Submission to Health and Ambulance Services Committee Public Health (Childcare Vaccination) and Other Legislation Amendment Bill 2015

A submission by:
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Summary

The proposed legislation seeks to give the person in charge of an approved education and care service the option to refuse, cancel or place a condition on the enrolment or attendance of a child who is not vaccinated, or not up to date with their scheduled immunisations.

The following submission recommends that the **proposed legislation be rejected**. It does this on the basis of the negative consequences that flow from enabling the exclusion of children who are incompletely vaccinated and the minimal impact such a measure would have on vaccination rates and disease control.

This submission recommends that **new legislation be proposed that requires all approved education and care services in the early childhood period to request and record evidence of age appropriate immunisation or a medical or vaccine objector exemption.** It does this on the basis of evidence that such a requirement will increase vaccination rates. This would strike the right balance – **reminding forgetful parents while making things procedurally complex for refusers** such that only the most entrenched obtain them. It is fair and proportional to the contribution that vaccine refusers make to under-vaccination which is recorded as 2.17% in Queensland. The other group – up to 4% – are willing but not fully vaccinated due lack of opportunity, logistical and service accessibility. Universal record check requirements will remind and help these families prioritise vaccination in all centers, not just those who decide to enact their provisions. Mandatory record checks with exemptions could be added to the existing provisions from the Public Health Act 2005 that enable appropriate exclusion of unvaccinated during an outbreak of an infectious disease.

The proposed legislation

The proposed amendment to the Public Health Act 2005 means that, at their own discretion, the person in charge of a childcare centre will be able to exclude unvaccinated children and there will be no capacity to provide an exemption to a family who refuses to vaccinate. The amendment has prima facie appeal and is politically populist if one takes the dominant media-based narrative about vaccine refusers as the sole cause of vaccine preventable disease outbreaks. However, it is based on only a partial understanding of the under-vaccination problem and as a policy, may do more harm than good. Specifically it:

1. **Punishes children for the decisions of their parents by restricting their access to educational opportunities afforded by childcare.**

   Early childhood education is beneficial to children. In 2008, the Commonwealth and the States and Territories signed a National Partnership Agreement on Universal Access to Early Childhood Education to ensure that all children have access to early childhood education. Enabling discretionary exclusion unfairly targets the children of vaccine refusers while not

addressing other significant sources of disease spread. The concern is amplified for two groups of vulnerable children of vaccine refusers: those who are under the supervision of the Family and Community Services where childcare has been recommended for child welfare or those living with deprivation whose access to childcare exponentially improves their educational and social outcomes.

2. **Is not a panacea for disease control because others too spread disease and need vaccination - parents, childcare workers, and travellers.**

   Disease control in childcare should be a shared responsibility, not placed solely with children of vaccine refusers. Adults too spread vaccine-preventable diseases. One review found that up to 50% of infants hospitalised with pertussis contracted it from a parent or sibling.(1) This is because most adults have immunity that has waned and parents can pass pertussis to their infants. Vaccination rates are much lower in adults than in children, although a vaccine may be recommended and free. To protect infants, all states implemented a vaccination of pregnant women and rates have now reached approximately 18%.(2)

   Vaccination rates in childcare workers need more attention. A NSW study of 319 childcare centers containing 3574 workers, only 29.4% were fully vaccinated.(3)

   The efficacy of the acellular pertussis vaccine means that, while it prevents severe disease quite well, it is less effective in preventing milder or subclinical infection.(4) Hence it is still possible to spread it even if vaccinated. For this reason it is false to assume that the exclusion of the unvaccinated will lower the risk level as substantially as hoped.

   Measles is another disease of concern. Unlike pertussis, the measles-mumps-rubella (MMR) vaccine confers immunity in about 95% of those vaccinated. This means that measles does preference the unvaccinated more than pertussis. But how can it be better controlled? One of the key groups of unvaccinated is travellers who bring measles into Australia from endemic countries, often young adults.(5) Those who return from visiting friends or relatives overseas are most at risk. Government should seek ways to improve vaccination rates among travellers.

   The Public Health Act of 2005 includes provisions for the exclusion of the unvaccinated during a disease outbreak. This should be retained as a way to lower the risks to the unvaccinated and the spread of disease.

3. **Will fail to convince the entrenched.**

   Some assume that the threat of childcare exclusion will make parents vaccinate. A minority of vaccine refusers may do so but most tend to be entrenched. Rather it will do the opposite, further alienating these parents from the system. What has the greatest chance of changing the minds of vaccine refusers is their family doctor. A US study surveyed parents who had decided to vaccinate having previously chose not to with advice from the family doctor as the most common reason.(6) Requiring vaccine refusers to obtain an exemption means they must attend a health care provider or doctor to discuss their decision and have the exemption signed. Sometimes these encounters lead to partial then even full vaccination. Incentivising this encounter through mandatory record checks means that non-vaccinating parents engage with the health care system.

4. **The policy could result in a situation which corrals the unvaccinated, causing a critical mass of non-immune to more readily seed an outbreak;**

   Enabling centres to ban the unvaccinated will mean that this requirement is implemented variably. Should a sufficient number of centers ban the unvaccinated, there would be more clustering of the unvaccinated in the permissive centres. An outbreak in these centres would spread much more rapidly as has occurred in Steiner schools, religious communities in the Netherlands, and other such communities. Rather than better controlling diseases, this may have the effect of seeding their spread even more readily than the current clustering of refusers allows.

   A 2013 study warned in relation to dismissing families who refuse vaccination from a primary care practice that "heterogeneity in tolerance and dismissal policies will cluster unvaccinated children in a smaller number of practices, which may differentially increase the risk of exposure for some children."(7)

5. **Leaving enforcement in the hands of childcare providers leads to role conflict.**

   Some childcare providers see their role as providing early childhood education, not to enforce health related behaviours. However, some will face pressure from parents to apply their discretionary powers. This could lead to an adversarial situation. A recent editorial in the New England Journal of Medicine cautioned,

   > "Forcing school administrators and day-care directors to act against the educational interest of their charges and convert trusting relationships with parents into adversarial ones is bad policy. We believe that state laws should instead task health departments with enforcement responsibility for vaccination mandates."(8)

Why are children incompletely vaccinated?

The following section outlines the reasons for low immunisation rates and what might be most effective in improving them. In this section, 'under-vaccination' means when a child is not up to date with all recommended vaccines at key milestones. It includes children who have received some vaccines and a smaller group who have received no vaccines at all.

Immunisation rates have been holding steady since 2004 when they reached 92% (figure 1). However, a coverage gap persists. In this gap are those whose parents object to vaccination and those whose parents do not object but rather face practical or logistical barriers to full and timely vaccination.

QLD has a registered conscientious objection rate of 2.17% as recorded on the Australian Government website.(9) However, immunisation coverage for children aged 24-27 months is 91.27%. This means there is a larger group of 6.56% of children who are not up to date according to the Australian Childhood Immunisation Register (ACIR) and not registered with a conscientious objection. A subset of this 6.56% will actually be up to date. Here an error in transmission of data to the ACIR has meant they are wrongly recorded as being partially vaccinated.(10, 11)

The remainder, possibly about 4% are not up to date and have no objection recorded. Studies find they come from families who support vaccination but face practical barriers including: child born overseas and is yet to catch up on QLD schedule, Aboriginal or Torres Strait Islander, out of home care, home-boundedness, single parent, more than 3 children, mental distress and other factors related to the social determinants of health.(12, 13) A service may be difficult to access or be off putting for cultural reasons.(14) Sometimes a primary care provider wrongly believes that

immunisations are contraindicated in the child or that they should be delayed in receiving vaccines due to a minor illness.(15)

Figure 1 Queensland immunisation coverage for children aged 24 months, 1999-2015

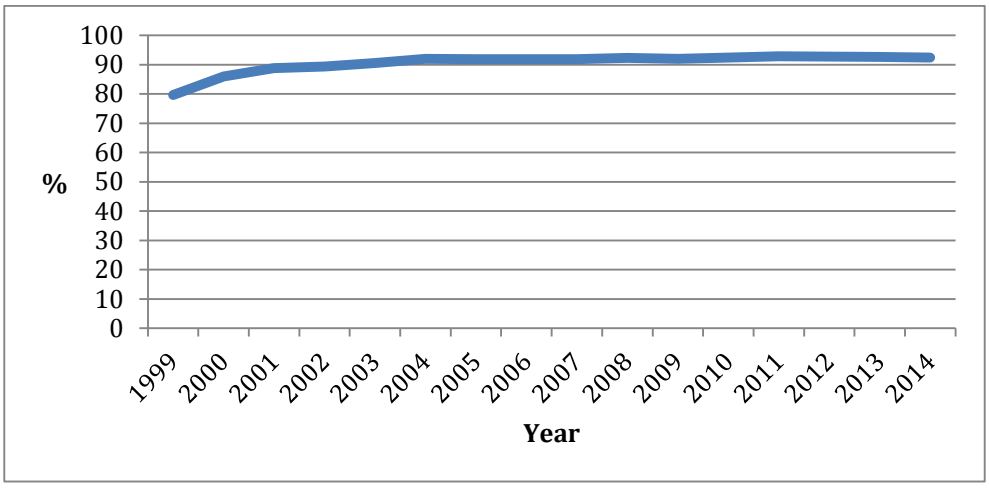

Table 1: Immunisation coverage in QLD

Group	Percentage
Immunisation coverage for children aged 24-27 months in QLD, 2015[1]	91.27%
Registered "conscientious objectors" aged 7 years or less in QLD, 2015[2]	2.17%
Not up-to-date and not registered objector	6.56%
Total	**100%**

1. Australian Government Department of Health http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/acir-curr-data.htm
2. Australian Government Department of Health http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/acir-s-t-cons-objection-data.htm

How can childhood vaccination rates be improved?

The Queensland government is clearly committed to improving vaccination rates. Efforts to improve vaccination rates that focus on such groups are identified in Figure 2 below. It shows that vaccination requirements for childcare/school attendance have been shown to be effective in the US context.(16) However, key vaccine policy researchers and epidemiologists caution strongly against extending this removal of exemptions:

> "As legislators, they are looking for a direct legislative fix by proposing to eliminate nonmedical exemptions altogether. Unfortunately, despite the good intentions, this approach is imprudent."(17)

They state that it is possible to make exemptions more stringent without the full removal of them.

In consideration of the above evidence, my submission proposes that government **consider an alternative legislation of vaccination requirements for childcare enrolment with exemptions**

and outbreak exclusions. This strikes a reasonable balance between reminding late parents – the approximately 4% – and enabling the children of refusers – the 2.17% – to still access the educational opportunities afforded by childcare. NSW successfully adopted such a policy in 2014.

And while such a requirement has a much greater impact on vaccination timeliness of children, it will not ensure *all* children are fully vaccinated. This remaining group need other measures, some of which are noted in Figure 2 which has been informed by systematic reviews in Australia and the USA.(16, 18) The US review notes insufficient evidence for the following: client-held paper immunisation records; clinic-based education when used alone; community-wide education when used alone; monetary sanction policies; and provider education when used alone.

Figure 2: Strategies to improve vaccination coverage in children that come with strong or sufficient evidence of effect (in black) and insufficient evidence (in red).

Australian evidence(18)	International evidence(16)
<u>Increasing community demand</u> • Multi-component strategies (≥ 2 individual strategies) - usually incl. education +/- promotion • Patient recall/reminders • Checking immunisation status as part of routine health assessments (those with intellectual disabilities only) <u>Enhance access</u> • Home visits • Accelerated schedules (hepatitis B only) • Catch-up plans (children, migrants/refugees) <u>Provider based interventions</u> • Routine audits of provider records • Individual provider support (e.g. GP visits) <u>Regulatory interventions</u> • Policy for routine vaccination of at-risk groups (e.g. hepatitis B) • Parental immunisation incentives (Maternity Immunisation Allowance and Child Care Benefit)	<u>Increasing community demand</u> • Community-based interventions implemented in combination incl. education • Patient recall/reminders (postcard, letter, phone) • Patient incentives <u>Enhance access</u> • Reducing out of pocket costs (inherit in Au) • Home visits <u>Provider based interventions</u> • Direct provider incentives • Provider assessment & feedback (e.g. record audits) • Provider reminders • Clinical decision support systems <u>Regulatory interventions</u> • Immunisation information systems (i.e. ACIR) • Standing orders when used alone • Linking immunisation to childcare/school entry

Source: Kirsten Ward, National Centre for Immunisation Research and Surveillance

The 2.17% group of vaccine refusers are a problem, particularly since they cluster in some communities. Government can keep them at a minimum and communities safe by:

- Enforcing the exclusion of the un-vaccinated during an outbreak.
- Yearly registration of an objector exemption with a health care provider instead of once-only.
- Implementing a parent peer advocate program in communities with higher rates of refusal to reduce the social influence of the phenomenon;
- Teaching health professionals counselling techniques to help vaccine-hesitant parents so they don't become vaccine-refusing parents.
- Encouraging midwifery and antenatal educator curriculum to have a strong component of vaccine education. These professionals influence parents at formative stages of vaccination decision making. It is crucial that midwives are confident and knowledgeable about vaccination so they educate and encourage hesitant parents and do not create hesitancy.

The QLD immunisation strategy 2014 – 2017 appears to have been removed from the government website this year. However, to my recollection that strategy included a comprehensive set of measures to improve coverage. One measure recently announced – the `Drive for 95' phone call program is aligned with *Client reminder and recall systems* that have been shown to be effective as noted in Figure 2. Other systemic measures would need to be implemented for such goals to be sustained over time. In addition, I strongly recommend that government ensure enough local Indigenous health workers to take an active liaison role in their communities reminding and encouraging them.

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