Public Health Association of Australia submission on South Australian Public Health (Early Childhood Services and Immunisation) Amendment Bill

Contact for recipient:
Communicable Disease Control Branch
Health Regulation and Protection
Department for Health and Wellbeing, SA
A: 11 Hindmarsh Square, Adelaide SA 5000
E: HealthCommunicableDiseases@sa.gov.au

Contact for PHAA:
Terry Slevin – Chief Executive Officer
A: 20 Napier Close, Deakin ACT 2600
E: phaa@phaa.net.au T: (02) 6285 2373

28 June 2019
Preamble

The Public Health Association of Australia

The Public Health Association of Australia (PHAA) is recognised as the principal non-government organisation for public health in Australia working to promote the health and well-being of all Australians. It is the pre-eminent voice for the public’s health in Australia.

The PHAA works to ensure that the public’s health is improved through sustained and determined efforts of the Board, the National Office, the State and Territory Branches, the Special Interest Groups and members.

The efforts of the PHAA are enhanced by our vision for a healthy Australia and by engaging with like-minded stakeholders in order to build coalitions of interest that influence public opinion, the media, political parties and governments.

Health is a human right, a vital resource for everyday life, and key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions that underpin people’s health. The health status of all people is impacted by the social, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease. These determinants underpin the strategic direction of the Association.

All members of the Association are committed to better health outcomes based on these principles.

Vision for a healthy population

A healthy region, a healthy nation, healthy people: living in an equitable society underpinned by a well-functioning ecosystem and a healthy environment, improving and promoting health for all.

The reduction of social and health inequities should be an over-arching goal of national policy and recognised as a key measure of our progress as a society. All public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.

Mission for the Public Health Association of Australia

As the leading national peak body for public health representation and advocacy, to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.
Introduction

PHAA welcomes the opportunity to provide input to the Inquiry into the South Australian Public Health (Early Childhood Services and Immunisation) Amendment Bill.

PHAA strongly supports immunisation and the role of Governments to lead, inform, regulate, monitor and enforce strong vaccination policies within communities, workplaces, and healthcare organisations and to encourage people to recognise the role they play in protecting themselves and others.

PHAA Response to the consultation paper

Enrolment

Do you agree that, with rare exception, children in SA should be fully vaccinated for age as a condition of enrolment into early childhood services?

PHAA does not support this strict position as it is stated. The ‘rare exemption’ criteria do not capture the majority of children who are un- or under-immunised.

PHAA is a strong advocate for a well-immunised community, but does not support efforts that will disadvantage individual children socially or financially or impede access to health or education.

PHAA does not support the intended Phase 2 Bill which will potentially provide for exclusion of unvaccinated children from enrolment in and potentially attendance at early childhood care and services and calls upon governments to reconsider strategies that inevitably harm children.

If so, which of the described options do you consider to be the best? Please provide your reasons.

Option 1 – ‘Pause’. This option proposes to fully implement the Phase 1 Bill before considering the need for further change and would be the most palatable to the PHAA. This option will focus on the minimisation of threat of disease transmission in the event of an outbreak. In addition, it includes mandatory documentation, supported by evidence that it improves coverage. It strikes a balance between effectiveness in nudging vaccination for the merely late and equity for children of vaccine refusers.

This option will only consider removing children from early education services to protect their own wellbeing.

Furthermore, South Australia has already made gains in recent years. Since 2016, coverage for five-year olds has risen by 3.4% to 94.7% by December 2018. In NSW (with policies akin to option 2), coverage rose by 1.5% and in Victoria by 2.5%, suggesting that Option 2 may be less effective. Accounting for register recording error, SA coverage is likely to be 1% higher in reality taking it beyond target levels of 95%.1

If no or unsure, what do you suggest as an alternative proposal or activity to improve immunisation rates among young children?

PHAA supports campaigns designed to understand all barriers to full vaccination.

The two major factors are confidence and convenience, with the latter prevailing in at least 50% of the under-vaccinated. The 2004 Longitudinal Study of Australian Children (LSAC) noted the “majority of
incompletely immunised infants in LSAC did not have mothers who disagreed with immunisation but were instead experiencing a heterogeneous range of barriers”.

Being delayed for vaccination was 23% of the sample and demographics of having 2 or more children, no private health insurance, or lone parent household accounted for most of this group. Being completely unvaccinated accounted for 2% of the sample among whom disagreeing with vaccination was a major factor. This indicates that efforts to remove barriers may provide more gains than those to coerce the reluctant.

PHAA agrees that “...the characteristics of local populations should be considered when designing programs to increase uptake”, rather than an all-encompassing approach.

Studies from Australia and overseas show that improving coverage should include: improving the quality of recording on the Australian Immunisation Register, pre-vaccination reminder systems, home visiting programs, increased after-hours access to services, more timely access to special immunisation service clinics and improved cohesion of health professionals involved in the child’s care. To address vaccine hesitancy (which can lead to refusal), parents need an opportunity to articulate their concerns and barriers, and receive tailored advice from knowledgeable professionals in primary care. Studies find that parents often do not have these conversations with their GP as they either feel pressured to vaccinate, felt their concerns were not taken sincerely or that the GP was too busy, and they didn’t wish to bother them. Experienced immunisation nurses or specialist GP’s with motivational interviewing skills would be better placed at engaging with individual hesitant parents in a non-threatening environment. This requires appropriate support for continuing education of providers and better medical and nursing pre-registration program education.

Should option 2 or above be taken, child care centres should receive intensive support to implement and enforce requirements. This includes appropriate funding and a plan for implementation and evaluation at policy commencement. Under that scenario, mandatory documentation of vaccine refusal by health care provider and parent would incentivise parents who intend to refuse vaccination to discuss their decision with a GP or other appropriately qualified professional. This incentivises engagement with the health care system where sometimes parents change their minds. It is estimated that 11% of parents who originally objected to vaccination went on to fully vaccinate their children under the previous federal system of requirements with objector exemptions.

Do you agree that children on an approved catch-up schedule should be permitted to enroll?

Yes.

Parents who face barriers, including concerns and fears, require time to build rapport with a provider, digest information and proceed with immunisation. Due to required minimum interval between vaccines, extensive immunisation catch-up programs may take several months to complete. Children should not be withheld from enrolling in or attending early childhood services while they complete a catch-up vaccination program. This is particularly the case for migrant and refugee children.

To assist in meeting the proposed immunisation requirements, what resources and/or support should SA Health provide to persons in charge of early child care services, families and/or immunisation providers?

All stakeholders will require extensive support, resourcing and education to effectively meet any of the proposed requirements.

Persons in charge of early child care services would require, on enrollment, permission from parents to access the child’s AIR record. This will require a change in legislation as these providers cannot currently apply for AIR secure site access. Currently, many early child care services request parents to provide
immunisation records but do not have power to enforce this if the parent refuses or does not provide the records for other reasons. Clear and consistent guidelines, outlining rights, responsibilities, timelines and mechanisms for management will be required for early child care services to manage a lack of compliance. The example of the current guidelines in NSW are informative. PHAA recommends that advice from NSW Health be sought on the outcomes from that state’s experience.

**Do you agree with the listed advantages and disadvantages? Please provide evidence to support your views, including any likely overall financial impacts.**

PHAA agrees that the listed advantages of Option 1 – Pause, are acceptable. The PHAA however, does not support the full list of disadvantages for this option.

Options 2 and 3: added to list of disadvantages:

- reports of informal childcare arrangements in communities with high rates of refusal
- inadequate provisions for medically complex cases within existing medical exemption arrangements
- abuse of nurses and GP’s when parents cannot access medical exemptions.
- iresulting for refugee and migrant families who lack language, financial and material resources to understand and meet catch up and immunisation requirements.

With enhancement of the current range of multifactorial efforts to increase coverage, SA’s immunisation rate is unlikely to fall below the national target.

Strategies to better engage, not alienate, vaccine refusers are more likely to be effective: An article published in the Harvard Business Review stated,

> “Nothing is more important in a cooperative system than communication among participants. When people are able to communicate, they are more empathetic and more trusting, and they can reach solutions more readily than when they don’t talk to one another. Over hundreds of experiments spanning decades, no single factor has had as large an effect on levels of cooperation as the ability to communicate”.  

The article also highlights that people care about being treated fairly and “We shouldn’t try to motivate people only by offering them material payoffs; we should also focus on motivating them socially and intellectually by making cooperation social, autonomous, rewarding, and even—if we can swing it—fun”.

PHAA acknowledges “Children of vaccine-refusing parents are likely to remain unvaccinated and so vulnerable to VPDs” is indeed true, however it would argue that the likelihood of this is decreased when the child is in a ‘herd’ environment. The unvaccinated child would be at higher risk of VPD if they were excluded from mainstream early childhood services and corralled into totally unvaccinated groups.

The financial impact would be felt across all stakeholders; government monitoring compliance of such a policy, early childhood services in upskilling staff, employing additional staff and implementing new systems of compliance, and parents; particularly women. An article on working women stated that motherhood can “necessitate her to take more than available leave options, and job security can be at risk”. This proposed policy will severely impact on mothers, who will ultimately be the parent forced out of the workplace to care for children excluded from early learning services. This would cause major financial grief to families, especially single parent families.
Can you identify any additional advantages and disadvantages? Please include quantitative evidence of any likely impacts.

Additional disadvantages are to the child’s development. Evidence tells us that a person’s life successes, health and emotional wellbeing have their roots in early childhood. The early years of a child’s life is crucial for the physical, emotional, psychological and social development of the child which underpins the successes they have in life. Early learning is a child’s introduction to community; community participation, responsibilities and positive influence. Denying a child of this experience is not supported by PHAA.

There is also strong evidence for improvement of coverage with requirements of vaccination with exemptions. In addition, there is experimental evidence for reactance among those against vaccination – who become even less willing to vaccinate.

Exemption

Do you support the provision of exemptions to the immunisation requirements for vulnerable and/or disadvantaged children as described?

Yes with caveats. See below.

Are the proposed categories of vulnerable and disadvantaged children which may be exempt from the immunisation enrolment requirements appropriate?

PHAA acknowledges the list of exemptions for vulnerable and disadvantaged children includes some, but not all children at risk of being un- or under vaccinated. The PHAA agrees that SA Health must explore ways to assist under vaccinated children but insists excluding children from attending early learning services is not an appropriate way forward.

The current Victorian provisions also provide a useful model.

General questions

Can you identify any additional regulatory proposals that should be considered or any other way of achieving higher immunisation rates for young children in SA? Please provide details as well as supporting evidence where possible.

Equitable access for all people living in Australia to quality immunisation services provided by health professionals who have been deemed competent to deliver vaccination in both public and private sectors will sustain and promote the highest possible immunisation coverage in children, adolescents and adults.

Inequities currently exist for individuals who live and work in Australia, but who are ineligible for Medicare. Higher immunisation rates for young children in these families may be achieved by rectifying this inequity and ensuring all children living in Australia have access to tax-payer funded National Immunisation Program vaccines.

In addition, we draw your attention to advice made to the NSW government in 2016 by Associate Professor Julie Leask of the University of Sydney, which remains relevant to your current considerations.
Do you have any additional comments in relation to the proposed Phase 2 Bill to strengthen immunisation enrolment requirements for early childhood services?

At the conclusion of the PHAA National Immunisation Conference 2018, the PHAA called on Australian governments to appropriately evaluate the “No Jab – No Pay” and the “No Jab – No Play” policies in their broad community context and to use the outcomes of such evaluations to adopt more refinements to these policies so that no family is inappropriately disadvantaged.

The Federal Government evaluated the implementation of No Jab No Pay in 2016, but has not released the evaluation report. The PHAA is not aware of any planned evaluations of the Federal policy. Without evaluation and strong evidence of success, the PHAA cannot support ongoing policies that have a potential to cause community division and disadvantage to children.

The PHAA has reservations about No Jab No Play policies as the issues of un- or under-vaccinated children are complex and require a range of strategies that are responsive to the actual cases of under-vaccination.

**Conclusion**

PHAA is particularly keen that the following points are highlighted:

- children will be disadvantaged in multiple ways if they are excluded from early learning services
- financial hardship will result if parents are forced out of the workforce to care for excluded children
- children at risk of VPD due to parental refusal of vaccination, will be at increased risk if corralled into communities where rates of vaccination are low
- more effort should be given to exploring options of increasing vaccination rates

PHAA appreciates the opportunity to make this submission and the opportunity to advocate for parents, providers (health and early child services) and for children.

Please do not hesitate to contact us should you require additional information or have any queries in relation to this submission.

Terry Slevin  
Chief Executive Officer  
Public Health Association of Australia

Angela Newbound  
Co-convener, PHAA Immunisation  
Special Interest Group

28 June 2019
References