Submission to Senate Community Affairs Legislation Committee regarding the SOCIAL SERVICES LEGISLATION AMENDMENT (NO JAB, NO PAY) BILL 2015

Submission by
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Summary

While vaccination is well supported by research, the proposed amendment is not grounded in evidence from the behavioural sciences and brings a series of unintended deleterious consequences. This submission urges government take a more rational and considered approach to increasing vaccination rates consisting of comprehensive, multifactorial approaches that amount to firm but fair policy and continue to hold vaccine refusers to account. In addition, shutting out the unvaccinated from childcare by removing its affordability will not shut out the risks from vaccine-preventable diseases. All Australians have a responsibility to protect the vulnerable. This submission makes recommendations in relation to the bill including options for amendments and monitoring of impacts and other considerations.

Background

Government has linked eligibility for social security payments to immunisation status beginning in 1998 with eligibility for a single $200 payment, later escalated to include child care rebates, and in 2012, other family payments.(1) Parents whose child was not fully vaccinated could retain eligibility by having an immunisation provider certify on a form that the risks of non-immunisation had been discussed on “conscientious” or religious grounds or that there was a medical contraindication to receiving a vaccine(s). Early studies indicated that these measures were effective.(2) But because some parents were still not fully vaccinating their children, more needed to be done.

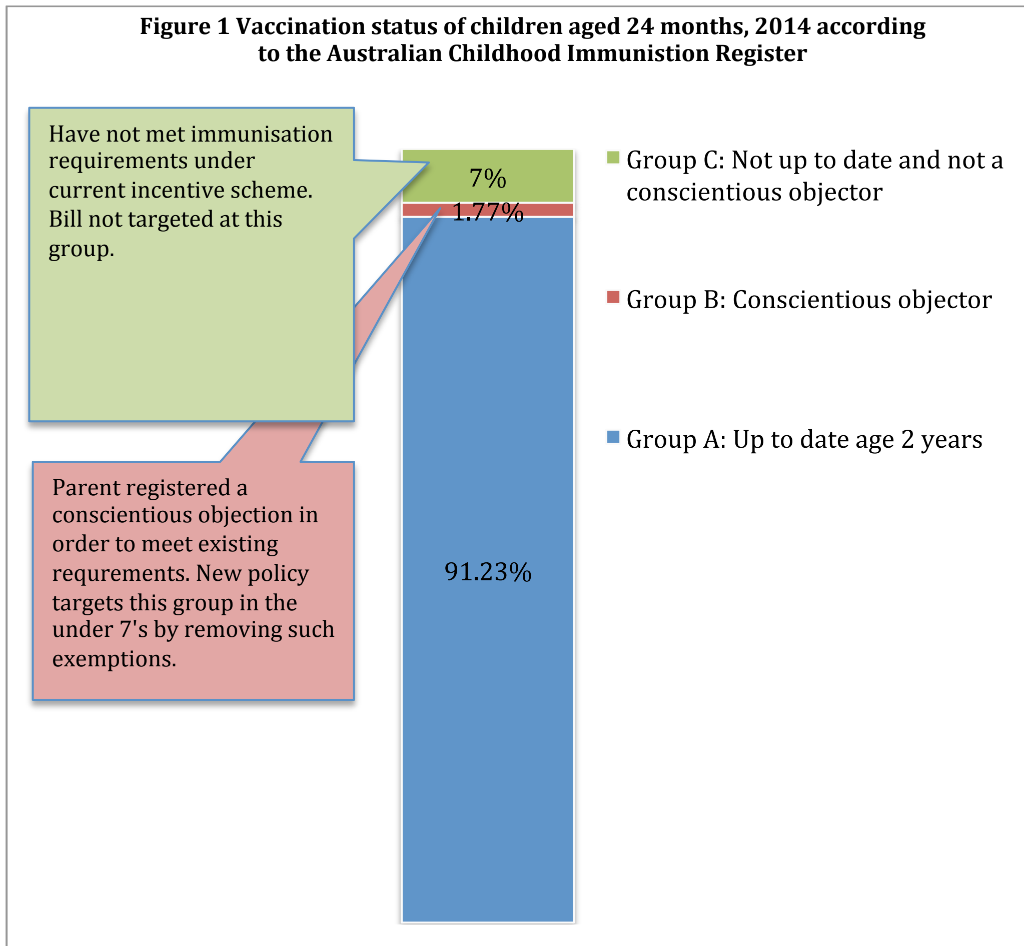
Vaccine refusal is a vexed problem and the evidence base for addressing it is wanting.(3) Studies have found that what might intuitively seem to work (eg, giving information) can have the opposite effect, further entrenching vaccine refusers.(4) Governments have sought answers, turning to what is within their control to effect. Accordingly, the amendment bill proposes to:

1. Remove exemptions for conscientious objectors to receive payments
2. Extend the vaccination requirements from up to 7 years to all of childhood (up to age 18 years)
3. Completely remove the capacity for ACIR to register and monitor objection to vaccination.

It is essential to understand under-vaccination to appreciate the bill’s limitations. Figure 1 below sets out three relevant groups in children aged 24 months with data taken from the Australian Childhood Immunisation Register (ACIR).

- Group A are up-to-date for vaccines given at 2, 4, 6, 12 and 18 months of age. The vaccines include those against hepatitis B, diphtheria, tetanus, pertussis, haemophilus influenzae type b, polio, measles, mumps and rubella, pneumococcal, varicella and meningococcal C.
- Group B are children whose parents have registered a conscientious objection.
- Group C are neither up-to-date on ACIR nor have a registered conscientious objection. They are either partially or completely unvaccinated.

Figure 1 Vaccination status of children aged 24 months, 2014 according to the Australian Childhood Immunistion Register



Pragmatic and ethical considerations with the bill.

1 Pragmatic considerations

1.1 The bill misses the target

The bill is targeted at those who currently register an objection (Group B) at 1.77% of all children. However, those not up-to-date and not registering objection are the largest of the two under-vaccinated groups at 7% of all children. The existing requirements to vaccinate or lose benefits have not made them vaccinate. Studies indicate that this group is likely to include

- children who are actually up-to-date but recording error has resulted in them being falsely classified as not up-to-date on the ACIR;
- children of 'silent' unregistered objectors;
- children of the vaccine-supportive who are late for a range of practical and logistical reasons.

Group B are likely to remain incompletely vaccinated unless the removal of objection provisions reduces under-reporting to the register or raises awareness of the existing requirements among the willing but unaware. Those who are willing but late for practical reasons need other measures that focus on removing logistical and financial barriers and minimizing missed opportunities. The plan by the Department of Health to provide a $6 provider incentive for catch up is expected to help many and will probably raise vaccination rates because the group it targets is larger, more motivated and usually unwittingly not up to date (e.g., the child is born overseas and is yet to catch up on the Australian schedule).

In addition, the plan to extend vaccination requirements to older children is likely to prompt catch up and reduce circulation of disease in the community. It will prompt parents of children born overseas to fully vaccinate and enable them to access vaccines for free. Such children were thought to be a major contributor to outbreaks of measles in particular because they arrived unvaccinated from countries that did not provide the vaccine and were not prompted to be vaccinated because they were over 7 years. (5)

1.2 Many vaccine objectors will remain unmoved by the requirements

While some vaccine objecting parents will fully vaccinate their children as a result of the policy, many will not. Of the 1.77% in group B who register as objectors, two sub-groups will likely be unmoved:

- those who are not eligible for the income tested payments (FTB-A supplement and childcare benefit) and where the childcare rebate makes little difference. These higher income families are also more common among vaccine refusers.(6) Specifically, those registering objection are approximately twice as likely to reside in the top 10% of SES postcodes compared with the bottom 10% as measured by the Socio Economic Indexes for Areas (SEIFA).
- those who are eligible for payments but continue to remain too fearful or mistrusting of vaccines to change. A reasonable behavioural marker for this group is their children having no vaccines recorded. This is approximately one half of the group now registering objection with the other half having one or more vaccines recorded.

One media report stated that 14,000 families of the 39,000 registering objection to vaccination under 7 years would be affected. Assuming the 39,000 is the 1.77% who register objection, this 14,000 equates to 0.6% of all children. In a best case scenario where the policy convinced half of them to vaccinate, it would increase child immunisation coverage overall by 0.3%. However, it is not possible to confirm these figures as they have not been provided by government, only the media. Government predicts savings of $508.3 million over the forward estimates, indicating that government anticipates that family non-eligibility for payments will result because many won't be incentivised by the bill.

1.3 The bill will remove the requirement for parents to discuss vaccine refusal decision with a doctor or immunisation provider - a more constructive approach.

To meet existing objector eligibility requirements, parents must have a form signed by an immunisation provider or doctor after having the risks and benefits explained to them. The removal of objection requirements will remove such opportunities and create more alienation from a healthcare system that vaccine refusing parents already struggle to trust. Quality engagement with a health professional is a much more ethical and satisfactory way to approach non-vaccinators than monetary sanctions.

While many refusers hold fixed beliefs, when they do change it is most likely through an interaction with the family doctor or nurse. One US study of those who delay or refuse vaccination then change their minds found information or assurances from a health care provider to be the main reason in 50% of respondents.(7) Our recent interview study with 26 immunisation providers indicated that they see the form signing requests as a challenge but also an opportunity to make headway with some vaccine refusers and build bridges. We also have anecdotal accounts of the form-signing requirements spurring interactions with immunisation experts in public health units or adverse events clinics. They can build trust and answer their questions with some reporting a high rate of eventual compliance. It is not clear whether the more punitive approach to refusal will have the same impacts.

1.3 There will be pressure on providers to give a medical exemption when it is not warranted

The bill will lead to conflict between parents and GPs, practice and community nurses. Parents who refuse vaccines will now seek the only escape hatch available to them – the medical exemption. Medical exemptions are only legitimate in a very narrow subset of children. Providers rightly applying these narrow requirements will encounter hostility and conflict.

1.4 The bill goes against what evidence suggests is the best approach

A US review examining impact of monetary sanctions in raising immunisation rates showed insufficient evidence to support such a strategy, with authors warning that negative impacts on relationships with other services could occur.(8) Rather, the weight of the evidence suggests supportive strategies are more effective, such as those that remove barriers to vaccine access. Incentives are also effective, which is what is currently in place through existing requirements.(2)

Many Australians are angry at vaccine refusers. A whooping cough epidemic and the tragic deaths of infants have perpetuated this anger. Since 2013, Newslimited has campaigned to remove objector provisions in both state and federal policies. This has met with some community support. Among the majority who are supporters of vaccination, there is a dislike of the notion of vaccine refusers being supported by family assistance payments. Early agenda-setting media coverage of vaccination rates framed under-vaccination as exclusively the result of vaccine refusers with the implied solutions that changing their behaviour would remove the risks or at least ameliorate the moral outrage from their ability to claim payments. But despite media claims to the contrary, vaccination rates have held steady.(9) Refusal rates have increased from 0.23% in 1999 to 1.77% in 2014, an absolute increase of 1.54% assumed to be because of increased awareness of government provisions for non-vaccinators. This assumption is based on the lack of a concurrent reduction in immunisation rates.

Vaccine refusal is a problem but not the only contributor to outbreaks. Other children and adults contribute to disease spread. For whooping cough, the vaccine is very safe and has reduced rates of severe disease but less so, mild disease. It also gives shorter lasting immunity, creating susceptibility in a range of age groups. Dr Wiley's review showed that more than fifty per cent of infants hospitalised from pertussis caught it from a parent. (10) Along with having generally high childhood vaccination coverage, targeted solutions are needed for better control of pertussis: re-introducing the 18 month booster dose to address waning immunity in pre-schoolers and vaccinating pregnant women to provide direct protection to the infant. For the 1.77% who are vaccine refusers, policies and programs should prevent their growth in number and continue to make vaccine refusal logistically challenging with form signing requirements. Community based engagement strategies have also been tried with a recent study showing some promise.(11)

1.5 Loss of national registration of vaccine objection removes the nation's ability to monitor vaccine refusal rates.

Under the amendment, registration of vaccination objection will end as of January 2016. This will remove the capacity to record and monitor objection to vaccination over time and identify regional variations. Some regions have low vaccination rates but low objection rates. For example, a region that has a vaccination rate of 89% but only 1.5% objection rates will ascertain that the problem is likely to relate to access to services or families falling through the gaps. This allows them to target solutions well. From 2016, local planners will be unable to determine why children are under-vaccinated. Without such information, solutions may not match the cause of the problem (e.g., an education campaign when poor transport and disadvantage is the problem). Australia currently has no other way of monitoring vaccine sentiment at a regional level to enable local planning.

For this reason, this submission recommends that either the objection provisions be retained or government initiate yearly monitoring of vaccine sentiment. As objection to vaccination is estimated to be approximately 2% of the parent population (when accounting for silent objection), the sample size must be large enough to enable precise estimates and sufficient sample power for key comparisons (e.g., education level or region). Restrictions on access to ACIR to

conduct such research would need to be addressed so that program planners can better understand the reasons for under-vaccination.

Such a survey would enable ongoing performance monitoring against the National Immunisation Strategy Priority 6: *Strengthen monitoring and evaluation of the national immunisation program through assessment and analysis of immunisation register data and vaccine-preventable disease (VPD) surveillance.*

1.6 Loss of a vaccine objector registration system used by states that have childcare entry requirements.

The federal amendment brings a knock on effect: state-based policies that require full vaccination for entry to childcare have relied on the ACIR-based conscientious objection form to provide exemptions. These policies have maintained a firm but fair approach – prompting the late vaccinators, and ensuring those remaining unvaccinated can be excluded during an outbreak and children of objectors can otherwise access childcare. Now, QLD has passed a bill allowing childcare directors to exclude the unvaccinated and with no provisions for objector exemptions, stating that the removal of the government registration system made such provisions infeasible. Victoria has announced plans to remove the objector exemptions in 2016 when it brings in a new childcare enrolment vaccination requirement that previously had planned the exemption.

2. Ethical issues

The bill has ethical issues related to equity, autonomy and reciprocity.

2.1 The bill effectively mandates vaccination lower income families but with no accompanying vaccination injury compensation scheme.

By removing the capacity for vaccine objectors to obtain family assistance payments, the sub-set on lower incomes with the most to lose may be feel coerced to vaccinate. One of the central tenets of ethical medical practice, including procedures like immunisation, is informed consent to proceed. Ethically, true informed consent cannot involve any real or perceived coercion. This bill comes perilously close to financial coercion for the lower income vaccine-refusing families.

Coercion may be warranted when risk to the community is immediate (such as quarantine for infectious diseases or daycare exclusions for the unvaccinated during an outbreak). In addition, policies must consider any risks from the action being required. Vaccination is associated with the occurrence of rare serious adverse events. These are not the alleged and erroneous adverse effects purported by the anti-vaccination movement and claimed in many of the submissions against this bill (such as autism, diabetes, SIDS). Rather, they are a limited set accepted by Brighton Collaboration and listed in the Australian Immunisation Handbook. Because of these rare serious adverse events, governments that mandate vaccination are obliged to provide a system for assessing and awarding vaccine injury compensation as has been done in 19 countries.(12) It is not clear to what extent the NDIS will cover all such instances. Ethically, if government expects parents to fulfill the social contract to have their children vaccinated and bear risks of rare but serious adverse events, they should similarly fulfill a reciprocal obligation to compensate for such events.

2.2 Removing access to childcare through rebate removal makes the children of vaccine refusers pay twice.

The bill will have significant equity ramifications downstream. Some families won't be able to afford childcare without the rebate. In one study, 55% of respondents whose children were not fully vaccinated indicated that they could not afford childcare without the rebate.(2) Such families may either stop using it and mothers or fathers will have to remove themselves from the workforce to care for them or they may seek childcare arrangements where refusers cluster. The capacity of such settings to seed and spread outbreaks has been noted in overseas settings.(13) The propensity for such adverse impacts needs to be carefully monitored.

Finally, that some children will not access the benefits of early childhood education because of their parent's misguided decision contravenes the National Partnership Agreement on Universal Access to Early Childhood Education signed by the Commonwealth and the States and Territories in 2008.

Recommendations

This submission proposes the following:

1. Retain the extension of the requirements to children over 7 years along with free vaccination for catch-up;
2. Amend bill to retain conscientious objections provisions and require conscientious objection forms to be signed by a provider each year;
3. Conduct a national audit of the accuracy of the Australian Childhood Immunisation Register (ACIR) to improve quality and reduce under-reporting;
4. Make provisions for regular studies of the under-vaccinated through improving access to ACIR for the purposes of research;
5. A full review of the implementation issues in 2017 with subsequent amendments to legislation as needed;
6. A full evaluation of the policy's impact in 2018-19 on vaccine refusing families on low incomes, vaccine confidence, immunisation providers and primary care service delivery, vaccination rates, refusal rates, childcare arrangements of vaccine refusers, outbreaks and any other impacts.
7. Introduce a no fault vaccination injury compensation system for vaccine injury.
8. Require Primary Health Networks to provide at least two part-time vaccination coordinators as part of funding agreement;
9. Evaluate strategies to address vaccine refusal:
    a. parent peer-advocate training in regions with higher rates of vaccine refusal;
    b. competitively awarded funding for local community campaigns designed by and for each community;
    c. inclusion of education about vaccination in high school core curriculum;
    d. funds to support more access to immunisation nurse accreditation training and better access to, and incentivisation of, training and updates for midwives;
    e. greater time for vaccination in medical curriculum.

Conflicts of Interest

Julie Leask receives part salary support the National Centre for Immunisation Research and Surveillance (NCIRS). She has funds from the Department of Health through the NCIRS funding agreement that involves developing a communication support package for primary care providers. She has sought funds for research on measuring vaccine acceptance and conducting research in vaccine-refusing communities.

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