Vaccination and the law

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Background

Debate on whether vaccination should be made mandatory through law is vexed and centres on the rights of the community versus those of the individual – in particular, their right to make decisions in the best interest of their child.

Objective

This review examines the role that legislation and case law play in determining whether it is in the child's best interest to be protected against vaccine-preventable diseases.

Discussion

Legislating to make vaccination mandatory raises conflicting issues. Legal compulsion may impinge on a parent's right to choose what they consider is in the best interest of their child. The dilemma is whether achieving herd immunity, in particular the protection of children against serious and preventable diseases, justifies infringing on these rights.

Public immunisation programs reduce mortality and morbidity in vaccine-preventable diseases, and are considered to be safe by governments, health advocates and practitioners. However, there is strong opposition to their implementation from certain lobby groups,[1] resulting in a complex interaction between regulatory bodies, parents, lobbyists and health practitioners. Ensuing information and misinformation has caused many parents to question whether vaccinating their child is acting in the child's best interest.

Debate on whether vaccination should be made mandatory through law is vexed. It centres on the rights of the community versus those of the individual, in particular, the individual's right to make decisions in the best interest of their child. The success of vaccination has meant near or total eradication of serious and often fatal childhood illnesses. Ironically, it is this success that has led to parental complacency and has given rise to concern that vaccine-preventable diseases will return.

While it remains the responsibility of parents to make the decision on whether to vaccinate their child, legal disputes have arisen between the child's parents, and between parents and the state. Both sides acknowledge that vaccination carries risk, but the degree differs markedly, and the courts have to arbitrate while maintaining the rights and best interest of the child in every instance.

Vaccination and public health

Ideally, governments formulate their health policies and regulations more broadly, and are concerned with the national interest. They take into account the risks to individuals, including vulnerable groups such as children. Parents, on the other hand, are primarily concerned with the wellbeing of their child. Understandably, their decision is emotional and practical when they weigh up the risks of vaccination versus non-vaccination.

A wealth of information on the potential side effects of vaccination is now available. Unfortunately, misinformation that instils fear about purported adverse effects can result in a decrease in coverage rates below those required to achieve herd immunity. Typically, vaccine-related reactions may include fever, rash and upper respiratory tract symptoms; however, lowest risk reactions such as encephalitis can understandably cause the most alarm because of the potentially fatal consequences.[2–4]

Encouragement and incentive to vaccinate is best enshrined in policies and delivered through effective communication strategies. This is countered by the view that legal enforcement resolves all those cases where the parent is apathetic, plus the law can be flexible to allow for those who make a deliberate conscientious objection.

Federal, state and territory governments are concerned about the repercussions of low vaccination rates in certain areas and the potential of disease outbreaks,

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particularly in our increasingly mobile population. The independent National Health Performance Authority's (NHPA's) report on childhood immunisation rates found that despite the high percentage of children who were fully immunised, there was still a large number of children who were not, or were only partly, immunised. These cases were spread unevenly across the country. For example, for children aged five years, the report identified low immunisation rates around Byron Bay (about 67%) but high rates in the Illawarra region (about 98%).[5]

Consent and the law

Until the late 20th century, common law assumed that a person under 18 years of age did not have the capacity to make health decisions, including consenting to (and by default declining) medical treatment on their own behalf. This position changed following the English case *Gillick v West Norfolk & Wisbech Area Health Authority*[6] for determining a child's competence. This followed with the High Court of Australia's case *Department of Health and Community Services (NT) v JWB and SMB* (commonly known as 'Marion's case').[7]

The two cases introduced the 'mature minor principle', where minors (under 18 years of age) may be able to make healthcare decisions on their own behalf if they are assessed to be sufficiently mature and intelligent to do so. It is in this context that Australian courts would rule, in assessing the best interest of the child, whether the child refusing vaccination is 'competent' to make that decision.

Vaccination through case law

There have been a number of cases in Australia and internationally where courts have authorised the vaccination of a child against the wishes of at least one of the parents (Box 1). In all cases, the judges ruled that they were acting in the best interest of the child and based their decision on the scientific evidence presented, including risk assessments by medical practitioners.

In one instance,[8] the parents defied the New South Wales Supreme Court's order to vaccinate and concealed the child until the period of effectiveness had lapsed. While the judge defended *parens patriae* – the power and authority of the state to protect persons who are unable to legally act on their own behalf – this case shows that monitoring compliance with the court's directions can present a problem, particularly if treatments are ongoing. *Parens patriae* may also empower the courts to overturn the decisions of minors who refuse treatment, no matter how 'competent' they are deemed to be.

In another case, this time in the UK,[9] two children were deemed to be

Box 1. Court cases on vaccination and the best interest of the child

***Duke-Randall & Randall* [2014] FamCA126**

This Family Court of Australia case involved a divorced couple with opposing views on vaccination. The mother's objections were based on the associated risks, while the father's concerns included the impact of limitations placed upon his children if they were not vaccinated. The children were found by an immunologist not to be susceptible to a greater risk of vaccine-related harm and Justice Foster deemed this evidence to be determinative. In this case, Justice Foster ruled that the father could have his children vaccinated.

***Re H* [2011] QSC 427**

This Queensland Supreme Court case involved both parents who refused to vaccinate a child born to a mother with chronic hepatitis B, thereby exposing the child to a 10–20% risk of infection. If infected, the child had a 90% chance of developing a chronic infection, and consequently a 25% chance of developing cirrhosis and/or hepatocellular carcinoma. The baby could not be tested until nine months of age, but could be vaccinated against the possibility of infection immediately. The medical team contended that the child should be vaccinated to greatly reduce the risk of infection. In this case, Justice Dalton ordered that the child be vaccinated.

***Re Jules* [2008] NSWSC 1193**

This New South Wales Supreme Court case related to administering the hepatitis B vaccine to a child. The parents defied the order to vaccinate and concealed the child until the period of effectiveness had lapsed. As the treatment could no longer be administered, Justice Brereton ordered that the responsibility be given back to the parents. He defended *parens patriae* as necessary to 'safeguard and oversee the welfare of those who are unable to attend to their own welfare and, in particular, children'.

***F v F* [2013] FamEWHC 2683 (UK)**

This UK case involved two children, 11 and 14 years of age at the time, who were considered 'competent' and, thus, whose views were sought. They did not want to be vaccinated because they believed it was dangerous. Their father, who was originally opposed to vaccination, changed his mind due to reports of an outbreak of measles and the discrediting of research linking the measles, mumps, and rubella (MMR) vaccination to autism. Justice Theis ordered the children be vaccinated, stating that she was 'only concerned with the welfare needs of these children' and also had 'to consider their level of understanding of the issues involved and what factors have influenced their views'.

***Re Kingsford and Kingsford* [2012] FamCA889**

This Family Court of Australia case for vaccination was complicated by the promotion of homeoprophylaxis, a homeopathic vaccination purported by the anti-vaccination lobby to be an alternative to conventional vaccination without the side effects. Justice Bennett ruled for the father seeking to have his child conventionally immunised, which was contrary to the mother's wishes to have the child homoeopathically immunised. Here, the scientific evidence presented was paramount in the judge's decision that conventional vaccination was acting in the best interest of the child.

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'competent' as they possessed the necessary reasoning abilities to have their views against vaccination taken into account. However, the judge decided for vaccination, stating she was 'only concerned with the welfare needs of these children'. A decision by an Australian court in this instance would be guided by the *Gillick* and *Marion* cases.

In early 2015, the gulf between pro- and anti-vaccination groups was again illustrated in a German regional court. It decided for a doctor claiming a reward from a biologist who had offered €100,000 for scientific evidence proving the measles virus, but then refused to pay.[10]

Anti-vaccination lobby

Anti-vaccinationists have existed for as long as vaccines and have always agitated strongly against vaccination. Dr Sherri Tenpenny regularly delivers seminars on what she believes are the negative impacts of vaccines on health. One of her books was promoted as a 'comprehensive guide' and explains why vaccines are 'detrimental to yours and your child's health', which she attributes to 'vaccine injuries' such as autism, asthma and autoimmune disorders.[11]

Dr Tenpenny has warned that 'each shot is a Russian roulette: you never know which chamber has the bullet that could kill you'.[12] She argues that adverse reactions listed in the package inserts include encephalitis and criticises 'deceptive research', claiming a shot of aluminium was used as the placebo during a safety study with the Gardasil vaccine.[11] The anti-vaccination movement has increasingly used the internet and social media to distribute largely unchecked, alarmist and misleading material. It has therefore been impossible to enforce uniform ethical approaches from the pro- and anti-vaccination advocates.

In some instances, courts and tribunals have addressed the distribution of misleading material regarding vaccination. What remains unclear is whether the anti-vaccination lobby is legally required to adhere to the standards that health professionals are, namely to conduct themselves in a manner prescribed under professional codes and legislation.[13] Failure to comply could potentially result in the loss of registration and/or practising rights.[14]

In the New South Wales case of *Australian Vaccination Network Inc v Health Care Complaints Commission*, Justice Adamson ordered that it was not within the Commission's jurisdiction[15,16] to issue a public warning against the Australian Vaccination Network in relation to 'engaging in misleading or deceptive conduct in order to dissuade people from being, or having their children, vaccinated'.[17] However, in February 2014, following a jurisdictional change in the law, the New South Wales Administrative Decisions Tribunal upheld an order from the Office of Fair Trading for the Australian Vaccination Network to change its name to the Australian Vaccination-Sceptics Network to more accurately reflect the advice it dispenses.

Federal, state and territory vaccination initiatives

The Australian Government is implementing its National Immunisation Strategy for Australia 2013–2018 through a set of strategic priorities,[18] which includes:

- improving immunisation coverage through secure and efficient supply of vaccines
- community confidence
- a skilled immunisation workforce
- effective monitoring and analysis of results.

Essential vaccines are provided free of charge to eligible infants, children, adolescents and adults, meeting international goals set by the World Health Organization. Vaccinations are monitored under the independent NHPA, which was set up under the *National Health Reform Act 2011*. Program funding agreements between governments are set up under the National Partnership Agreement on Essential Vaccines.[18]

State and territory governments are instituting more requirements to ensure children are vaccinated. In New South Wales, the *Public Health Act 2010* was amended so that from 1 January 2014, before enrolment at a childcare facility, a parent/guardian is required to show that their child is fully vaccinated for their age, has a medical reason not to be vaccinated or is on a recognised catch-up schedule for their vaccinations. Otherwise, they have to declare a conscientious objection to vaccination.[19] This followed prolonged measles outbreaks in 2011 and 2013, and a subsequent 'No Jab No Play' campaign, which resulted from findings that some communities in New South Wales had vaccination rates under 50%.[20] The Queensland Government has announced its intention to introduce similar legislation in 2015. At the federal level, vaccination eligibility requirements have been introduced for entitlements such as Family Tax Benefit B.

Compulsory vaccination has been effective in preventing disease outbreaks, and as such justifies government intervention.[21] However, debate on mandatory vaccination must be open and factual.[22–24] Official exemptions on various grounds address protests regarding the 'nanny state' levelled against governments; however, exemption rates as low as 2% can increase a community's risk of disease outbreaks, depending on the disease. Fortunately, in the case of rotavirus, 80% coverage resulted in significant herd immunity and subsequent decrease in hospitalisations.[25]

In accordance with legislation and case law, it is in a child's best interest to be protected against vaccine-preventable disease. It is also in the community's best interest that children are protected against outbreak and spread of disease. To date, this is best achieved through programs that are accessible, well communicated and supported by law, so that parents can make informed decisions. It also counters the misinformation distributed by those opposed to vaccination.

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Since this article's submission, from 1 January 2016, conscientious objection will be removed as an exemption category for the Child Care Benefit, Child Care Rebate and Family Tax Benefit Part A end of year supplement.[26] Existing exemptions on medical or religious grounds will still apply with the correct approval. Importantly, immunisation requirements for payments will also be extended to include children of all ages except those under 12 months (based on early childhood immunisation status).[26]

Key points

- Vaccination reduces mortality and morbidity in vaccine-preventable diseases.
- Debate centres on the rights of the community versus those of the individual.
- Misinformation can result in a decrease in coverage rates required for herd immunity.
- A large number of children are not, or are only partly, immunised, and these cases are spread unevenly across Australia.
- Courts have authorised the vaccination of a child against the wishes of at least one of the parents, in all cases acting in the best interest of the child.
- The anti-vaccination movement has distributed misinformation and it is unclear whether it is legally required to adhere to the same standards that apply to health professionals.
- The National Immunisation Strategy for Australia 2013–2018 sets out strategic priorities and meets international goals set by the World Health Organization.
- On 1 January 2014, New South Wales legislated requirements to ensure children are appropriately vaccinated before enrolment at a childcare facility.

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References

1. Vines T, Faunce T. Civil liberties and the critics of safe vaccination: *Australian Vaccination Network Inc v Health Care Complaints Commission* [2012] NSWSC 110. J Law Med 2012;20:44–58.
2. Peltola H, Hemonen OP. Frequency of true adverse reactions to measles-mumps-rubella vaccine. Lancet 1986;1:939–42.
3. Fenichel GM. Neurological complications of immunization. Ann Neurol 1982;12:119–29.
4. Adetunji J. Schoolgirl dies after cervical cancer vaccination. The Guardian 2009 September 29. Available at www.guardian.co.uk/uk/2009/sep/28/hpv-cervical-cancer-vaccine-death [Accessed 18 August 2014].
5. National Health Performance Authority. Healthy Communities: Immunisation rates for children in 2012–13. NHPA: Canberra, 2014.
6. *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.
7. *Department of Health and Community Services (NT) v JWB and SMB* (1992) 175 CLR 218.
8. Director-General, Department of Community Services. *Re Jules* [2008]. NSWSC 1193:7.
9. F v F [2013] Fam EWHC 2683.
10. Bajekal N. German biologist who denied measles exists ordered to pay more than 100,000. Time World 2015 March 13. Available at http://time.com/3743883/german-biologist-measles-pay [Accessed 15 March 2015].
11. Tenpenny S. Saying no to vaccines: A resource guide for all ages. New York: NMA Media Press, 2008.
12. Tenpenny S. The ten reasons to say no to vaccines. Vaccination Council 2011 January 9. Available at www.vaccinationcouncil.org/2011/01/09/the-ten-reasons-to-say-no-to-vaccines [Accessed 10 February 2015].
13. Health Practitioner Regulation National Law, s 139B(1)(a)(i), adopted by New South Wales through the Health Practitioner Regulation (Adoption of National Law) Act 2009 (NSW).
14. Health Practitioner Regulation National Law 2009 (NSW), s 55.
15. The Australian Traditional-Medicine Society. Submission to the Committee on the HCCC Inquiry into False or Misleading Health-related Information or Practices. December 2013.
16. *Australian Vaccination Network Inc v Health Care Complaints Commission* [2012] NSWSC 110.
17. Evans L, HCCC investigator. Investigation report regarding the Australian Vaccination Network. Ms Meryl Dorey (File No 09/01695 & 10/00002) (7 July 2010) p 2 (Investigation Report). Available at www.stopavn.com/documents/HCCC-Report.pdf [Accessed 31 August 2014].
18. Department of Health. National Immunisation Strategy for Australia 2013–2018. Canberra: Department of Health, 2013.
19. *Public Health Amendment (Vaccination of Children Attending Child Care Facilities) Act 2013* (NSW Bills) No 127.
20. National Health Performance Authority. Healthy communities: Immunisation rates for children in 2011–12. Canberra: NHPA, 2013.
21. Salmon DA, Teret SP, MacIntyre CR, et al. Compulsory vaccination and conscientious or philosophical exemptions: Past, present, and future. Lancet 2006;367:436–42.
22. Javitt G, Berkowitz D, Gostin LO. Assessing mandatory HPV vaccination: Who should call the shots? J Law Med Ethics 2008;36:384–95.
23. Regan DG, Philp DJ, Hocking JS, et al. Modeling the population-level impact of vaccination on the transmission of human papillomavirus type 16 in Australia. Sex Health 2007;4:147–63.
24. Zimmerman RK. Ethical analysis of HPV vaccine policy options. Vaccine 2006;24:4812–20.
25. Dey A, Wang H, Menzies R, Macartney K. Changes in hospitalisations for acute gastroenteritis in Australia after the national rotavirus vaccination program. Med J Aust 2012;197:453–57.
26. Australian Government Department of Social Services. Strengthening immunisation requirements: Fact sheet. Canberra: 2015. Available at www.dss.gov.au/sites/default/files/documents/04_2015/immunisation_fact_sheet_-_12_april_2015.docx [Accessed 14 September 2015].

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