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, 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.

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,
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* 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’). 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, 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, two children were deemed to be...
‘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 jurisdiction15,16 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.
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.
• 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.

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References
6. Gillick v West Norfolk and Wisbech Area Health Authority (1986) AC 112.
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.