficulties.	Up to 1 in 7 patients die. The bacteria release a toxin, which can produce nerve paralysis and heart failure.	About 1 in 10 has local swelling, redness or pain at the injection site, or fever (DTPa/dTpa vaccine). Booster doses of DTPa may occasionally be associated with extensive swelling of the limb, but this resolves completely within a few days. Serious adverse events are very rare.
Hepatitis A – virus spread by contact or ingestion of faecally contaminated water/food or through contact with the faecal material of a person infected with hepatitis A.	At least 7 in 10 adult patients develop jaundice (yellowing of the skin and eyes), fever, anorexia (decreased appetite), nausea, vomiting, hepatic (liver) pain and malaise (tiredness).	About 1 in 5 will have local swelling, redness or pain at the injection site. Serious adverse events are very rare.
Hepatitis B – virus spread mainly by blood, sexual contact or from mother to newborn baby; causes acute hepatitis (liver infection) or chronic infection ('carrier').	About 1 in 4 chronic carriers will develop cirrhosis or liver cancer.	About 1 in 20 will have local swelling, redness or pain at the injection site and 2 in 100 will have fever. Anaphylaxis occurs in about 1 in 1 million. Serious adverse events are very rare.
Hib – bacteria spread by respiratory droplets; causes meningitis (infection of the tissues surrounding the brain), epiglottitis (respiratory obstruction), septicaemia (infection of the blood stream) and septic arthritis (infection in the joints).	About 1 in 20 meningitis patients dies and about 1 in 4 survivors has permanent brain or nerve damage. Epiglottitis is rapidly and invariably fatal without treatment.	About 1 in 20 has local swelling, redness or pain at the injection site. About 1 in 50 has fever. Serious adverse events are very rare.
Human papillomavirus – virus spread mainly via sexual contact; up to 80% of the population will be infected with HPV at some time in their lives. Some HPV types are associated with the development of cancer.	About 7 in 10 cervical cancers worldwide have been associated with HPV-16 and 1 in 6 with HPV-18.	About 8 in 10 will have pain and 2 in 10 will have local swelling, redness or pain at the injection site. Headache, fever, muscle aches and tiredness may occur in up to 3 in 10 people. Serious adverse events are very rare.
Influenza – virus spread by respiratory droplets; causes fever, muscle and joint pains, pneumonia. About 1 in 10 to 1 in 5 persons will get influenza every year.	There are an estimated 3000 deaths in people older than 50 years of age each year in Australia. Causes increased hospitalisation in the very young (under 5 years of age) and the elderly. Other high-risk groups include pregnant women, people who are obese, diabetics and others with certain chronic medical conditions.	About 1 in 10 has local swelling, redness or pain at the injection site. Fever occurs in about 1 in 10 children aged 6 months to 3 years. Guillain-Barré syndrome occurs in about 1 in 1 million. Serious adverse events are very rare.
Measles – highly infectious virus spread by respiratory droplets; causes fever, cough and rash.	About 1 in 15 children with measles develops pneumonia and 1 in 1000 develops encephalitis (brain inflammation). For every 10 children who develop measles encephalitis, 1 dies and many have permanent brain damage. About 1 in 100 000 develops SSPE (brain degeneration), which is always fatal.	About 1 in 10 has local swelling, redness or pain at the injection site, or fever. About 1 in 20 develops a rash, which is non-infectious. Low platelet count (causing bruising or bleeding) occurs after the 1st dose of MMR vaccine at a rate of about 1 in 20 000 to 30 000. Serious adverse events are very rare.
Meningococcal infection – bacteria spread by respiratory droplets; causes septicaemia (infection of the blood stream) and meningitis (infection of the tissues surrounding the brain).	About 1 in 10 patients dies. Of those that survive, 1 to 2 in 10 have permanent long-term problems, such as loss of limbs and brain damage.	About 1 in 10 has local swelling, redness or pain at the injection site, fever, irritability, loss of appetite or headaches (conjugate vaccines). About 1 in 2 has a local reaction (polysaccharide vaccine). Serious adverse events are very rare.

Source: Australian Technical Advisory Group on Immunisation. *The Australian Immunisation Handbook*. 10th ed. Canberra: Australian Government Department of Health and Ageing; 2013. Inside back cover.

DISEASE	EFFECT OF DISEASE	SIDE EFFECT OF VACCINE
Mumps – virus spread by saliva; causes swollen neck and salivary glands, and fever.	One in 5000 children develops encephalitis (brain inflammation). One in 5 males (adolescent/adult) develop inflammation of the testes. Occasionally, mumps causes infertility or permanent deafness.	About 1 in 100 may develop swelling of the salivary glands. Serious adverse events are very rare.
Pertussis – bacteria spread by respiratory droplets; causes 'whooping cough', with prolonged cough lasting up to 3 months.	About 1 in 125 babies under the age of 6 months with whooping cough dies from pneumonia or brain damage.	About 1 in 10 has local swelling, redness or pain at the injection site, or fever (DTPa/dTpa vaccine). Booster doses of DTPa may occasionally be associated with extensive swelling of the limb, but this resolves completely within a few days. Serious adverse events are very rare.
Pneumococcal infection – bacteria spread by respiratory droplets; causes septicaemia (infection of the blood stream), meningitis (infection of the tissues surrounding the brain) and occasionally other infections.	About 3 in 10 people with meningitis die. One-third of all pneumonia cases and up to half of pneumonia hospitalisations in adults is caused by pneumococcal infection.	About 1 in 5 has local swelling, redness or pain at the injection site, or fever (conjugate vaccine). Up to 1 in 2 has local swelling, redness or pain at the injection site (polysaccharide vaccine). Serious adverse events are very rare.
Polio – virus spread in faeces and saliva; causes fever, headache and vomiting and may progress to paralysis.	While many infections cause no symptoms, up to 3 in 10 patients with paralytic polio die, and many patients who survive are permanently paralysed.	Local redness, pain and swelling at the injection site are common. Up to 1 in 10 has fever, crying and decreased appetite. Serious adverse events are very rare.
Rotavirus – virus spread by faecal-oral route; causes gastroenteritis, which can be severe.	Illness may range from mild diarrhoea to severe dehydrating diarrhoea and fever, which can result in death. Of children under 5 years of age, before vaccine introduction, approximately 10 000 children were hospitalised, 115 000 needed GP visits and 22 000 required an Emergency Department visit each year in Australia.	Up to 3 in 100 may develop diarrhoea or vomiting in the week after receiving the vaccine. About 1 in 17 000 babies may develop intussusception in the first few weeks after the 1st or 2nd vaccine doses. Serious adverse events are very rare.
Rubella – virus spread by respiratory droplets; causes fever, rash and swollen glands, but causes severe malformations in babies of infected pregnant women.	Patients typically develop a rash, painful swollen glands and painful joints. One in 3000 develops low platelet count (causing bruising or bleeding); 1 in 6000 develops encephalitis (brain inflammation). Up to 9 in 10 babies infected during the first trimester of pregnancy will have a major congenital abnormality (including deafness, blindness or heart defects).	About 1 in 10 has local swelling, redness or pain at the injection site. About 1 in 20 has swollen glands, stiff neck or joint pains. About 1 in 20 has a rash, which is non-infectious. Low platelet count (causing bruising or bleeding) occurs after the 1st dose of MMR vaccine, at a rate of about 1 in 20 000 to 30 000. Serious adverse events are very rare.
Tetanus – caused by toxin of bacteria in soil; causes painful muscle spasms, convulsions, lockjaw.	About 2 in 100 patients die. The risk is greatest for the very young or old.	About 1 in 10 has local swelling, redness or pain at the injection site, or fever (DTPa/dTpa vaccine). Booster doses of DTPa may occasionally be associated with extensive swelling of the limb, but this resolves completely within a few days. Serious adverse events are very rare.
Varicella (chickenpox) – highly contagious virus; causes low-grade fever and vesicular rash (fluid-filled spots). Reactivation of the virus later in life causes herpes zoster (shingles).	One in 100 000 patients develops encephalitis (brain inflammation). Infection during pregnancy can result in congenital malformations in the baby. Infection in the mother around delivery time results in severe infection in the newborn baby in up to one-third of cases.	About 1 in 5 has a local reaction or fever. About 3 to 5 in 100 may develop a mild varicella-like rash. Serious adverse events are very rare.