

**Submission to the Ministry of Health on the**  
***Public Health Legislation: Promoting public health, preventing ill  
health and managing communicable diseases, Discussion Paper***

**made by**

**The New Zealand Health Trust**

**Dated 4 April 2003**

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**SUBMISSION INDEX:**

SUBMITTER INFORMATION	page 2
EXECUTIVE SUMMARY	page 3
GENERAL COMMENT	page 5
SPECIFIC RESPONSES TO DISCUSSION PAPER	page 7
• INTRODUCTION	page 7
• FUNDAMENTAL PRINCIPALS	page 7
• INFORMATION	page 9
• PROMOTING PUBLIC HEALTH	page 15
• PREVENTING ILL HEALTH AND PROMOTING CHILD HEALTH	page 16
• CARE, MANAGEMENT AND COMPULSORY POWERS	page 27
CONCLUSION	page 32

## SUBMITTER INFORMATION

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- A. New Zealand Health Trust (NZHT) is a registered Charitable Trust established and run to act as a watchdog of consumer rights and choice in the health field.
- B. One of the roles of the NZHT is to stay informed of changes in health and welfare policy and/or legislation in New Zealand particularly such changes as affect the rights of consumers of health services in New Zealand. NZHT aims to contribute where possible to the development of New Zealand health policy and legislation on behalf of the increasingly large group of New Zealanders that have concerns about the safety and efficacy of pharmaceutical products. This is the context within which the NZHT makes the following submission.
- C. This submission is in response to the Ministry of Health document *Public Health Legislation Promoting public health, preventing ill health and managing communicable diseases Discussion Paper* are on the following pages. While our comments follow the structure of the Public Health Legislation discussion document the NZHT begins its submission with a bullet point executive summary and with some generalised comments on issues that arise numerous times throughout the document. This is followed by numbered points which address many of the questions raised in the document and subsequent submission booklet. NZHT acknowledges the support and assistance of the Immunisation Awareness Society in the preparation of this submission.
- D. Any communications relating to this submission should be directed to P David Sloan at
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- E. Should any hearing or inquiry be scheduled in relation to the proposed Bill then the NZHT wishes to appear at the same. In addition the NZHT would welcome the opportunity to present further detailed evidence or expert opinion to the Ministry in respect of any of the matters raised in this submission.
- F. The NZHT does not give permission for any personal details as above to be released to persons under the Official Information Act 1982.

## **EXECUTIVE SUMMARY**

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The views of the NZH expressed herein can be broadly summarised as set out below in bullet point form however this summary should not be seen as a full description of all matters put forward in this submission.

- To provide public authorities with the ability to enforce medical treatment on people against their will and in spite of their personal circumstances or beliefs and with almost no effective right of appeal, is an extremely serious infringement of basic civil liberties and is a breach of the Bill of Rights Act.
- It is a fundamental right that every patient must receive full information relating to their condition, the treatment options and the risks and likelihood of success associated with each. The patient must retain an absolute right of control over their treatment based on the provision of this information.
- Increased public participation in treatment programmes must come about as a result of increased education and confidence in the medical authorities and not through legislation forcing the same on an unwilling public.
- Every individual must retain the right to make their own risk/benefit analysis of any treatment proposed unless and until the treatment proposed can be scientifically and conclusively proven to be 100% safe for all people. The current medical climate is a very long way from being able to provide any such assurances.
- The proposals give insufficient recognition of and weight to the insufficient trials and evidence of the safety and efficacy of pharmaceutical products and the known high levels of illness and death caused by use of such products
- Proposals which have the wide ranging effect and implications of this proposal must have the widest degree of dissemination and consultation possible. This discussion document has not received anywhere near enough public debate and awareness. To the best of the knowledge of the NZHT the existence of the same was only posted on a government website where it is unlikely to be seen by any but the most dedicated watchers of policy developments. In addition submissions deadlines have meant in many cases that once the proposal was brought to an individual's attention, insufficient time remained to act on the same before the deadline passed.
- The proposed "future proofing" of the legislation gives a worrying high level of power to administrators without any effective means of public appeal or review leaving the industry wide open to the potential of decisions being driven by market forces and profit.
- Forcing treatment on people to prevent or treat conditions encourages both the individuals and the State to abrogate their base responsibility to identify and work with intrinsic precursors to health such as diet, exercise and healthy living conditions.

- One of the main sections of the proposal focuses on vaccination. Vaccination is a medical intervention for healthy people and has a range of side-effects from mild to severe, including permanent disability and death. Vaccination is never 100% effective and in many cases efficacy is very poor. Any immunity conferred by vaccination wears off over a period of time. Studies in New Zealand show that many vaccinated children still get the diseases for which they were vaccinated and more still have sub-clinical infections and unknowingly transmit disease to others. In reality, vaccinated New Zealanders are just as likely to transmit communicable diseases as unvaccinated people. While medical science can not guarantee the complete safety of all vaccines for all people removal of any of the existing rights of New Zealanders to informed choice regarding vaccination, or the right to refuse some or all vaccinations, or to discriminate against or punish the unvaccinated is a serious abuse of power and a denial of basic human rights.

## GENERAL COMMENTS

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- A. The title of the legislation, Public Health Bill, appears to be somewhat misleading and there seems to be a lack of clarity in the discussion paper of just what elements this Bill will comprise. There is mention of the addition to the Public Health Bill of legislation dealing with drinking water and screening programmes. However, other than these two issues it appears that the Public Health Bill concentrates on communicable diseases. Section two (General Framework) asserts that this Bill will be “the primary statute for action by the Director-General of Health to protect public health”. We dispute this statement as insufficient consideration is given to a wide range of public health issues and diseases apart from those concerning communicable diseases. Cardiovascular disease, diabetes, obesity, chemical sensitivities, autism and other developmental disorders, among many, many other diseases and conditions, are public health issues but get insufficient attention in the proposed legislation. This is not a comprehensive “Public Health Act” but rather legislation which provides a framework for managing communicable diseases in New Zealand.
- B. The NZHT is particularly concerned about the way that individual rights are treated in the proposals. There are frequent suggestions that the public good and “protection of public health” is of greater importance than individual rights. The rights of individuals to informed consent should not be extinguished by the rights of any group of people, and the right to informed consent, upheld by several pieces of New Zealand legislation, by definition confers the right to refuse medical treatment.
- C. The proposals state that, although under the New Zealand Bill of Rights Act (1990) individuals have the right to refuse medical treatment, “these rights are not absolute”. Until such time as any medical treatment or intervention, including but not limited to vaccination, can be categorically proven to be 100% safe for all people, then all New Zealanders must retain the right to refuse such medical treatment.
- D. A very small percentage of medical treatment and intervention is actually evidence based:

In 1978, the U.S. Office of Technology Assessment of the U.S. Congress estimated that “only 10 to 20% of all procedures currently used in medical practice have been shown to be efficacious by controlled trial.”

Ellis, J., Mulligan, I., Rowe, J., Sackett, D.L.: Inpatient general medicine is evidence based, *The Lancet*, Aug 12, 1995; 346: 407-10.

In 1979, Williamson *et al.* concluded that fewer than 10% of common medical practices for three subspecialties of internal medicine have any foundation in published research.

Williamson, J.W., Goldschmidt, P.G., Jillson, I.A.: Medical practice information demonstration project: final report. Baltimore, MD: Policy Research, 1979. (Cited in Ellis *et al.* 1995.)

In 1983, the U.S. Office of Technology Assessment of the U.S. Congress repeated its estimate that “only 10 to 20% of all procedures currently used in medical practice have been shown to be efficacious by controlled trial.”

Office of Technology Assessment of the Congress of the United States, *The impact of randomized clinical trials on health policy and medical practice*, Washington, D.C., U.S. Government Printing Office, 1983. (Cited in Ellis *et al.*, 1995.)

In 1991, the editor of the *British Medical Journal* noted that a health care conference in Manchester, UK, had been told that “only about 15% of medical interventions are supported by solid scientific evidence.”

Smith R. Where is the wisdom... the poverty of medical evidence, *BMJ* 1991;303: 798-99. (Cited in Ellis *et al.* 1995)

In 1992, the same editor of the *British Medical Journal* further lamented the paucity of solid scientific evidence for most medical interventions.

Smith R.: The ethics of ignorance, *J Med Ethics*, 1992; 18: 117-18. (Cited in Ellis *et al.* 1995)

- E. To suggest that New Zealanders should offer up their own health, and sometimes their lives in the interests of the “public good” is absurd given that many of the medical treatments or interventions that they may be forced to submit to are without scientific evidence of efficacy or safety. While certain measures, such as quarantine or isolation of people with communicable diseases, are appropriate in certain cases, forcing healthy people to submit to so-called “preventive” treatment, and sick people to a treatment that has little proven benefit and often great physical and personal cost, is an outrageous abuse of human rights. Attempting to ensure that everyone enjoys the highest attainable standard of physical and mental health is admirable and supported by the NZHT. However, it must be recognised that not all New Zealanders’ belief systems encompass a singular allopathic model of health, and that for some people, many medical treatments (drugs, therapy, surgery, etc.) represent a loss of health rather than an improvement in health. One only needs to look at the incidence of iatrogenic disease and death both here and overseas, widely publicised in recent months, to realise that for many people conventional medicine has been an abject failure.
- F. The results of a national survey undertaken by Dr Peter Davis *et al.* has shown that 12.9% of hospital admissions at 13 publicly funded hospitals were as a result of the adverse effects of medical treatment and that 35% of those adverse effects were highly preventable\* ; 4.5% involved death.<sup>i</sup> Based on hospital discharge data<sup>ii</sup> (where discharges ≈ admissions) and the figures from Davis *et al.*, more than 4000 New Zealanders die each year as a result of the adverse effects of medical treatment; 1500 of those deaths are preventable. With 4000 plus deaths per year, death from the adverse effects of medical treatment is the third biggest killer of New Zealanders behind cancer (7582 deaths in 1998) and heart disease (6203 deaths in 1998)<sup>iii</sup>.
- G. In light of these statistics New Zealanders must retain the right to refuse medical treatment and intervention, particularly while such gross and lethal failures in the public health system continue.
- H. Medical treatment is often driven by tradition and increasingly, in a world controlled by large multinational companies, by market forces and profit. Any medical treatment or intervention offered to New Zealanders must be accompanied by full disclosure of all the benefits and risks of the treatment or intervention. This information must be provided without bias or censorship, without the use of emotive or coercive language and without the influence of individuals or organisations that have a vested financial interest in the use of the proposed treatment or intervention.

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\* Preventability of an adverse effect was assessed in the Davis *et al.* study as an error in health care management due to failure to follow accepted practice at an individual or system level.

## SPECIFIC RESPONSES TO DISCUSSION PAPER

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### INTRODUCTION

#### 1. Section 1.4

The discussion paper acknowledges that “infectious diseases disproportionately affect disadvantaged and marginalised groups” yet later in the document there is disproportionate support for increasing vaccination coverage with little discussion on solving the socio-economic factors which largely control health. Improvements in the quality of life in the “disadvantaged and marginalized groups” such as improved diet, reduction in overcrowding, improvements in dwellings, reduction in exposure of people (particularly children) to passive smoking and a wide range of other environmental toxins, better education, etc. would have considerable positive impact on the incidence of, and rapid recovery from, not only communicable diseases but other chronic health conditions.

### FUNDAMENTAL PRINCIPLES

#### 2. Section 3.3

The proposal to compulsorily subject to Maori and other indigenous groups, to a wide range of drugs and vaccines is a continuation of the colonisation of these people with little or no regard for their culture and spiritual beliefs.

Ngai Tahu, in their submission to the Royal Commission on Genetic Modification, wrote of their abhorrence of those involved in genetic modification "acting as God and interfering with the blueprint of life".<sup>iv</sup> It is highly likely that many any Maori would find the use of vaccines and drugs manufactured using animal tissue offensive\* if they were indeed provided with all the information they need to make an informed decision about a medical treatment or intervention.

It is widely accepted within the medical community that a person’s emotional health and spiritual well-being can have a marked impact on their physical health. Even without entering into any discussion on the efficacy and safety of a treatment, the damage caused by imposing a medical treatment on someone who finds it spiritually or emotionally abhorrent may grossly outweigh any positive benefit conferred by the treatment.

In accordance with basic human rights and the obligations of the Ministry of Health under the Treaty of Waitangi, all people and particularly Maori must have the right to refuse any medical treatment, including vaccination, which may be incompatible with their spiritual beliefs.

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\* Members of other cultures would also find the use of animal tissue in vaccine manufacture, particularly human diploid cells derived from tissue taken from aborted human fetuses (rubella, hepatitis A and chickenpox vaccines) to be abhorrent and culturally offensive.

### 3. **Section 3.4**

The NZHT is very supportive of measures that reduce inequalities in health, both in the delivery of health care and in addressing the underlying causes of poor health. One of the cornerstones of the health philosophies of the vast majority of our members is improving health and maintaining wellness through diet and other lifestyle measures. Of great importance is antenatal health, breastfeeding, adequate sleep and exercise, good living conditions that don't include overcrowded and substandard dwellings, lack of exposure to tobacco smoke and environmental toxins, and an emotionally supportive and loving family environment. All these things boost the immune system of adults and children and facilitate wellness.

The NZHT believe that education and information empowers people to make the best decisions for themselves and their dependent families. Any legislation should focus on education rather than regulatory powers. Obviously to achieve these improvements within the wider community, particularly within marginalised and disadvantaged groups, the collection of accurate information is vital to implementing programmes and actions. However, an environment where information is freely given and received in an atmosphere of trust and co-operation should be enabled rather than the use of a heavy handed legislative approach which is liable to alienate people and breed mistrust.

The NZHT has considerable concerns about issues concerning notification regulations and vaccination as a "preventive" health measure. However, it is more expedient to discuss those issues as they arise in the discussion paper.

### 4. **Section 3.5**

The NZHT is particularly concerned at the provisions for "future-proofing" the legislation. While we clearly see the need for any legislation to be written in such a way that it is not necessary to make frequent and costly amendments to such legislation, and to provide for emerging diseases, future research and new technology, we hold grave concerns about the degree of vagueness in this "future-proofing". The proposals include a range of regulation making provisions that may be enacted subsequent to the passing of the Public Health Bill and without the need for parliamentary approval. The proposals are not specific about what those regulations might be and, while consultation is discussed later on the proposals, the opportunity for public comment is dependent on how actively submissions are sought. The NZHT has been very disappointed in the level of publicity for the current proposals and the invitation for submissions to be made. It has been difficult to gain any great appreciation for the Ministry's genuine desire to obtain input on these proposals.

This insidious regulatory creep will result in the incremental reduction in the ability of New Zealanders to take responsibility for their health and welfare. At a time when New Zealanders should be encouraged to be taking greater responsibility for their health and the health of their dependents, the Ministry of Health is, in fact, encouraging people to abrogate that responsibility. Such regulatory creep is almost always justified as being in the "public interest", however it leads to more and more counterproductive regulation. With a public health system that is riddled with financial problems and systemic failure to enhance or protect the health of many New Zealanders, New Zealand should not be looking to introduce a "cradle to the grave" nanny system of public health. Government should encourage New Zealanders to take more and more of the responsibility for their wellness, through lifestyle and informed choices, and to reduce the burden on the state and taxpayer.

These "future-proofing" proposals permit the introduction of sweeping regulations that will trample on current rights to refuse medical treatment, and result in discrimination against, or

punishment of, those who make informed decisions not to undergo medical treatment or intervention.

Specific provisions for enacting regulations and other “future-proofing” proposals are discussed in more detail in subsequent sections.

## INFORMATION

### 5. Section 4

The NZHT is concerned about the implications of the collection of information on individuals and how that information will be used and by whom. While we understand the need for the collection of information and welcome the collection of certain sorts of information, particularly as that pertains to the underlying cause of poor health, an improved understanding of adverse effects of medical treatment and a greater appreciation for the effectiveness of certain medical treatments or interventions, we are concerned that information collected on individuals is not used to discriminate against or punish those individuals or families who either “opt” out of the allopathic medical model or who embrace holistic and alternative health therapies (either in conjunction with allopathic medicine or to the exclusion of allopathic medicine).

Also of concern is the availability of the results of the analysis of such information to the general public. Concerns have been raised, for example, that medical injury statistics have been stripped from data available to the general public and the Minister of Health has denied that medical injury is a significant problem despite it being the third leading cause of death in New Zealand. Recent media reports have suggested that surgery waiting lists in public hospitals have been manipulated to give the impression that waiting lists have been reduced, yet doctors advise that many on waiting lists have been forced into reassessment which takes them off surgery waiting lists while no increase in actual numbers receiving surgery has occurred. Professor Geoffery Horne, of Wellington Hospital, was quoted as saying that “it was ‘deceptive and dishonest’ of district health boards to claim they were reducing waiting lists when they were manipulating figures.”<sup>v</sup>

If the Ministry of Health expects co-operation in the gathering of information it must be more open about the results of analysing that information and the implications for the performance of the Ministry in improving public health.

A vital factor in the collection of information must be informed consent of the individual on whom the information is collected. This should include providing the individual with clear information on what the collected information comprises and for what purpose.

When researchers analysed audiotapes of conversations between doctors and patients, who knew they were being taped, to study communication effectiveness, they found that adequate information for informed consent was given only 9% of the time! This was a large study - over 3,500 medical decisions. The results were even worse for complex decisions; only 0.5% of patients were given adequate communication for an informed decision.<sup>vi</sup>

Another factor is the robustness with which information is gathered. For example, there is increasing pressure for blood collected on every baby under the guise of the Guthrie test gathered over the past 30 years or so to be used for forensic purposes - and yet there are no statutory guidelines regarding the protocol used to collect such (even mothers were not consulted) nor would the evidence be verifiable as evidence in a court of law.

The NZHT supports the requirement that a person whose identifiable health information is to be disclosed must be informed that notification is to be made. However, this should be

accompanied by provisions for, depending on what the specific information comprised, the right to appeal notification. Depending on the sorts of regulations that are subsequently enacted (including but not limited to proposals to introduce criminalisation of non-compliant behaviour – discussed in detail later), this is particularly important where notification may lead to restrictions on, discrimination against, or punishment of the individual.

#### 6. **Section 4.4**

The NZHT has a number of concerns about the proposals for notification particularly in light of proposals outlined later in the discussion paper. The proposals state that there “would be a general obligation that any condition, disease, risk factor or other matter of concern that is specified in regulations as ‘notifiable’ must be reported to the specified authority.” This is of concern in light of the definition of “condition” (see Number 0 below). Under these proposals individuals and families who have made lifestyle choices that in themselves are not precursors to disease, but are perceived within the confines of current medical beliefs to constitute an increased risk for certain diseases, could find themselves being notified despite being in rude good health. For example:

A child who has not been vaccinated against measles, mumps and rubella could be “notified” as having a risk factor for disease. However, a child who has suffered either primary or secondary vaccine failure and is just as likely to contract one of the diseases and to transmit the disease to other people would not be “notified” as having a risk factor for disease. In addition, the unvaccinated child may have already had a clinical or sub-clinical episode of the disease and have immunity, may not have been notified as having the disease at the time if the disease was undiagnosed or misdiagnosed or the child had not seen the doctor, and subsequently had a lower risk for the disease.

It is vitally important for the Ministry of Health to remember that medical advances often result in recently held beliefs about factors that improve health or behaviour that is a risk to health being turned upsidedown. Imagine if such notification legislation had existed in the 1970s and 80s. In an era when it was believed that babies should be put to sleep on their tummies, and that sleeping on the back was a risk factor for Sudden Infant Death Syndrome (SIDS), many babies would have been “notified” as having a risk factor for SIDS, and under later proposals in the discussion paper for criminalising non-compliant behaviour, parents who put their babies to sleep on their backs may have been punished or discriminated against.

It goes without saying that notification does not exist for its own sake. If the Ministry is going to go to the trouble of collecting such information it clearly intends to act on the information. This intention is spelt out in subsequent sections of the proposals.

#### 7. **Section 4.4.2**

The NZHT opposes the “empowering” style of the proposals for the Bill. Again, such “future-proofing” regulatory creep enables almost any lifestyle choice, no matter how minor or insignificant, to be added to an ever increasing list of conditions or risk factors that may be notified. There needs to be limits set on the sort of condition, disease, risk factor or other matter of concern that is notifiable and controls set on who makes these decisions and how. Such a broadbrush approach opens these regulations up to abuse and the vagaries of personal beliefs and peculiarities. For example:

Walking barefoot could be perceived as being a risk factor for injury and disease, e.g. tetanus, anaphylactic reaction to a bee sting, septicaemia from a cut or graze. All these outcomes would result in a burden on the public health system. Some bureaucrat in the Ministry of Health could make walking barefoot in public a notifiable condition or risk factor.

To avoid such ludicrous eventualities, and to prevent such outrageous interference in the everyday activities of New Zealanders, the legislation will have to be very specific about the

purposes, criteria, and categories for notification, who makes the decisions about notification and how this information is ultimately used.

8. **Question 1** *It is proposed that the term ‘condition’ be used instead of ‘disease’ (in relation to notification and other topics discussed in this paper). This would include, as well as disease, clusters of symptoms and risk factors (para 4.4.3).*

The NZHT does not agree with the use of the term condition instead of disease.

This is “disease mongering”: the social construction of disease or medicalising of normal life. A condition is not a disease and a risk factor is not a disease. What constitutes a risk factor for disease in one person may be totally inconsequential in another. This sort of terminology makes hypochondriacs out of healthy people and does nothing to improve public health. For example:

It is believed that the human papilloma virus is related to the development of cervical cancer. The virus is sexually transmitted, therefore any woman that has sexual intercourse has a risk factor for cervical cancer and any man who has sexual intercourse could be at risk of transmitting a communicable disease. Should we make sexual intercourse a notifiable risk factor?

Moynihan *et al.* make the point that the medicalising of normal life turns ordinary ailments into medical problems, sees mild symptoms as serious, treats personal problems as medical, and sees risks as diseases.<sup>vii</sup> They also state that "disease mongering" extends the boundaries of treatable illness to expand markets for new products. Thus the only sectors of our community to benefit are the profit driven pharmaceutical and medical technology companies who like nothing better than to “discover” a new disease in order to create a “cure” from which they will derive an obscene amount of money.

There needs to be strict delineation between diseases, risk factors and other terms in order that healthy people are not deemed to be “sick-and-therefore-must-be-treated” when there is no need for it. We already have sufficient numbers of New Zealanders in dire need of medical treatment who suffer from real diseases without artificially generating large groups of “sick” people who don’t really need any treatment at all.

There also needs to be a distinct category for the adverse effects of medical treatment. If these adverse effects were to be lumped in with diseases and risk factors it would be very easy for health professionals to lose sight of the fact that these “conditions” are caused by medical treatment. There is a none too subtle difference between illhealth caused by lifestyle choices or exposure to disease that is a part of life and illhealth caused by a treatment promoted and carried out by a medical professional, often without full disclosure of the risks and benefits, and thus without informed consent having been obtained (contrary to the current legislative provisions under the Health and Disability Commissioners Act 1994, Code of Health and Disability Services Consumers’ Rights 1996 and Privacy Act 1991).

9. **Section 4.4.3**

The NZHT wholeheartedly supports the notification of adverse reactions to vaccinations. However, this will need a major shift in the attitudes of health professionals and ministerially supported groups, committees and organisations. Currently, there is a culture of denial of the severity and frequency of adverse reactions. As vaccination is something that is vigorously promoted as a “preventive” treatment for healthy people and largely for the most vulnerable and voiceless sector of our community, the notification of adverse reactions to vaccination is more important than the notification of any other disease, risk factor or matter of concern. This is particularly so as there is no way of knowing prior to the event which person will suffer a reaction and many reactions cause long term health problems.

For notification of adverse reactions to vaccines to be anything more than an empty gesture more information must be provided to the vaccine recipients or their caregivers on the range of adverse reactions that may occur, including severe reactions, reactions that become apparent days or weeks after administration of the vaccine and long term impacts on health. In addition, frontline health professionals need to be provided with training in recognition of adverse reactions, otherwise any notification system will suffer the same fate as all other passive reporting systems: variability in reporting standards, reporter bias and significant under-reporting of events.<sup>viii</sup> It is well documented that only a fraction (1 – 10%) of adverse reactions are reported to the passive surveillance systems that are in operation in many countries.<sup>ix, x, xi</sup>

10. **Question 2** *A range of purposes for notification is proposed, including the care and management of a person with a communicable condition, monitoring, identification of risk factors etc (para 4.4.4).*

NZHT believes that it is important to have a range of non-identifying information on the health status of people who suffer from certain diseases. This may be vitally important in establishing causal links between exposure to certain activities or chemicals and the incidence of disease. For example, information on the incidence of asthma and the vaccination status of sufferers might demonstrate if one or more vaccines appeared to predispose some people to asthma, as has been suggested by some research.

In addition, it is important to have information on the health status of people who die from certain diseases particularly communicable diseases. This would provide a better basis for assessing the role of vaccination and drug therapy in reducing mortality.

However, NZHT absolutely opposes the notification of risk factors under the conditions set out in this section. This particularly applies to unvaccinated people and their perceived risk for contracting and transmitting a communicable disease. The existence of a risk factor does not inherently make a person sick or make them capable of transmitting a disease. People with a risk factor but no disease are no more capable of putting other people at risk from disease than people without the supposed risk factor. For example, unvaccinated people are often believed by the medical profession and the public to be the source of communicable disease. However, research has shown that the vaccinated may be just as likely to transmit disease. Many vaccinated people suffer primary or secondary vaccine failure and as a result many vaccinated people develop sub-clinical infection. While exhibiting no symptoms they are capable of transmitting disease. Indeed, perhaps more so as the lack of symptoms of illness does not confine them to their beds or homes, leaving them to move freely in the community transmitting the disease to more people. Recent research shows that the measles virus can circulate within fully protected populations in the form of sub-clinical or asymptomatic infections.<sup>xii</sup> Damien *et al.* found that susceptibility to subclinical secondary immune response was five to eight times higher after vaccination than after natural infection and concluded that protected (vaccinated) but infectious people could be important in the epidemiology of the disease.

The notification of people with “risk factors” and “managing” them is discriminatory. These proposals are reminiscent of the leper colonies of years gone by and raise the spectre of the 1980s argument for segregation of people with HIV. Had the proposed legislation been in place fifteen years ago and a McCarthy style bureaucrat in power then all people who were HIV positive, homosexual men, any man suspected of being homosexual (that is, anyone our bureaucrat wants segregated) and even contacts could have been segregated.

Regarding the proposals to “monitor the health status of people in relation to specified risk factors or matter of concern,” why doesn’t the discussion paper just recommend tattooing such people across the forehead or plastering a yellow star on them for easy identification.

These proposals, if passed, label large groups of healthy people as a risk to the health of other members of the community, and legislatively segregate, and discriminate against them.

The 1996 mission statement of the Public Health Commission was "to improve and protect the health of the nation by working in an open and responsive way to ensure the provision of information, advice and public health programmes, that enable all groups of people to make individual and collective choices that assist in their achievement of full and healthy lives". These proposals take away the ability of normal healthy New Zealanders to make "individual and collective choices" about their health care and place many of those healthy New Zealanders under the "care and management" of a group of unspecified bureaucrats that currently can't even ensure the improvement in health of many of our sickest citizens.

11. **Question 5** *It is suggested that there could be provision for regulation-making powers following reports from bodies (such as the National Mortality Review Committee) responsible for investigating issues relating to individual safety (para 4.1.2).*

Yet again the proposals suggest provision for unspecified regulation making powers. More regulatory creep. Just what would these regulations be?

12. **Section 4.4.5**

The NZHT opposes the proposals that "the list of notifiable conditions would not be specified in the body of the Bill, which would simply state that whatever was specified in the schedule or regulations as 'notifiable' must be notified." (see Point 7 of this submission) Given the nature of the proposals discussed above in relation to the purposes of notification, such sweeping provisions would enable the health bureaucrats to notify and subsequent "manage" (a euphemism for control) the health of almost anyone for the most trivial of reasons.

13. **Question 7** *It is proposed that the Bill could include an obligation or discretion to notify non-notifiable conditions with unusual features (para 4.4.6).*

The NZHT agrees with this proposal but with considerable discretion applied. Where identifying information would be included informed consent must be obtained.

14. **Question 10** *It is proposed that laboratories be required to notify as well as, or in some cases instead of, medical practitioners (para 4.4.9).*

The NZHT believes that any notification involving identifying information should be made by the General Practitioner and informed consent must be obtained. Laboratory staff are unlikely to be in a position to obtain informed consent.

15. **Question 12** *The chapter sets out some possibilities as to which authorities notification should be made (para 4.4.10). Comments and suggestions:*

The Bill needs to be very careful how many authorities are notified when identifying information is included in the notification. Of concern is the extent of the health information provided in the notification and whether or not that pertains specifically to the communicable disease or broader health and personal information that is included. Issues of privacy are of paramount importance and privacy will be non-existent if every regulatory authority in New Zealand is provided with all the details of a person's health. The way in which these authorities use such information must be provided for so that such information cannot be used to discriminate against, or penalise, the person involved. There are implications for a person's security and equality of employment and future employment opportunities, health insurance and other financial matters, etc. as well as their emotional and spiritual well being.

16. **Section 4.4.11**

The NZHT opposes the proposals for notification of such information as risk factors as lumped together under the term “condition” as discussed in the answer of NZHT to Question 1. Where notification refers to a disease the NZHT has no objection to the information listed in this section.

17. **Question 13** *It is proposed that the Bill provide a number of ways in which the privacy of people who have had information about them notified could be protected (para 4.4.13).*

The NZHT strongly agrees with the need for strict confidentiality and the obligation of those making the notification to protect those people who are subject of such notification. In addition, we agree that identifying information should only be supplied where absolutely necessary.

18. **Question 14** *It is proposed that people who are the subject of notification could be informed accordingly (para 4.4.13).*

The NZHT believe that stating that “reasonable efforts” should be made to inform that person of notification is not worded sufficiently strongly in the proposals. Informed consent must be obtained where identifying information will be included and “all possible efforts” to inform the person concerned should be made. It is not good enough that a health professional might make a few attempts to contact the person involved by telephone on a single day. If it is a disease of sufficient seriousness as to warrant urgent notification, the possibility that there would be a need to notify higher medical authorities, in accordance with the legislation existing at the time, should be discussed at the initial consultation (and on subsequent occasions of contact should there be any). Not doubt if a serious disease were confirmed, and one that required urgent notification, the health professional would be in urgent contact with the person involved to tell them the outcome of any tests, etc.

Under these circumstances, stating that “reasonable efforts” had been made to contact the person is clearly not sufficient and is an abuse of the persons right to both privacy and informed consent.

## PROMOTING PUBLIC HEALTH

19. **Section 5.1:** The NZHT agrees that housing, income, employment, education, nutrition and smoking are important contributing factors to the health status of New Zealanders. The NZHT note that this section fails to mention the impact of a wide range of environmental toxins and believe that this should be added to the list of factors which contribute to ill health. We are very disappointed that the proposals for this “Public Health” Bill do not commit greater space and consideration to these factors and instead focuses on the notification of “conditions”, “preventing” communicable disease through vaccination, and registers for all manner of things. This section of the proposals conclude that “the major causes of population ill health today are those broadly categorised as ‘non-communicable’” yet this document focuses on communicable disease and fails to adequately address other vitally important public health issues. We refer the reader to the first of our general comments on the naming of this legislation.

The proposals list chronic and major diseases, such as cardiovascular disease, cancers, diabetes, osteoporosis, respiratory disorders and oral ill health together with injury. The proposals mention other legislative frameworks for injury-related issues, but what are the legislative frameworks for cardiovascular disease, cancers, diabetes, osteoporosis, respiratory disorders and oral ill health as clearly it is not the “Public Health” Bill.

The components listed in the *Ottawa Charter for Health Promotion* are of great interest given the tone of the proposals for the Public Health Bill. In fact, the over-regulation and

implementation of a medical “nanny-state” suggested by the proposals seem to be diametrically opposed to the spirit of the statements:

- creating supportive social, physical and cultural environments for health
- developing personal skills so people can take action to improve their own health
- reorienting health services if necessary to make them accessible and acceptable to the population they serve. (this author’s emphasis)

The proposals ask the question: Should the Public Health Bill include provisions aimed at reducing morbidity from non-communicable diseases and injuries? Clearly the answer is yes! It is not within the scope of the NZHT’s purpose, or the time available, to suggest what might be appropriate and feasible for legislation to achieve in this area, however, the Ottawa Charter seems to be an excellent place to start.

The paragraph following these questions in the discussion paper seems to signal the intention of the Ministry of Health to absolve themselves of any responsibility for improving public health through changes in the factors previously recognised as having considerable impact on public health, leaving that responsibility to other legislation and other ministries. For example, diet is one of the single biggest influences on health, and while income and education in turn influences the quality of a person’s diet, surely the Ministry of Health has a senior role to play in improving the diet of New Zealanders. An education programme, one that reaches every sector of the public and business community, and supported by public health legislation, would be a cost effective and long term way in which to improve public health.

20. **Question 15** *Do you agree that the Public Health Bill should refer in its purpose to public health promotion, the prevention of non-communicable diseases, as well as risk factors relevant to both communicable and non-communicable conditions (para 5.5)?*

The Public Health Bill should not only refer to the prevention of non-communicable diseases in its purpose but should tackle the issues more thoroughly than that. Communicable diseases represent a very small burden on the public health resources of this country compared to non-communicable diseases. For example, a look at the mortality (1998) and morbidity (1998/99) statistics together with basic arithmetic skills reveals that communicable diseases are a very small pimple on the face public health compared to the very large boil that is non-communicable disease. Of the 26,459 people who died in 1998 only 528 (1.9%) died from communicable diseases\*.<sup>iii</sup> Compare this with ischaemic heart disease (6203), cancer (7582) and cerebrovascular disease (2492). Only 25,615\* out of 704,195 (3.6%) hospital discharges were for patients with communicable diseases.

## **PREVENTING ILL HEALTH AND PROMOTING CHILD HEALTH**

21. **Section 6.1:** The discussion paper discusses issues surrounding participation in health services and quality, privacy issues and benefits of the health service offered. Conspicuously absent is any mention of safety issues and the provision of information about risk. Given that one of the two main preventive strategies that is mentioned is vaccination, the issue of risks

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\* These figures are probably overstated as in some categories the figures were combined and it was unclear what proportion involved communicable disease.

versus benefits, and provision of full, unbiased information on the safety of such “preventive” treatment should have been a major consideration in this section.

22. **Question 19** *It is suggested that the Bill could specify as one of its purposes the importance of child health, possibly with a reference to the United Nations Convention on the Rights of the Child (para 6.1)*

The NZHT agrees that the Bill should specify as one of its purposes the importance of child health. However, we oppose any interpretation of the UN Convention on the Rights of the Child (articles 24(c) and 24(f) which state: “To combat disease... through readily available technology.” And “To develop preventative healthcare”) that supports the use of mass vaccination programmes as a preventive treatment for communicable disease. No independent long term studies have proven that mass vaccination improves the long term health of children and there are increasing numbers of studies that indicate that vaccination causes long term chronic health problems (this is discussed in greater detail with support from the relevant medical literature in following points). The NZHT find an odd irony in the juxtaposition of the following statements (taken from the discussion paper) regarding the promotion of child health:

- prevention of vaccine-preventable disease and disability (both for individual children and for the contacts of children)
- the early detection, surveillance and appropriate management of diseases and disability that may occur in childhood or other conditions occurring in childhood that may result in long-term adverse health consequences
- other strategies relevant to the prevention and management of risks to child health.

The first perpetuates the myth that vaccination is an important factor in the prevention of disease in children and the authors of the discussion paper seem blithely unaware that many chronic conditions and disabilities suffered by children have been linked to vaccination (discussed in detail later) and that one very important strategy in the prevention and management of risks to child health would be to cease vaccinating young New Zealanders.

23. **Question 20** *Are there any other issues relating to child health not covered in this chapter (or elsewhere in this discussion paper) that you think should be included in the Public Health Bill?*

- a) **Antenatal Health and Breastfeeding:** Of utmost importance to child health are the health of the unborn child and breastfeeding. While antenatal health and issues surrounding pregnancy may be covered in other legislation, it would be particularly pertinent to refer to these vitally important issues in any legislation which purports to be promoting public health. Breastfeeding should be supported, and its promotion and acceptance in the wider community legislated for if necessary. Breastfeeding is the single most important thing that a mother can do for the health of her child, the value of which should not be underestimated in a public health context.

Despite the plethora of scientifically proven benefits of breastfeeding for both mother and child, the NZHT does not support the mandating of breastfeeding nor the mandatory reporting of non-breastfeeding mothers under the pretext of such behaviour being a 'risk factor.' This is in line with the NZHT's opposition to any legislation introduces a mandate for treatment or removes the right to informed consent.

- b) **Emotional and Spiritual Health:** The emotional and spiritual well-being of the child from its first days should be acknowledged as an important factor in the overall health of both the child and the adult he or she grows into. While emotional and spiritual well-being are part of a more complex interaction of factors, they have an important role in determining the health status of the child.
- c) **The Role of Parents:** There are many factors which influence whether or not a child makes it through childhood with their health intact. One of the greatest of those influences is the parent-child relationship and the beliefs and values instilled in the child by the parent. The Bill should provide legislative support for parents to take responsibility for the health of their children and for them to provide the healthiest environment possible (nutrition, exercise, protection from environmental toxins, education, etc.). Unfortunately many of the proposals for this Bill take away from parents the ability to take responsibility for the health of their children and encourages them to leave that to the state.
- d) **Vaccine Damage:** The Bill should provide a specific section on the damage caused to children's health by vaccines. It is clear that, rightly or wrongly, vaccination is pivotal in the Ministry of Health's disease prevention strategy. The provision of information on the risks of vaccination, implementation of a process of truly informed consent, and a system for reporting all possible vaccine reactions is insufficient. There is a need for people who have had adverse reactions to vaccines to be acknowledged and to receive assistance and/or compensation for the damage suffered as a result of the administration of an unproven medical treatment for which there are grossly insufficient safety tests, and which is vigorously promoted to all children and the majority of adults by the leading health authority in this country.

24. **Question 21** *It is proposed that there could be a set of general provisions to allow registers on specific subjects to be established by regulation following consultation (paras 6.2 and 6.2.1).*

Another example of regulation making provisions while the proposals for the legislation remain vague on the scope of those regulations. The NZHT remains concerned about any future opportunities that the public and advocacy organisations such as ourselves will have to contribute to the development of regulations on registers.

Our main concerns for the establishment of registers are privacy and for what purpose such registers will be used. Privacy issues have been discussed at length in relation to notification and the same concerns expressed in those points are relevant to registers. It would be possible to use an "immunisation" register to discriminate against those children and adults who have chosen not to have vaccinations. Already we have seen political moves to link vaccination status to welfare payments (A move which suggests that if you vaccinate your child then that is all you really need to do, while ignoring the obligation of parents to adequately feed, clothe, care for and love their child. If the Ministry of Health wants to implement registers to see who is doing their bit to prevent ill health, perhaps they should establish a register that lists those who eat five plus servings of fresh fruit and vegetables per day, or a register for those parents who ensure that their children get sufficient sleep each day.).

Healthy unvaccinated children are excluded from school during outbreaks of measles and whooping cough even while vaccinated children who are often susceptible to contracting and transmitting the disease are allowed to remain in class. Subsequent suggestions in the discussion paper include criminalising behaviour which is perceived to be a breach of a person's duty to prevent or minimise the risk of transmission. "Immunisation" registers aid and abet the discrimination of unvaccinated people who might be regarded as having breached their duty of care to "prevent or minimise the risk of transmission" of a communicable disease simply by the act of refusing to be vaccinated.

However, used judiciously and with strict criteria for access, “immunisation” registers could be used in conjunction with other information to analyse the efficacy of vaccination and the link between specific vaccines and other health problems (e.g. the suggested link between asthma and vaccination<sup>xiii</sup>, the flu vaccine and Guillain-Barre syndrome<sup>xiv</sup>, and diabetes and the Hepatitis B vaccine<sup>xv</sup>).

25. **Section 6.2.1**

The proposals refer to consultation procedures regarding the establishment of registers. However, the National Immunisation Register is in the process of being implemented. The NZHT are aware that the Immunisation Awareness Society was not provided with an opportunity to make submissions on the National Immunisation Register. The establishment of this register, one of the two main registers mentioned in the proposals, appears to be legislated for in retrospect and without widespread consultation. This lack of consultation with a substantial stakeholder (The Immunisation Awareness Society represents a large number of present and past members who have made informed decisions not to vaccinate) does not inspire confidence in the proposals for regulations relating to the establishment of registers. In light of this it would be preferable to conduct a review of the National Immunisation Register, for which widespread opinion on its establishment and use would be sought from the general public and stakeholder organisations.

This section also refers to registers, the purpose of which include monitoring the health status of people with risk factors. The NZHT has the same concerns about the inordinate attention given to unspecified risk factors, given the absence of serious discussion on nutrition, overcrowding and exposure to environmental toxins, as discussed in its answers to Questions 1 and 2. Clearly some “risk factors” are ultimately precursors to disease. However, many perceived risk factors are only risk factors relative to current medical knowledge, and may cease to be risk factors with improved knowledge. For example the food pyramid is in the process of being turned upside-down. If public health officials could have mandated a 'healthy diet' a few years ago and placed anyone not following that diet on a register for risk factors, all those on the register and being “monitored” could now be taken off and many who were previously regarded as having a healthy diet now put on a register for dietary risk factors. This is bureaucratic nonsense and seems to be “list making” for the sake of it.

The NZHT is also concerned about the suggested purpose of registers being to provide information. Given the Ministry’s propensity to manipulate the information that it collects to suit its own biases and agendas (cf. medical injury statistics, surgery waiting lists) the NZHT has little confidence in the value and veracity of information supplied from such registers. Obviously, previously expressed concerns about privacy are equally as valid in this situation.

26. **Question 22** *Proposals are set out for possible register purposes, privacy and disclosure provisions, types of registers and operational procedures (paras 6.2.2 and 6.2.3).*

The NZHT is concerned that disclosure of information held in a register includes the wording “as otherwise provided for in the regulations.” Yet again there is a complete lack of certainty within the legislation about how information is going to be used and by whom, relying instead on subsequently enacted regulations to safeguard people’s privacy. Of particular concern is the suggestion that “people associated with any health or disability service to which the register relates” and “researchers studying any health or disability issue to which the register relates” should be able to have access. Does this mean that the person who answers the phones for a health organisation to which the register relates in some vague way can have access to the information? If information from registers can be made available to such a wide range of people all identifying information must be withheld.

Registers must be a matter of informed consent and there must be no “comprehensive” register on which people have no choice about being listed. Differing registers may be opt-on

or opt-off depending on the use to which the information was put. All individuals about whom a register holds information must be advised and must give their informed consent for the information to be contributed to the register.

There must be no information sharing between registers without notification to the individuals whose information is to be shared and individuals must be able to access and amend information held on any register.

27. **Section 6.3**

The issue of differences in opinion between parents and health professionals over what is in the best interests of the child is an area fraught with argument. However, in the case of vaccination, where a medical intervention is administered to a healthy child (as opposed to a treatment for ill health) the parents opinion must be paramount. The New Zealand “immunisation” schedule commences for most children at the age of six weeks and is largely completed before the child enters school. At this age the child is not capable of making an informed decision. This is the role of the parents and their right and duty must not be usurped by health professionals or governmental bureaucrats.

Coverage and eradication of disease: The data on vaccination coverage is notoriously unreliable with estimates of between 75% and 94% depending on what age group is considered and who is doing the estimating. However, the real issue is not whether or not coverage can or should be improved but whether or not high levels of coverage will eradicate disease. This is the myth of herd immunity. There are numerous studies documenting outbreaks of disease in highly vaccinated populations, some outbreaks have occurred in 100% vaccinated communities. In New Zealand in 1999, 67% of the notified cases of whooping cough were fully vaccinated.<sup>xvi</sup> In the 1984-85 New Zealand measles epidemic, in children over 15 months old 40% of the cases of measles occurred in vaccinated children.<sup>xvii</sup> In the US there are frequent measles outbreaks in 98% to 100% vaccinated communities.<sup>xviii, xix</sup> Outbreaks of mumps,<sup>xx</sup> rubella<sup>xxi</sup> and polio<sup>xxii</sup> have also occurred in highly vaccinated populations.

When the abundant evidence for widespread vaccine failure (both primary and secondary) is considered, together with the evidence for sub-clinical infection in vaccinated people, the whole concept of artificially induced herd immunity clearly needs to be reconsidered.

Since the 1960s the Medical Establishment has been steadily shifting the vaccination goal posts closer and closer to 100% vaccination rates in an attempt to achieve this elusive herd immunity. Yet the documented outbreaks of disease in 100% vaccinated populations continue to mount up.

Major outbreaks of polio and measles in highly vaccinated populations have led to some authors reassessing the possibility of eradication of these diseases. When the measles vaccine was introduced in the 1960s there was talk of eradication within a year. However, this may not be possible or desirable. There is continued subclinical infection among vaccinees,<sup>xxiii</sup> who then transmit the virus to susceptible members of their communities and subclinical infection may be an all important booster for the rapidly waning artificial immunity provided by vaccines.<sup>xii</sup>

Among other authors who have expressed doubts about creating this medical unicorn called ‘herd immunity’ Trier and Ronne conclude that if “wild virus can be spread via individuals with subclinical infections, it is doubtful whether population immunity (herd immunity), which is necessary to eliminate [measles, mumps and rubella], can be attained in large populations.”<sup>xxiv</sup>

28. **Question 23** *It is suggested that the empowering provisions for making regulations on immunisation be drafted to allow for various options (paras 6.3 and 6.3.3).*

The NZHT harbours serious concerns about the “powers of Medical Officers of Health and public health units in relation to non-immunised children.” The Medical Officers of Health already have the power to exclude unvaccinated children from school, powers which discriminate against healthy unvaccinated children and deny them the right to an adequate education on the basis of equal opportunity. Some healthy children have been excluded from school for several periods of two weeks very close together because of measles outbreaks originating with vaccinated children. Such action severely interrupts their education at crucial times. Medical research has shown that many children suffer from primary and secondary vaccine failure. Many outbreaks of vaccine “preventable” disease involve high numbers of cases in fully vaccinated children. In some instances (e.g. whooping cough in 1999<sup>xvi</sup>) the incidence in vaccinated children was as high as would have been expected in the same group had they not been vaccinated. Clearly, vaccinated children both contract and transmit disease in the community, often, as frequently as do unvaccinated children. Therefore, excluding unvaccinated children, or discriminating against them in any other way, offers no benefit in either preventing disease or limiting the spread of disease in an outbreak. Any specific powers in relation to unvaccinated children represent totally unjustified discrimination and must not be permitted in any legislation.

The proposals also refer to emergency powers to deal with outbreaks of vaccine-preventable diseases” but do not offer any indication as to what those “emergency powers” might include. The NZHT oppose any provisions for “emergency powers” that would result in unvaccinated individuals being treated any differently from vaccinated individuals. There is insufficient evidence about the efficacy of vaccines and abundant evidence that any immunity conferred by vaccines is lost over time. The act of making an informed decision not to vaccinate oneself and ones children must not carry with it any form of punishment or discrimination even during an outbreak of disease.

The proposals in Section 6.3.3 state that “the provisions for immunisation status certification in relation to school and pre-school enrolment and attendance could be phrased generally to enable quite different regulations to be drafted.” This opens the way for the introduction of compulsory vaccination for school entry to which the NZHT are absolutely and categorically opposed. Compulsory vaccination for school entry would contravene the UN Convention on the Rights of the Child, to which New Zealand is a signatory, which specifies that a child has a right to an education on the basis of equal opportunity. The Association of American Physicians and Surgeons (AAPS) voted to oppose mandated (compulsory) vaccination in the United States saying that “Safety testing of many vaccines is limited and the data are unavailable for independent scrutiny, so that mass vaccination is equivalent to human experimentation and subject to the Nuremberg Code, which requires voluntary informed consent.”<sup>xxv</sup> They called for a “moratorium on vaccine mandates and for physicians to insist upon truly informed consent for the use of vaccines.”

Any provisions for future regulations to be enacted that would enable compulsory regulation would contravene existing legislation compelling the provision of informed consent and would be an outrageous denial of basic human rights. Until such time as vaccines can be categorically proven to be 100% safe for all people, New Zealanders must retain the right to refuse vaccinations for themselves and their children under all circumstances.

29. **Question 24** *One option that could be allowed by regulation-making powers is for children to be immunised unless a conscientious objection is stated or a reasonable possibility of an adverse reaction exists (para 6.3.3).*

The NZHT oppose any requirement for a conscientious objection or a doctor’s reasonable belief that the vaccine would cause an adverse reaction, or any other reason to be officially provided to justify non-vaccination and make it “legally” acceptable. All that should be necessary is for the parents or guardian to state that an informed decision has been made to refuse vaccination. The vast majority of people who make informed decisions not to vaccinate

themselves or their children do so after considerable research and much soul searching. It is not a decision that is made lightly. That they have made an informed decision, as opposed to non-vaccination for reasons such as negligence, laziness, fear of needles and so on, should be sufficient in itself and no further documentation or support from a health professional should be necessary. That parents have not had their child vaccinated should be sufficient evidence that they have made a decision not to vaccinate. Statutory declarations are an unnecessary waste of time and money for both the parents and the medical authorities.

It is natural as children to mature and make other decisions regarding their lives that they will take over the responsibility for deciding what if any vaccinations they should have. This is no different from any other health issues that ultimately become decisions for a child becoming an adult to make. The point at which this transition occurs should depend entirely on the evolving maturity and understanding of the child, not some politically appointed age.

30. **Question 25** *Should references to immunisation be focused mainly on child health (para 6.3)?*

The NZHT disputes that vaccinations prevent disease and improve health whether the reference is to child health specifically or to children and adults. The NZHT believes that vaccination adversely impacts on health in the short and long term and is, at least in part, responsible for the epidemic increase in the incidence of autoimmune disease such as Guillain-Barre syndrome, asthma, multiple sclerosis, thrombocytopenia, Crohn's disease, arthritis, diabetes, chronic fatigue syndrome, etc., some of which have been causally linked with certain vaccines.

Professor Campbell Murdoch has expressed concern "about the cumulative impact on the immune system of a series of immunisations against a whole cluster of diseases."<sup>xxvi</sup> In discussing AIDS, asthma, cervical cancer, SIDS (cot death) and chronic fatigue syndrome – all related to autoimmune problems – he said "we're observing across the world in massive proportions illnesses which have their root in the acquisition of an immune deficiency. My intellectual response is to look at factors that have changed in the ecology of the population in the last 25 years. One thing is that we've immunised the majority of the population [with live viruses]."<sup>xxvi</sup>

Vaccination has not been responsible for the major decline in infectious diseases<sup>xxvii</sup>, despite what the medical establishment would have New Zealanders believe. Improvements in living conditions including improved sanitation, hygiene, water supplies and housing, better nutrition and isolation procedures have been the main reasons for this.<sup>xxvii</sup> In New Zealand the death rate from childhood diseases declined by up to 98% between 1890 and the 1940s before vaccination was introduced (please refer to the graphs below).<sup>xxviii</sup> The death rate from diseases for which no vaccine was used also declined, for example Scarlet fever, declined steadily throughout the 20<sup>th</sup> century to the point of being almost eradicated without the use of vaccination. The decline in the death rate from measles, whooping cough, tuberculosis and diphtheria before vaccination is mirrored in other countries such as the United States,<sup>xxvii</sup> England and Wales<sup>xxix</sup> and Australia.<sup>xxx</sup> It has been estimated that only 3.5% of the decline in death rate from infectious diseases can be attributed to vaccination and drugs.<sup>xxvii</sup>

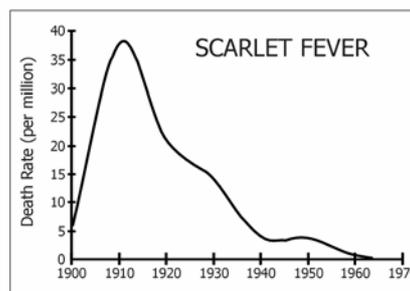
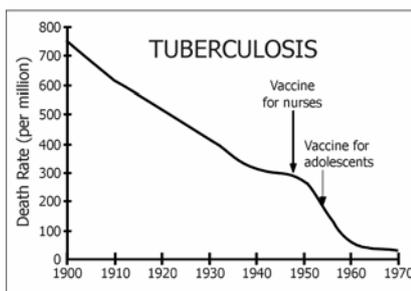
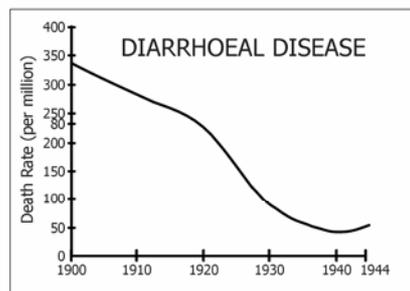
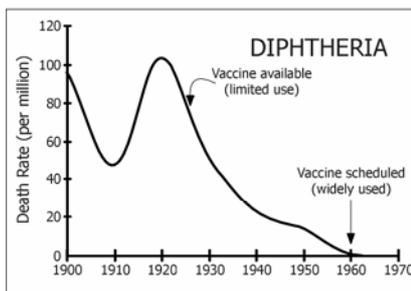
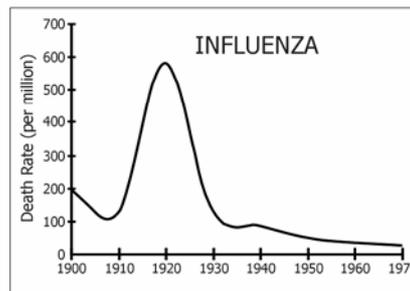
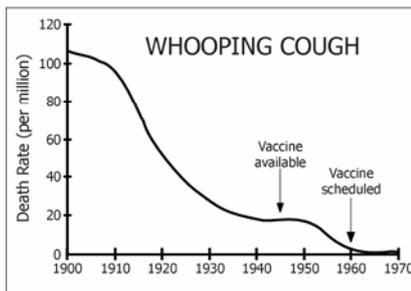
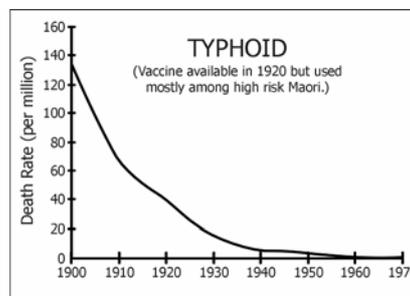
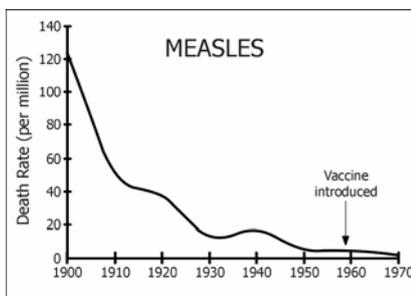
Professor Campbell Murdoch states that "immunisation barely figures as a protection against death." He quotes official New Zealand figures:

*"Before the age of one the [main] cause of death is congenital abnormality, respiratory infection and other infections; from one to four years it's congenital abnormalities and accidents; from five to 14 years it's accidents; from 15 to 24 it's accidents... At the end of the day, whether you immunise or not isn't going to make a hell of a lot of difference to the death rates."<sup>xxvi</sup>*

The focus on vaccination should be first and foremost on safety and ensuring that children and adults are not left damaged by vaccination. There should be a free flow of unbiased information, unencumbered by propaganda issued by those with vested financial interests, to all New Zealanders who are in a position to consider the risks and benefits of vaccination. There needs to be genuine informed consent that is provided for and upheld by the legislation.

31. **Question 26** *Or should references to immunisation also extend to adults where appropriate (eg, workplaces) (paras 6.3 and 6.3.3)?*

An individual's ability to perform a job is not related to their vaccination status. A person's occupation must not have any effect on their right to make an informed decision about vaccination and the legislation must include provisions to prevent discrimination against those who refuse vaccination, including threats to job security or qualification for promotion.



In those workplaces where certain vaccinations are perceived as being desirable full disclosure of the risks and benefits should be made in such a way that the employee may make an informed decision free from coercion or pressure to comply.

The requirement or desirability for certain occupational groups to be vaccinated is neither logical or supported by the medical evidence. Often such vaccination will cause lasting damage to the employee and offer no benefit to them or the general public. For example:

One suggestion made in recent months is that hospitality workers might be required to be vaccinated against hepatitis A. The live hepatitis A vaccine virus can be transmitted from the vaccine recipient to contacts. Huang *et al.* investigated the horizontal transmission of hepatitis virus after vaccination in a group of 82 vaccinated children and 117 contact children, all healthy and previously determined not to have hepatitis A virus antibodies.<sup>xxx1</sup> Not only were 97.6% of the vaccinated children found to have developed hepatitis A antibodies but also 13.7% of the unvaccinated contact group. Hepatitis A virus was also detected in faecal samples from 89.5% of the vaccinated children and 70.7% of the unvaccinated contact children (no liver abnormality was found in either group). The authors concluded that the vaccine virus could be transmitted from vaccinees to contacts and be actively propagated in both groups, but that in this study the virus did not induce clinical symptoms of infection. Clearly, in trying to prevent the transmission of the hepatitis A virus from hospitality workers to the general public by vaccinating them could, in fact, transmit far more virus than if incidence of the disease were managed through isolation and contact tracing.

Another vaccine that is often required for occupational purposes is the hepatitis B vaccine. However, this is one of the most damaging vaccines in the arsenal. Such illustrious members of the Medical Establishment as Dr Jane Orient of the AAPS,<sup>xxv</sup> and Dr Bonnie Dunbar,<sup>xxxii</sup> an expert in immunology and vaccine development, have criticised the vaccine and its use on babies and young children as well as adults. There is sufficient concern about the trail of destruction left by this vaccine that in 1999 the US Government convened Congressional hearings on the safety of the hepatitis B vaccine.

In their testimony to the Congressional hearings, the AAPS said that the US Vaccine Adverse Events Reporting System (VAERS) contained 25,000 reports related to the hepatitis B vaccine, about one-third of which were serious enough to lead to an emergency room visit, hospitalisation, or death. Noting that only 10% of reactions are reported, they calculate that the risk of a serious adverse reaction is about four in 1000 doses<sup>xxxiii</sup> (for a three shot course the risk is about one in 80 people).

Dr Dunbar, in her testimony to the Congressional hearings, related her own experience with the serious and apparently permanent adverse reactions of two people working in her laboratory, one of whom was her brother, Dr. Bohn Dunbar.<sup>xxxii</sup> She describes the severe disability that the two suffered as a result of the vaccine:

*“Dr. Bohn Dunbar ... developed seriously chronic joint and muscle pain, fatigue, and multiple sclerosis-like symptoms. And now he has further been diagnosed with POTS (an autoimmune, cardiovascular, and neurological problem) and subsequently with chronic inflammatory, demyelinating polyneuropathy. His problems have been attributed to the Hepatitis B vaccine by over a dozen different specialists around the United States of unquestionable medical expertise. He has now been rated permanently and totally impaired at greater than 90%. My other student went partially blind following her first booster injection, a medical condition that was markedly exacerbated by her second booster that resulted in hospitalisation.”*

As Dr Dunbar discovered, the hepatitis B vaccine causes serious neurological and central nervous system damage, particularly in the form of demyelinating diseases such as multiple sclerosis. Renard *et al.* report on a 16 year-old girl who developed regressive acute cervical transverse myelitis following a booster shot of recombinant hepatitis B vaccine.<sup>xxxiv</sup> Other

cases include two patients who developed neurological symptoms, with evidence of central nervous system demyelination, six weeks after administration of recombinant hepatitis B vaccine<sup>xxxv</sup> and a 56 year old man who developed acute myelitis three weeks after vaccination with the vaccine.<sup>xxxvi</sup> The authors of the latter study pointedly remarked that “the frequency of this complication would be more accurately determined if all neurological manifestations occurring after hepatitis B vaccination were reported.” [this author’s emphasis] Other neurological damage includes encephalitis<sup>xxxvii</sup> and acute cerebellar ataxia.<sup>xxxviii</sup>

There are numerous reports of the hepatitis b vaccine triggering persistent and sometimes disabling arthritis and rheumatic conditions in people in whom there was no previously diagnosed rheumatic disease.<sup>xxxix, xl</sup> In a French study 22 vaccinees developed rheumatic conditions within two months of vaccination; in all patients there was no previously diagnosed rheumatic disease.<sup>xi</sup> Pope *et al.* reported on 11 patients who developed arthritis following vaccination, nine of whom had to take anti-rheumatic drugs and in whom inflammatory arthritis persisted for more than four years.<sup>xlii</sup>

Dr Barthelow Classen published data in the *New Zealand Medical Journal* in 1996 linking a large epidemic of insulin dependent diabetes (IDDM) in New Zealand to a hepatitis B vaccination campaign that commenced in 1988. He stated that the incidence of IDDM rose 60% in the years following the vaccination campaign (1989-1991) and maintained an average incidence of 18.2 cases per 100,000 of population (aged birth to nineteen years) per year, compared to an average incidence of 11.2 cases per 100,000 per year in the years prior to the vaccination campaign (1982-1987).<sup>xliii</sup>

A study by Fisher *et al.* involving 6515 children in 1994 found that the hepatitis B vaccine is positively associated with prevalent arthritis, acute ear infections, pharyngitis and nasopharyngitis.<sup>xliv</sup> Linder *et al.* found that the incidence of unexplained fever in hepatitis B vaccinated new-born babies was significantly higher than in unvaccinated new-borns.<sup>xlv</sup> There are many other adverse reactions reported in the medical literature, including thrombocytopenia purpura<sup>xlvi, xlvii</sup>, vasculitis<sup>xlviii, xlix</sup> and visual disorders.<sup>1, li</sup>

Yet despite this evidence, many New Zealanders are being coerced into having this vaccine in order to take up or continue their employment and the discussion paper implies legislative support for the compulsory vaccination of certain occupational groups.

32. **Question 27** *It is suggested that the Bill could specify that a disease is notifiable if the vaccine for that disease is on the general immunisation schedule (perhaps with exceptions) (para 6.3.2).*

The NZHT believes that accurate data on disease distribution is essential in assessing the efficacy of vaccination and identifying susceptible groups of the population. However, any such data collection is subject to inherent frailties: misdiagnosis of the disease, the lack of consultation with a health professional for many cases particularly where parents feel confident in managing the disease at home (the loss of these cases from the database would seriously skew the incidence of disease figures) and biases of the reporting health professionals. Medical professionals are often reluctant to diagnose illness in a vaccinated child, and in the absence of blood tests, clinical diagnoses may be influenced by the beliefs of doctors in the efficacy of vaccines. This is supported by the findings of Cherry *et al.*, who concluded that observer bias “can significantly inflate calculated vaccine efficacy. It is likely that all recently completed efficacy trials have been affected by this type of observer bias and all vaccines have considerably less efficacy against mild disease than published data suggest.”<sup>lii</sup> Such biases would need to be overcome (through education and further professional development) before notification figures could be regarded as a valid reflection of the incidence of disease.

33. **Question 28** *Should emergency powers envisage vaccinating people without their consent – adults as well as children – in situations of extreme risk such as terrorist-introduced smallpox (para 6.3.5)?*

The NZHT categorically opposes vaccination for any reason under any circumstances without informed consent. The smallpox vaccine is one of the most catastrophic vaccines created. Huge sectors of the community fall into groups that are contraindicated for vaccination against smallpox: children under one year, pregnant women, people with immunodeficiency diseases, people with or who have suffered eczema, people who are suffering from other skin conditions (burns, chickenpox, shingles, impetigo, herpes, severe acne, or psoriasis), people who have a moderate or severe short-term illness, women who are currently breastfeeding, and people who are using steroid drops in their eyes.<sup>liii</sup> The US Centres for Disease Control have estimated that 15- 18% of the general population have an “at-risk” condition.

Those people who suffer from eczema are more susceptible than most to serious complications from the vaccine, and can be affected not only by the vaccine but by coming in contact with someone who has been recently vaccinated. Eczema sufferers are more likely to develop eczema vaccinatum which can lead to scarring, blindness and death (fatality rate is 1 to 6% of sufferers).

There are many myths and misunderstandings about the nature of smallpox, its virulence and its infectiousness:

Smallpox is not highly contagious: *"The infection is spread by droplet contamination. Coughing and sneezing are not generally part of the infection. Smallpox will not spread like wildfire."* Walter A. Orenstein, MD, Director of the CDC's National Immunization Program (NIP), CDC meeting June 20, 2002.

Smallpox is not spread by casual contact: *"Transmission of smallpox occurs only after intense personal contact, defined by the CDC as constant exposure, occurring within 6-7 feet, for a minimum of 6-7 days."* Joel Kuritsky, MD, Director of the National Immunization Program and Early Smallpox Response and Planning at the CDC. Am. J. Epid. 1971; 91:316-326.

The death rate from smallpox is not 30%: *Case fatality rate in adults was "much lower than generally advertised" and closer to 10 percent to 15 percent in adults. "Even without mass vaccination, smallpox would have died out anyway. It just would have taken longer."* Dr. Tom Mack, USC, CDC meeting June 20, 2002

*In 1900, 21,064 smallpox cases were reported, and 894 patients died -- that is 4.2 percent.* MMWR. Achievements in Public Health, 1900-1999 Impact of Vaccines Universally Recommended for Children -- United States, 1990-1998. April 02, 1999/48(12);243-248

Dr. Kuritsky, the CDC's director of the Preparedness and Early Smallpox Response Activity for the National Immunization Program, dispels other smallpox misconceptions:

1. "When people develop the smallpox prodrome, they are sick; they will be in bed and not out walking around [therefore their exposure to the general public would be limited]."
2. "Transmission through bed clothing contamination is extremely rare. The virus is NOT spread in food or water."
3. "Contagiousness can be 'interrupted' by the use of a properly fitted, filtered respiratory mask."

No New Zealander should be subjected to the risks of smallpox vaccination against their wishes. If the health professionals really believe that vaccination is so successful at preventing

disease then the people who choose not to be vaccinated are a danger to only themselves. The reality is that vaccines are highly imperfect and any immunity conferred is relatively short-lived. Primary and secondary vaccine failure is frequent. New Zealanders must not be forced to sacrifice their health and their lives at the hands of such an imperfect tool whether or not an emergency situation exists.

34. **Question 29** *Are powers for making regulations needed to specify circumstances in which screening would be appropriate (para 6.4)?*

Any participation in screening programmes should remain entirely voluntary and as a result of informed consent. Full and unbiased information on the administration of the screening programme, testing method, the disease risks and details of how any data collected will be used, needs to be provided to each individual prior to participation. Previously discussed privacy concerns are an issue.

Many New Zealanders have been lulled into a false sense of security in relation to their participation in screening programmes. This has been starkly illustrated by the tragedy of the cervical cancer screening programme. Women have been led to believe that by having cervical smears they would have advance warning of the development of cervical cancer and would be able to take appropriate steps to protect or cure themselves. Failures in this system and the tragic outcomes for a number of women have resulted in a wariness in many women and their families, as well as within the wider community, of the ability of screening programmes to offer positive health outcomes.

Thus any legislative mandate to make any screening programmes compulsory, particularly for children (e.g. Guthrie's test), is likely to be resisted no matter the good intentions. As many screening tests are invasive procedures, participation in any screening programmes must remain a matter of informed consent, all individuals must retain the right not to participate for any reason they choose and programmes must be "opt-on" rather than "opt-off". Education is the method of choice for widening participation, not legislation. In addition the limitations, of screening programme's ability to improve health, must be "owned" by the Ministry of Health and failures of both the systems and the individual tests openly discussed with potential participants in such programmes.

Legislation does have a role in providing a framework for the administration of screening programmes, determining the way in which the data collected is used, protecting the privacy of the individual, ensuring that the technology and methodology used in individual screening programmes is the most appropriate and effective available (quality assurance). Legislation might also have a role in ensuring that the systems failures that led to the debacle that has come to represent cervical cancer screening in New Zealand does not occur again.

## **CARE, MANAGEMENT AND COMPULSORY POWERS**

35. **Section 7.2**

There needs to be a clear delineation between certain types of infectious or communicable disease. An individual having the mumps should be considered quite differently from an individual who might have a disease such as ebola. While the severity, virulence, progression of, and degree of contagion of some diseases pose a serious risk to even healthy individuals, many diseases circulate freely in the community and to legislate for active management of individuals who have a common disease is an outrageous intrusion into the life of such individuals and a gross abuse of human rights.

36. **Question 33** *It is proposed that the Bill would allow action to be taken in relation to people whose condition and behaviour creates risks for others. For which conditions might these powers be exercised and by whom (para 7.2.6)?*

\* **Option 1:** Medical Officer of Health discretion – that is, the Medical Officer of Health decides when, and in relation to what conditions, it is appropriate to use the specified powers, taking into account specified criteria.

\* **Option 2:** The full range of care powers could be invoked only for conditions specified for that purpose in regulations.

\* **Option 3:** A specified list of high-risk conditions for which the more restrictive powers may be exercised, but for which a court order would be required, while a Medical Officer of Health would be able to invoke the less restrictive powers to deal with any communicable condition.

The NZHT strenuously oppose Options 1 and 2 and give qualified support to Option 3 with following amendment:

*A specified list of high-risk conditions for which the more restrictive powers may be exercised, but for which a court order would be required, while a Medical Officer of Health would be able to invoke the less restrictive powers to deal with a second specified list of lower-risk communicable condition. Some communicable conditions are not subject to any restrictive powers or the imposition of any action by health authorities.*

No treatment should be administered without the informed consent of the individual.

The proposals in the discussion paper discriminate against those with clinical infection while not addressing the problem of disease transmission by individuals who have sub-clinical infection. The proposals also do not differentiate between diseases such as the common cold, a highly contagious communicable disease which rages through communities unabated, and rarer or more exotic diseases, such as tuberculosis, yellow fever, etc.

While the safety and efficacy of much medical treatment is either unproven or in dispute, while there are constant reversals in many long held medical beliefs, and while there is such a high level of morbidity and mortality as a result of the incorrect or inappropriate use of medical treatment, New Zealanders must retain the right to decide what medical treatment, if any, is the most appropriate for their illness. Of far greater concern are the actions of so called medical professionals in the development of antibiotic resistant bacteria through the gross overuse of antibiotics, the prescription of dangerous drugs and medical treatment without due consideration of the rights of individuals to full disclosure of all the risks and benefits of such drugs and treatment (e.g. third generation contraceptive pills, HRT, drug and mechanical intervention in birth for the convenience of the doctor not the improved health of babies and their mothers, the use of surgery and drugs for stomach ulcers when scientists have known for years that they were caused by a bacteria, the prescription of thalidomide to pregnant women in the 1960s.... The list goes on and on and on).

With such a history of disastrous medical decisions it is outrageous to consider imposing compulsory treatment on individuals with communicable diseases. Often the treatment of choice is bedrest and support of the body's innate ability to heal itself without the use of drugs which often, at best, mask or suppress symptoms and prevent the healing process from occurring as quickly as it otherwise might. For example, the overzealous attempts by many in the medical profession to reduce fever, the body's natural mechanism for fighting infection, at all costs:

*“There is no convincing evidence that naturally occurring fevers are harmful. In contrast, animal studies have shown that fever helps animals to survive an infection whereas antipyretic increases mortality. Moreover there is considerable in vitro evidence that a variety of human immuno-logical defences function better at febrile temperatures than at normal ones.” (The Lancet, Volume 337, March 9, 1991)*

*“There is overwhelming evidence in favour of fever being an adaptive host response to infection... as such, it is probable that the use of antipyretic/anti-inflammatory/analgesic drugs, when they lead to suppression of the fever, result in increased morbidity and mortality during most infections; this morbidity and mortality may not be apparent to most health care workers...” (Infect Dis Clin North Am, 1996, Mar; 10(1) : 1-20.)*

*“Fever is an important indicator of disease and should not be routinely suppressed by antipyretics... fever may actually benefit the host defence mechanism... fever is short-lived and causes only minor discomfort... routine antipyretic therapy should be avoided but may be necessary in individual patients with cardiovascular or neurologic disorders.” (Infect Dis Clin North Am, 1996 Mar; 10 (1) 211-216)*

Again, the NZHT points out that New Zealanders have no need for a “cradle to the grave” nanny state telling them what to take, how to take it and when. They have no need for legislation that confers powers of compulsory care and treatment of individuals with communicable disease on a select few unnamed bureaucratic authorities and individuals. What they need is a health system that works, and first and foremost causes no harm! When that responsibility of the state has been accomplished the state may be in a better position to turn its attention to imposing 100% safe and efficacious medical treatment on its citizens.

**37. Question 34 *Proposals are set out for possible rights and duties of people with communicable conditions (para 7.2.3).***

The NZHT agrees that individuals must have a right to:

1. full information about the condition and its implications
2. protection of the person’s privacy to the greatest extent practicable
3. appeal procedures, including to the courts, in relation to specified orders
4. access to legal or other support (friends, whānau, and so on, who can act as advocates, provide advice or explain information independent of the health authority).

The intent of the duties imposed upon individuals are admirable and in an ideal world they might be reasonable. However, for many of the less severe, contagious or lethal diseases these duties would be onerous and not adhered to by the majority of New Zealanders. The “sick leave” provisions for many people in the work force would make the obligations onerous and punitive. These fulfilment of these duties would be impossible to enforce. For most of the more severe diseases people are too sick to be much of a deliberate threat to the wider community. For those with subclinical infection or mild cases of serious illnesses, or symptoms which the sufferer is unaware represent a serious infectious disease, the burden on the health system to “capture” these individuals, confirm diagnosis and then enforce the obligation to minimise the risk of transmission to others would be prohibitively expensive, and an outrageous abuse of the limited funds available for public health in New Zealand.

While such obligations as listed are appropriate for serious diseases such as HIV/AIDS, tuberculosis and the occasional cases of highly contagious imported (exotic) diseases, they are impractical and punitive for the vast majority of communicable diseases, specially when the impact of the mortality and morbidity of communicable diseases is compared with other

public health issues in New Zealand (see General Comments and the answer of the NZHT to Question 15).

38. **Question 35** *Should the Public Health Bill include offences for behaviour that involves infecting other people (para 7.2.3)?*

The NZHT is outraged that criminalising “non-compliant” behaviour has even been considered. In serious cases, such as the reckless engagement in sexual activity of someone with HIV/AIDS, there are already sufficient legislative powers with which to deal with such people. Differences of opinion in what is the best way of treating or preventing disease may lead to an unnamed bureaucrat regarding a wide range of “risk factors” as “risk behaviour” that must be punished. At an extreme, a person whose health is compromised as a result of dietary choices, and who contracts a communicable disease could be charged with breaching their duty to minimise the risk of disease. A person who leaves home while suffering a cold or who sneezes in public without the protection of a handkerchief, could be regarded as being in breach of their duty to minimise disease.

In an environment where:

- health professionals and drug manufacturers are protected by a no-fault accident compensation system;
- where New Zealanders damaged by the incompetence of health “professionals” or through systems failures have to fight tooth and nail for recognition of their suffering and monetary compensation;
- where New Zealanders suffering from iatrogenic disease have no possibility of claiming, through civil action, any monetary award or compensation, much less an acknowledgement of the responsibility of those at fault;

it is outrageous that these same New Zealanders could be subject to criminal proceedings and punishment for not upholding their “responsibilities” to follow the instructions issued by the self same public health system that is responsible for so many (unaddressed and unpunished) failures.

The NZHT opposes any regulations that use fear of punishment as a means denying people both the right to make informed decisions about their health care and the right to refuse medical treatment.

39. **Question 36** *Some duties of health practitioners are proposed (para 7.2.4).*

The NZHT generally agrees with the duties of health practitioners as they are proposed notwithstanding the opposition to the proposed measures relating to the duties of the individual with the communicable disease stated in its answers to Questions 33, 34 and 35.

40. **Question 37** *A range of powers is proposed (potentially for people with communicable conditions of risk to others) (para 7.2.5).*

The NZHT opposes these proposals for the same reasons as stated in its answers to Questions 33, 34 and 35. While these powers to compel individuals to undergo counselling, supervision, education programmes, etc. may be acceptable in the case of deliberate and reckless endangerment by a person with a highly contagious and fatal disease, the proposals as set out in the discussion paper would permit widespread and outrageous abuses of power by medical bureaucrats. For example, a person, having made an informed decision not to have a vaccination (a decision which was, incidentally, supported by a review of the medical research) could be directed to submit to any or all of these conditions. While there is mention of invoking such powers only under extreme circumstances, just what criteria characterises

“extreme circumstances” is not discussed. These proposals are far too vague to reassure the NZHT that abuses of power and denial of human rights will not occur.

41. **Question 38** *If lists of conditions are to be specified, on what criteria do you think such lists should be based (para 7.2.6)?*

The “care powers”, if permitted at all, should only be applied in cases where the communicable disease was particularly contagious, intractable, with a high degree of mortality and which generally results in lifelong disability and illhealth (e.g. tuberculosis, HIV/AIDS). Diseases such as hepatitis A, measles, whooping cough, influenza and meningitis do not qualify for various reasons. These diseases circulate freely in the community, are often present as subclinical infections, or do not cause disease in all people who are exposed to the pathogens that cause them (meningitis B is included for this reason) and from which the vast majority of people recover with lifelong immunity and no ongoing disability or health problems.

42. **Question 39** *Do you agree that some powers should be exercised only by a Court (paras 7.2.6 and 7.2.7)?*

Yes. The NZHT agrees that many of the powers proposed, if included in the legislation, should only be able to be exercised by a Court. This would ensure that the individual for whom the court order is sought has legal representation, and an avenue of appeal, and that the medical authorities could not make frivolous and vexatious orders because an individual is seen as being subversive or difficult by virtue of questioning conventional medical “wisdom” and by asserting his or her right to refuse medical treatment.

43. **Sections 8 and 9**

NZHT does not have any particular mandate to comment on issues of contact tracing and border control. For this reason and because of the deadline for the submission of comments on the proposed legislation we do not address the issues raised in these sections nor answer the questions set out in these sections.

## CONCLUSION

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- Moynihan *et al.* point out “the lay populace has become more active, better informed about risks and benefits, less trusting of medical authority, and less passively accepting of the expansion of medical jurisdiction into their bodies and lives.” The proposals for the Public Health Bill represent just such an expansion of medical jurisdiction – an extremely unwelcome over-regulation of the health of New Zealanders. Further, the wording of the proposals gives the distinct impression that unidentified people would be legally empowered to make sweeping decisions on virtually any health matter with no wider consultation.
- While the NZHT accepts that there is a need to update the health legislation in New Zealand, it categorically reject any powers or regulations that infringe upon the rights of New Zealanders to make informed decisions about their health care and their rights to refuse any medical treatment or intervention. The NZHT views the proposals for the Public Health Bill as set out in the discussion document, as draconian and punitive, and as a significant infringement of the most basic Human Rights. The proposals have the potential to permit tyrannical regulations to be enacted in the future with no guarantee of public consultation. The NZHT wholeheartedly reject any such proposals.
- Mainstream medical treatments and pharmaceuticals are inherently dangerous and are one of the leading causes of illness and death in modern civilisation. There is insufficient knowledge and evidence of the effects of the same for them to be in any way considered to be safe for all people. Only an unacceptably small portion of the treatments offered are in fact clinically tested and fewer still can be shown to be free of any risk of adverse effects. Given this state of affairs to remove the right of each individual to assess the risk and possible benefit of each treatment for themselves is a totally unacceptable proposition.
- To have the ability to force any treatment on all peoples is philosophically, culturally and socially repugnant and does not reflect the obligations of the Government to the citizens of New Zealand under the Bill of Rights Act or the Treaty of Waitangi.
- Further the NZHT believes that the proposals have not been sufficiently brought to the attention of the New Zealand public particularly given the implications of the matters under discussion. These proposals must not, in the interests of good government, be progressed in any way without significant and widespread further consultation
- For the reasons set out above and contained in this Submission, the NZHT strongly opposes the proposals set out in the Discussion Paper.

This submission was prepared for, and on behalf of, New Zealand Health Trust.  
by P David Sloan/Amy Adams.

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