Submission to the Senate Inquiry on the Human Rights and Anti-Discrimination Bill 2012

Re The Australian Government's Vaccination Policies and the discrimination of healthy individuals in schools and the workplace.

Summary:

- Australian government vaccination policies are a human rights issue because the government has adopted coercive measures and a default position of vaccinating (rather than not vaccinating) which removes the free choice of individuals to use or not use this medical intervention.
- Australian vaccination polices are administered by the State and Territory Public Health Acts however they are implemented using federal government guidelines. This is resulting in a systematic discrimination of healthy individuals throughout Australia and the issue is of concern to all Australians. Therefore, this area of health should be included in the jurisdiction for the Federal Human Rights Commission.
- The vaccination of infants is within the scope of the Convention on the Rights of the Child Treaty and the United Nations General Assembly Declaration on the Rights of the Child. These treaties are within the jurisdiction of Australia's Federal Human Rights Commission.
- Coercion in the use of a medical procedure in healthy individuals must be proven to be necessary and safe using *disinterested* science before the practice is adopted.

Vaccination and Human Rights

Australian vaccination policies have become a major issue for parents all around Australia. This submission is a request to ensure that all medical procedures that are administered to healthy individuals are included in the jurisdiction for the Federal Commission for Human Rights and to ensure that individuals cannot be discriminated against in public life as a result of their vaccination status. Currently vaccination policies in Australia are administered by State and Territory government Acts however these policies are being implemented under national guidelines so the issues of concern are the same in all jurisdictions.

These policies are resulting in a systematic discrimination of healthy individuals across Australia. This is because many childcare centres, independent schools and employment settings are choosing against non-vaccinated children and employees. In particular, health students at tertiary institutions are being informed that they may not be able to complete their degree and work in clinical situations if they do not ensure they are up to date with 10 vaccines (Australian Government Immunisation handbook 9th ed; Curtain University). These policies are discriminatory and infringe upon the basic human right of bodily integrity. The Australian Government has not provided evidence that this policy is necessary for the good of the community in protecting against infectious diseases (Australian Government Immunisation handbook 9th ed).

Government policies that include a medical procedure such as vaccination infringe upon the individual's bodily integrity and our right to choose how we maintain our own health (Habakus and Holland 2011). Maintaining choice in vaccination is a basic human right because it is integral with life, liberty and bodily integrity (Habakus and Holland 2011). In the 1940's the

world adopted the human rights principles of the Nuremberg Code. This is a set of ethical principles for medical research that stipulated that experimentation on human subjects without free and informed consent was not permitted (Holland in Habakus and Holland 2011 ch. 1). In 1997 it was stated at the Council of Europe's Convention on Human Rights and Biomedicine that:

'*An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it'* (Habakus and Holland 2011 ch. 1).

Our freedom to choose what we inject into our body is inherent with human dignity: a value that has been protected in many basic laws. These include religious laws, the Universal Declaration of Human Rights (UDHR), the United Nations (UN) Charter, the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social, and Cultural Rights (ICESCR) (Habakus in Habakus and Holland 2011 ch.3). These laws have been combined to form what is known as the International Bill of Human Rights that applies to all countries (Habakus in Habakus and Holland 2011 ch.3).

Coercive and mandatory vaccination is a limitation on human rights and prominent health and human rights advocates have stated that governments must justify any restrictions to human rights that are enforced in public health policy (Holland in Habakus and Holland 2011 ch. 1). Although the right to choice in international law came from the Nuremberg Code and the prevention of experimentation on the human population, it is stated that '*the international right to informed consent now encompasses the free and informed consent for all medical decision-making* (Song in Habakus and Holland ch.2). The United Nations Education Scientific and Cultural Organisation (UNESCO) adopted the UNESCO Declaration in 2005 that states '*the*

interests of individuals cannot give way to the sole interest of science or society' (Song in Haberkus and Holland ch. 2).

Australia's vaccination policies infringe upon human rights in a discriminatory manner, in particular against healthy individuals, and the government must be accountable and ensure that vaccines are justified in a scientific and systematic way (Mann in Habakus and Holland 2011 ch.3). Academics at the Harvard School of Public Health argue that actions that restrict human rights must be taken as a last resort and must only occur under certain circumstances (Habakus in Habakus and Holland 2011 ch.3). The analysis these academics performed demonstrated that mandatory and coercive vaccination policies cannot be justified using a human rights framework (Habakus in Habakus and Holland 2011 ch. 3). Consequently our freedom to choose how we care for our own bodies is currently being removed and discriminatory vaccination policies are being introduced without proper justification.

The Australian Government's Vaccination Policies 2012

In 2012 the National Immunisation Program (NIP) recommends a schedule of vaccines that includes 16 vaccines to protect against infectious diseases even though the majority of these infectious diseases became a low risk in Australia from 1950 onwards (Commonwealth Yearbook 1937 – 1986, ABS 2001)**.** This was prior to the use of most vaccines. Since the inception of the government's immunisation program in 1993 the list of diseases on the NIP schedule has expanded from 10 to 16. Children are now recommended 7 vaccines at 2 months of age and 14 vaccines by 4 years of age. This results in approximately twenty-four inoculations/doses for full vaccination coverage by the age of four (DHA 2012).

During the nineties the Australian Government introduced the Maternity Immunisation Allowance (MIA) to increase the vaccination rates of children less than 4 years of age. This was implemented on the belief that infectious diseases could be eradicated *not* because these diseases represented a serious threat to the majority of children. The initiative was designed to act as an incentive and a reminder to parents to immunise their children on time. Since 2009 the MIA has been provided to parents in 2 payments. The first payment ($129) is when the child is aged between 18 – 24 months old and the second payment ($129) is between 4 - 5 years old. This payment will not exist after the 1 July 2012 as it is being replaced by the Family Tax Benefit A Allowance (DHA 2012).

Another welfare payment that parents have been able to receive under the IAP is the Child Care Benefit. This payment assists with the cost of day care centres and other childcare facilities. Again the benefit applies to children who are fully vaccinated or have an approved exemption from immunization.

Family Tax Benefit Part A Allowance

The MIA scheme is being replaced on the 1 July 2012 with the Family Tax Benefit Part A Supplement. This Supplement increases the incentive to vaccinate to $2,100 per child and this will be paid to parents of fully immunised children in 3 installments of $726 (DHA 2012). The government states that '*Families will now need to have their children fully immunised to receive the existing $726 per child Family Tax Benefit Part A supplement replacing the Maternity Immunisation Allowance from 1 July 2012'* (DHA 2012).

In order to obtain the new welfare benefit parents are required to have their children assessed by the Family Assistance Office (FAO) at one, two and five years of age (DHA 2012). Children

must be either fully vaccinated or on a recognised immunisation catch up schedule for parents to obtain this benefit. Parents of children who are not vaccinated or not on a recognised catch up schedule will need a valid exemption form signed by a health professional to obtain this benefit. The assessment of the immunisation status of children must take place during the financial year that each child turns one, two and five years of age in order to receive the benefit (DHA 2012). By 2013 the term 'fully vaccinated' will include 3 more vaccines than were recommended in 1990. 'Fully vaccinated' in 2013 will mean inoculation against 11 diseases before 12 months of age and against 12 diseases by 2 years of age (DHA IAP 2012).

The three new vaccines that are being added to the recommended government schedule on July 1 2013 are meningococcal C, pneumococcal and varicella (chickenpox). Although these vaccines have been available to parents for several years they have not been required to obtain government welfare payments. As of 1 July 2013 these vaccines will now be required for children to be assessed as 'fully vaccinated'. Varicella will be available in a new combination vaccine - Priorix-Tetra - at 18 months of age from July 2013. This will be the measles, mumps, rubella and varicella combination vaccine. The list of vaccines needed to be classified as 'fully' immunized in 2013 compared to 2012 is illustrated on the Immunise Australia Program website (DHA IAP 2012).

There are other vaccines that are available to children but they are not included in the recommended schedule of vaccines needed to be classed as 'fully vaccinated'. These are:

- the rotavirus vaccine (recommended against gastroenteritis in infants)
- influenza vaccine and
- hepatitis A vaccine

Vaccine Ingredients

The government and medical professionals have not ensured that parents are fully aware of the ingredients that are injected into infants with each vaccine that is used. Each vaccine contains approximately five or more ingredients and many of these substances are not inert. The government does not display these ingredients clearly on the Immunise Australia Program (IAP) website. In order to find the ingredients the public must look for 'components of vaccines' and these are located in Appendix 4 of the Immunisation Handbook (9^{th} ed) on the government website. Many of the substances in vaccines are known to be toxic and several are neurotoxins given to infants before the blood brain barrier is formed at 6 months of age (Cook 2006, Eldred 2006, Shoenfeld 2011). The health effects from low doses of toxins have not been established (Gilbert 2004).

The Australian government is not fully informing the public about this medical practice for healthy individuals and it has implemented a coercive policy (by linking the schedule to welfare benefits) with a default position of vaccinating. Parents who do not wish to vaccinate their children must make an appointment with their GP to obtain a doctor's signature to reject this medical procedure. This requirement goes against the right of individuals to give their informed consent to having a medical procedure: instead of giving their consent for doctors to use a medical procedure, healthy people are required to get a doctor's signature to *reject* a medical procedure.

Medical Education and Advertising

The line between medical 'education' and 'advertising' has also become blurred for doctors and industry. Whilst it is illegal for drug companies to offer doctors 'kick backs' to prescribe drugs to patients, an exemption is given if the information is provided for 'educational or research activity'. Under this umbrella the drug companies can present unlimited gifts to doctors so the drug companies decide whether their information is 'educational' or 'advertising' (Angell 2005). Drug companies are claiming that their 'advertising' is in fact 'education'.

In order for doctors to maintain their license they are required to undergo continual medical education from accredited institutions. In the US this education is controlled by the Accreditation Council of Continuing Medical Education (ACCME) (Angell 2005). It is this organisation that accredits companies to participate in the education of medical professionals. Pharmaceutical companies fund 60% of doctor's education and ACCME has accredited around 100 for-profit companies that are hired by drug companies to provide medical education to doctors (Angell 2005). This information is not impartial because the information is supplied by companies that are employed by drug companies. The ACCME board ignores this conflict of interest in the education of doctors because half of its board members are from pharmaceutical companies or other industries (Angell 2005). Again the authorities are 'pretending' that the medical information that doctors receive is from a disinterested source. Angell (2005), states that ACCME has even accredited Eli-Lilly pharmaceuticals to prepare and present education material for doctors (p.140).

In order to get support the medical schools and hospitals must go along with the sponsors. It has been demonstrated that doctors who have attended continuing education programs prescribe

more of the sponsor's drugs than any other drug (Angell 2005). Doctors may also receive training to join speaker's bureaus and speak on behalf of the industry (Angell 2005, Peterson 2008). Drug companies also try to recruit the heads of hospitals and other prominent medical experts in medical schools to act as 'leaders' and give talks at medical meetings. These individuals are enticed with 'food, flattery and friendship' (Angell 2005 p.142). This often includes favours, honoraria for being a consultant or a speaker or paying for posh resorts at conferences (Angell 2005). Doctors would lose travel and entertainment packages if industry was not paying for doctor's education and it is thought that membership of professional medical societies would be lower if this was the case (Angell 2005 p.147).

Pharmaceutical companies are also sponsoring 'patient advocacy groups' (Angell 2005 p.151). Many of these lobby groups are fronts for the drug companies to promote their interests and they are presenting science that is hindering public debate. The pretense that pharmaceutical marketing is 'education' involves the collaboration of both industry and the medical profession. It is well established that medical education requires an impartial assessment of all the evidence and this must be led by 'experts' that do not have vested interests. Knowledge that is influenced by commercial interests is not 'true' medical knowledge because it is not produced with the integrity of the scientific ethos (Angell 2005 p. 154).

The medical establishment has been complicit in the deception of the public and they have abdicated their duty of care to the public (Angell 2005). This is evidence that the medical profession has become corrupted by money and the overuse of drugs. Governments and the medical profession need to acknowledge that industries do not provide disinterested information about their own products (Angell 2005 p. 155). The influence of industry in the education of doctors and in medical research is a problem in all countries and government health policies

must demonstrate that disinterested science is being used to make decisions for the community good.

In 1980 the Patent Act was changed so that patentable inventions no longer had to be 'novel, useful and non-obvious' and this made it possible to patent many more 'inventions' (Angell 2005 p. 176). The most lucrative activity for industry is to create a monopoly on a drug through the US Patent and Trademark Office (USPTO) and ensure it is extended for as long as possible (Angell 2005 p. 173). Another method is to obtain exclusive marketing rights from the FDA (Angell 2005).

Conflicts of Interest in Policy Development

The new academic - industry paradigm has resulted in an unprecedented rise in conflicts of interest (COI) particularly in the areas of public interest research (Krimsky 2003). COI amongst scientists have been linked to research bias as well as the loss of disinterestedness among academic researchers. Researchers know that positive results get published and negative results do not, therefore they need to shape the results using selected criteria and methodologies in order to get the financial rewards (Krimsky 2003, Michaels 2008). The commercialization of universities results in laboratories selecting faculty members in line with their goals and fewer opportunities are available in academia for public-interest science. This has significant consequences to society.

When global market mechanisms are uncontrolled and focused on profit they threaten the objectivity of clinical research (Krimsky 2003). These mechanisms nurture the COI's that generate bias and unreliability into research and medicine. According to an Italian editor of an international medical journal:

'*Members of corporate driven special interest groups, in virtue of their financial power and close ties with other members of the group often get leading roles in editing medical journals and in advising non-profit research organizations'* (Krimsky 2003 p.10).

They act as reviewers and consultants with the task of systematically preventing dissemination of data which may be in conflict with their special interests (Giovanni 2001 in Krimsky 2003). This statement is supported by the previous editor of the New England Journal of Medicine (NEJM), Marcia Angell MD. She states:

'*It is simply no longer possible to believe much of the clinical research that is published, or to rely on the judgment of trusted physicians or authoritative medical guidelines. I take no pleasure in this conclusion, which I reached slowly and reluctantly over my two decades as an editor of the New England Journal of Medicine'* (Angell 2009).

Over the past three decades the research environment for scientists has changed significantly and it is now common for scientists to be affiliated with industry and to have equity in the companies funding their research (Krimsky 2003). The existence of COI in research institutions is also largely a hidden problem and the COI that the public hear about are only the tip of the iceberg (Krimsky 2003). The great majority remain undisclosed. In many universities and research institutions they are accepted as the norm and a person's position is rarely threatened even if it gives the appearance of bias. There are many types of COI and they are occurring with increasing frequency in academic institutions and non-government research centers. Some examples of COI are professorships within state owned universities that are being financed by private corporations (Krimsky 2003).

Conflicts of Interest in the Development of Australian Vaccination Policies

Australia's vaccination policies have been recommended to our Minister for Health by the Australian Technical Advisory Group on Immunisation (ATAGI). This group is also responsible for providing advice about funding to research bodies and to advise research organisations on additional areas where research funding is required (DHA 2012). In Australia the chairman of this body and several other representatives on this committee have declared conflicts of interest (COI) with vaccine manufacturers. It is important that any COI are transparent to the public because decisions made in public health policy should be founded on disinterested science.

Professor Terry Nolan has been the chairman of the ATAGI advisory group for several years and deputy chairman of the research committee of the National Health and Medical Research Council (NHMRC): the committee that allocates funding for research projects (DHA 2012). Professor Nolan's declared conflicts of interest include being a member of a CSL vaccine advisory board (at some time) and receiving nominal payments (honoraria) as well as support for conference attendance from CSL Ltd, Novartis and GlaxoSmithKline (Nolan et al 2010). He was also the chief investigator of the clinical trial for CSL's Panvax influenza vaccine in 400 children in 2009 (Nolan et al 2010) at the same time as being on the primary advisory boards for immunisation policy-decisions.

Other members of ATAGI (and other advisory boards) who have declared conflicts of interest include Professor Peter Richmond and Professor Robert Booy. Professor Peter Richmond was a member of the government's Influenza Specialist Group (ISG) (a body that is 100% industry funded) and also the Australian Technical Advisory group on Immunisation (ATAGI). At other times he has been a representative on a CSL vaccine advisory board (Bita 2010). At various

times he has received nominal payments from CSL and he was also an investigator in the CSL funded clinical trial for Panvax vaccine in 2009 (Nolan et al 2010).

Robert Booy is the co-director of the Australian Government's National Centre for Immunisation Research and Surveillance Unit (NCIRS). In 2010 he was also a member of the government's Influenza Specialist Group (ISG) (Sweet 2010). He was an investigator in the clinical trial for children's Panvax (H1N1) vaccine in 2009 which was funded by CSL and he has received support from CSL limited and other pharmaceutical companies to attend conferences (Nolan et al 2010). He has been a representative on a vaccine advisory board for these companies at various times and has also received funding from Roche, Sanofi, GlaxosmithKline and Wyeth for attending and presenting at scientific meetings (Nolan et al 2010). These activities are a possible conflict of interest with his role as a government policy advisor and director of the government's research and surveillance unit yet they are not openly revealed to the public.

In 2010 Dr. Alan Hampson was a member of the Influenza Specialist Group (ISG) and he had previously been the Research and Development Manager at CSL (Dean 2009). Anne Kelso was a member of the ISG in 2010 and she had shares in CSL, Australia's only flu vaccine manufacturer. She was also in charge of the WHO influenza laboratory in Melbourne (Bita 2011)

In addition, The Therapeutic Goods Administration (TGA) that approves medicines and vaccines for the Australian market is also 100% funded by industry (DHA TGA 2012). The role of this body is to approve drugs and monitor the safety of these drugs: this is described by the government as a 'Cost-Recovery' system or a 'user-pay' system which makes the TGA directly dependent upon the industry they regulate for funding (DHA 2012). In other words, the TGA is expected to protect the interests of industry by approving the products that its sponsors

recommend and protect the interests of the general public by monitoring the side-effects of the drugs that it approves. It is not possible for a committee to protect the interests of both of these stakeholders at the same time yet the government continues to justify this practice and denies that this is a problem. There are other members on government advisory groups who may have potential conflicts of interest with manufacturers and these are not being openly revealed to the public.

It is critical that public health policies are devised by policy-makers in an open and transparent manner with all COI available to the public. Whilst it is recognised that many researchers and scientists are now involved in financial arrangements with industry there is no justification for decision-makers to have financial arrangements with industry. Policy decisions should also be made by committees with the participation and consent of the general public. Yet the ATAGI committee consists of only one consumer representative and many technical experts and general practitioners: and there is no attempt to gain the participation and consent of the general public. If the general public is not properly represented on these committees and the public is not advised of conflicts of interest on these boards then the community is open to 'trusting' that these boards are acting in the public interest. This is not evidence-based practice and it puts population health at risk.

The health of all populations is dependent upon governments providing proof that decision-making boards are using disinterested science and ensuring that they are accountable for the policy-decisions that are made. If there are potential conflicts of interest then it is the government's responsibility to clearly inform the public of all COI. The public should not have to rely on 'faith' that conflicts of interest do not exist on these boards – the onus is on

governments ***to prove*** that this is the case when polices are implemented. Particularly when they involve coercive practices recommending a medical procedure to healthy individuals.

There is no place for coercion in the use of vaccines until the government provides evidence that public health policy is not being influenced by industry generated science and until the safety, efficacy and necessity for the use of so many vaccines has been supported with evidence. The public would like this issue to be included in the jurisdiction for the Federal Human Rights Commission. Current Australian vaccination policies are unethical because they have not been justified as necessary and they violate the Nuremberg code and the International Bill of Human Rights regarding informed consent and the use of a medical procedure.

REFERENCES:

Angell M, 2005, The Truth About Drug Companies: How they deceive us and what to do about it, Random House Trade Paperbacks, New York, USA

Angell M, 2009, Drug Companies and Doctors: a Story of Corruption, *The New York Review of Books* http://www.nybooks.com/articles/archives/2009/jan/15/drug-companies-doctorsa-story-of-corruption/

Australian Government, Australian Bureau of Statistics (ABS)

1301.0 Year Book Australia, 2001, Child Health Since Federation (updated 29.03.06)

Australian Government, Department of Health and Ageing, Immunise Australia Program, www.immunise.health.gov.au updated 25 November 2011 (visited December 2012)

a) About the Program

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

visited December 2012

b) Frequently Asked Questions (FAQ), last modified September 2010

http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/faq#1

visited 19.10.11

c) The list of vaccines required to be 'fully immunised'

d) Strengthening Immunisation for Children

http://immunise.health.gov.au/internet/immunise/publishing.nsf/Content/factsheet-strengthening-immunisation

e) Immunisation Handbook

http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook-specialrisk238 visited June 2012

f) Therapeutic Goods Administration, Cost Recovery Impact Statement (CRIS), Regulation of In-Vitro Diagnostic Devices, September 2009

http://www.tga.gov.au/pdf/archive/fees-cris-ivd-091020.pdf visited June 2012

Bita N, Consumer editor, 29th September 2010, A flu jab too close for comfort, *The Australian,* www.theaustralian.com.au/news/features/a-flu-jab-too-close-for-comfort/story-e6frg6z6-1225931148903

Bita N, 2011, Flu Advisor Defends CSL Shares, *The Australian*, 8th September

Commonwealth Department of Health, 1945 – 1986, Official Yearbook of the Commonwealth of Australia, (Com.Year) No. 37 – 72.

Cook M, 2006, Autistic Reactions, *The Australian Financial Review*, 24/03/06

www.afr.com

Dean T, 2009, CSL Speaks out on Vaccination 'Myths', *Australian Life Scientist*, 1 October

Eldred BE et al, 2006, "Vaccine components and constituents: responding to consumer concerns", *Medical Journal of Australia*, 184: No. 4: pp.170-175

Gilbert SG, 2004, A Small Dose of Toxicology: the health effects of common chemicals, Boca Raton Fla, CRC Press.

Habakus LK and Holland M (ed), 2011, Vaccine Epidemic: how corporate greed, biased science and coercive government threaten our human rights, our health and our children, Center for Personal Rights Inc, Skyhorse Publishing, 306th St New York,
http://vaccineepidemic.com/

Krimsky S, 2003, Science in the Private Interest: has the lure of profits corrupted biomedical research? Rowman and Littlefield Publishers Inc, USA.

Michaels D, 2008, Doubt is Their Product: How Industry's Assault on Science Threatens Your Health, Oxford University Press, New York, USA

Nolan T, McVernon J, Skeljo M, Richmond P, Wadia U, Lambert S, et al. Immunogenicity of a Monovalent 2009 Influenza Vaccine in Infants and Children: A Randomised Trial. Jama. 2010 jan 6:303 (1): 37-46: Supplementary online content.

Shoenfeld Y and Agmon-Levin N, 2011, ASIA – Autoimmunity/inflammatory syndrome induced by adjuvants, *Journal of Autoimmunity,* 36 p. 4-8.

Sweet M, *Crikey,* The shot of PR that could undermine public health policy. www.crikey.com.au/2010/09/29/the-shot-of-pr-that-could-undermine-public-health-policy

Visited 10.8.11