RACP
Specialists. Together
EDUCATE ADVOCATE INNOVATE

RACP submission to South Australian Public Health (Early Childhood Services and Immunisation) Amendment Bill - Consultation Discussion Paper

July 2019

About the Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 17,000 physicians and 8,000 trainee physicians, across Australia and New Zealand, including over 1,130 Fellows and over 500 trainees in South Australia. The College represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

Summary

Our Paediatrics & Child Health Division has recently published a position statement on 'Early childhood. The Importance of the early years.' and we would recommend the South Australian Government considers our recommendations on legislation to encourage immunisation on pages 37 and 38.

The RACP unequivocally and strongly supports immunisation as one of the most effective and cost effective public health interventions to reduce vaccine preventable diseases (VPDs). This includes efforts to ensure the highest possible vaccine coverage to protect both individual children and the population more generally.

All children living in Australia should be fully vaccinated, according to National Immunisation Programme Schedule[1], unless parents are advised by a qualified health professional that their child has a medical contraindication to receiving specific vaccines, as documented in the Australian Immunisation Handbooks.

We also support well-designed measures to increase vaccination. However, the RACP is concerned about the withdrawal of access to early childhood education and social benefits to families of children who are not fully immunised. "No jab, no play" policies must respect the need to provide the most comprehensive access to early childhood education and family support possible. This should be balanced against the need for protection against VPDs. As our Early Childhood Position Statement notes:

> Experts agree that the most effective and cost-effective way of increasing equality of opportunity is by providing high quality early childhood education in the first five years of life. [...] **quality preschool education has a bigger influence on children's literacy and numeracy skills at ages 11 and 14 than their primary school education** [emphasis added].[2]

The discussion paper itself acknowledges these significant disadvantages[3]. For this reason, any policy to exclude children from early childhood education needs to be given very careful consideration, and must take into account the potential detrimental impacts of exclusion on child development.

The growth and development of children in early childhood must remain the priority of all governments. This includes a specific focus on access to (and affordability of) early childhood education, which itself confers long-term health benefits. Lack of access to early childhood education is highly detrimental, especially from 3 to 4 years of age, and for children from already disadvantaged families. Early childhood education's importance in maximising health and development outcomes for children during their school years is supported by strong evidence.[4]

In short, early childhood education should not be seen as a policy lever by which to improve immunisation, but as an outcome that is at least equally as important as immunisation.

We are not aware of any published evaluation of the impact of NJNP policies on immunisation rates or rates of exclusion from early childhood education. Evidence suggests that the most common factors in under-immunisation are larger families, moving house since the birth of the child, and low social contact[5], and therefore policies that target these factors could be expected to have the greatest positive impact on immunisation rates. There is also a lack of evidence suggesting that NJNP policies effectively address vaccine refusal[6].

We have consulted with members of our Paediatrics and Child Health Division (PCHD), the PCHD Paediatric Policy Advisory Committee, the Australasian Faculty for Public Health Medicine (AFPHM) and the RACP South Australian Regional Committee to provide the following response to relevant consultation questions.

Responses to selected consultation questions

Enrolment

1. 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?

No.

The RACP unequivocally and strongly supports immunisation as one of the most effective and cost effective public health interventions to reduce vaccine preventable diseases (VPDs). This includes efforts to ensure the highest possible vaccine coverage to protect both individual children and the population more generally.

The RACP is also mindful that herd immunity benefits children indirectly who cannot benefit from vaccines directly due to young age or compromised immunity. Accordingly, we support compulsory documentation of a child's immunisation status or status in a recognised immunisation catch-up program.

With such compulsory documentation in place, allowing prompt exclusion of under-immunised children should a case of VPD occur, exclusion of under-vaccinated children when there is no outbreak of VPD adds little or no further protection. Prompt exclusion during VPD outbreak requires education providers to have rapid access to up-to-date information on the vaccination status of students, which means up-to-date documentation of status held by early childhood education providers should be obligatory.

While immunisation rates should be kept as high as possible, there is evidence that the current vaccination rate is sufficient to reduce the risk of measles[7] and pertussis disease at a population and individual child level in older pre-school age children.[8] Additionally, the risk of severe illness resulting from pertussis is highest for children under the age of 6 months, with hospitalisations much higher for this group than for children aged 6 months to 4 years.[9] [10] [11] In addition, measles outbreaks are usually caused by direct exposure to individuals returning from visiting countries where there is a significant measles problem, such as the Philippines or Thailand[12].

Measures to maximise protection against vaccine preventable diseases work best when coordinated with measures to maximise access to early childhood education. Excluding children who are not fully immunised and their families from parts of their normal lived environments (which includes early childhood education) is unlikely to be effective. Those children will still live in their communities and most will interact with fully vaccinated children, while their development is impeded by lack of access to early childhood education.

The consultation paper makes it clear that the NJNP policies in the relevant Australian states and territories are only part of a range of pro-immunisation policies and initiatives which have been implemented. The graphs of coverage increase over time show no strong evidence for any substantive change in rate following the implementation of NJNP in 2016, and when compared with the Australian states which have implemented NJNP, the SA rates are comparable with other jurisdictions. For example, the SA rates currently are significantly higher than the rates in NSW and QLD. None of the coverage increases indicated on the graphs is shown to be causally related to NJNP.

There are known to be areas of very low coverage in certain districts (e.g. Wudinna and central Adelaide). The RACP recommends further investigation of the reasons for this lower coverage rate needs to be undertaken as part of routine surveillance follow-up.

2. If so, which of the described options do you consider to be the best (i.e. option 1, 2a, 2b, 3a or 3b)? Please provide your reasons.

The RACP considers option 1 to be the best as it is a measured and evidence informed approach to this issue. Alongside the 'pause' option, the SA Government should seek advice from experts on the most effective ways to increase vaccination in localised areas where it is of concern. Proposals to increase

vaccination rates should also consider potential negative impacts on child health and development, particularly for families where other known risk factors for child health and development are present.

All other options beyond Option 1 exclude children from early childhood services even when there is no outbreak of VPD, at a known cost (in childhood development terms) without a known benefit (in health terms). The RACP does not support these approaches.

Except in the event of VPD it is problematic to exclude some children from an educational opportunity (especially for reasons over which the child has no control) when that exclusion has long term negative consequences.

We agree with the discussion paper's analysis of the main disadvantage:

> Children of vaccine-refusing parents will miss out on the educational opportunities of attending early childhood services. These children may be at a greater risk of long-term adverse impacts on healthy development and academic achievement. This can be particularly disadvantageous for children who are already at a socioeconomic disadvantage.[13]

However, it's not just children of vaccine-refusing parents; it's children who are under-vaccinated for any non-exempt reason. This is considered in more detail in the response to Q3.

We are concerned that the proposed options, with the exception of option 1, may have long term developmental consequences for excluded children. Ample research[14] demonstrates the benefits of early childhood education (ECE) as later life outcomes are long-term and far-reaching, particularly for disadvantaged children. Broader impacts of quality ECE, beyond improved school performance, include a higher level of employment, income and financial security, improved health outcomes and reduced crime.[15]

In short, early childhood education should not be seen as a policy lever by which to improve immunisation, but as an outcome that is at least equally as important as immunisation.

To date, none of the States that have implemented NJNP policies have reviewed their impact on either immunisation rates or access to early childhood education. The RACP recommends that South Australia does not implement NJNP policies until such reviews have been completed.

In line with an early childhood growth and development approach, the RACP strongly recommends that the SA Government conduct an impact evaluation (including specific analysis on this point) before considering legislating Phase 2 of the South Australian Public Health (Early Childhood Services and Immunisation) Amendment Bill.

3. […] What do you suggest as an alternative proposal or activity to improve immunisation rates among young children?

Such proposals and activities should reflect an important distinction. Some parents are vaccine-hesitant, delay vaccinations, accept them selectively, or assert conscientious objection to all vaccines. Other reasons for undervaccination include socioeconomic, logistical, and lack of availability in rural and remote areas. (Of course there are parents who fall in both categories.) Strategies—including legislated strategies—to increase vaccination rates in young children will need to be tailored accordingly.[16]

Geographical pockets of under-immunisation still exist, and a careful study of the population immunisation dynamics in these areas is likely to inform appropriately tailored responses. These may involve implementing outreach immunisation into community settings including homes, which has been shown to be effective.[17]

At a system level, it is important to recognise that the primary health network enables vaccination, and should be adequately funded and resourced.

Childhood vaccination is a vital public health measure that affects a new cohort of parents each time a baby is born. In fact, it is better to think of the parents whose permission for childhood vaccination needs to be obtained as a stream rather than a cohort. We do need to foster a culture of vaccination acceptance, and a culture of understanding about the benefits of vaccination. Above all we need ready vaccination availability at

multiple opportunities and in varied settings, along with ongoing education (including myth-debunking), and persuasive, non-punitive examples of the benefits of vaccination.

Alternative activities should be informed by research showing clearly that most un- or under-vaccinated children are not children of vaccination-opponents. Rather, under-vaccinated children mostly are children in multi-children families with busy lives including working parents with limited time off. Special strategies to reach children of single parent families and children experiencing factors related to socioeconomic disadvantage need to be developed.[18]

The understandable fear of injections should be acknowledged, along with (for older toddlers and up) the memory of previous injections and the understandable fear of future ones. Parental reluctance to cause or witness momentary pain should be acknowledged and contextualised against the long-term benefits, and practical measures developed to minimise this reluctance.

A further concept that may be of value would be to find strategies to increase the uptake of immunisation against pertussis and influenza during pregnancy. Understanding and acceptance of the value of this could foster a more positive attitude in the parents for vaccinating their children (over and above a degree of protection to the neonates and infants).

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

Yes.

5. 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?

This question is beyond the scope of our expertise.

However, the RACP recommends that early childhood educators should be fully immunised according to the National Immunisation Programme Schedule[19] before they can commence work in an early childhood setting. Accordingly, we recommend that the SA Government consider providing free or subsidised catch-up immunisation to early childhood educators in line with the National Immunisation Programme Schedule as some are likely to be susceptible to a range of VPD.

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

Please see comments above.

11. Do you have any additional comments in relation to the proposed Phase 2 Bill to strengthen immunisation enrolment requirements for early childhood services?

There is good evidence to suggest that early childhood education effectively supports optimal child development, including good health later in life.

Therefore, limiting access should not be done lightly, should never be done by default, and should not take place until reviews or studies *of its effect on access to education*[20] have been conducted in appropriately well designed and rigorous ways.

Until that occurs and the SA Government and the community (including the medical community) have an opportunity to scrutinise these reviews, we recommend the Government does not implement legislation that limits access to early childhood education.

[1] Department of Health website (2017). National Immunisation Program Schedule. Available at: https://beta.health.gov.au/topics/immunisation/immunisation-throughout-life/national-immunisation-program-schedule (accessed May 2018)

[2] See p. 37 of the RACP Position Statement *Early Childhood: The Importance of the Early Years*, which in turn cites Douglas B, Friel S, Denniss R, Morawetz D (2014). Advance Australia Fair? What to do about growing inequality in Australia. Report following a roundtable held at Parliament House Canberra in January 2014.

[3] See SA Health South Australian Public Health (Early Childhood Services and Immunisation) Amendment Bill Consultation Discussion Paper May 2019, p36.

[4] OECD (2016). Education Indicators in Focus: What are the benefits from early childhood education? Available at: http://www.oecdilibrary.org/docserver/download/5jlwqvr76dbqen.pdf?expires=1502928065&id=id&accname=guest&checksum=C859CF41C1EC2A2C5AE567C579429471 (accessed August 2017)

[5] Pearce A, Marshall H, Bedford H, Lynch J. Barriers to childhood immunisation: findings from the Longitudinal Study of Australian Children. Vaccine 2015; 33: 3377-3383.

[6] Beard, F, Leask, J. and McIntyre, P. 2017. No Jab, No Pay and vaccine refusal in Australia: the jury is out *Medical Journal of Australia,* 2017; 206 (9): 381-383

[7] Schlenker, T. (1992). Measles herd immunity. The association of attack rates with immunization rates in preschool children. *JAMA: The Journal of the American Medical Association*, 267(6), pp.823-826.

[8] Radke, S., Petousis-Harris, H., Watson, D., Gentles, D. and Turner, N. (2017). Age-specific effectiveness following each dose of acellular pertussis vaccine among infants and children in New Zealand. *Vaccine*, 35(1), pp.177-183.

[9] Pillsbury, A, Quinn HE, McIntyre PB. Australian vaccine preventable disease epidemiological review series: pertussis,2006–2012 (2014). Epidemiology of pertussis in Australia. Communicable Diseases Intelligence - Volume 38 Number 3 Quarterly report. Available at http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-cdi3803-pdf-cnt.htm/$FILE/cdi3803.PDF.

[10] Quinn, HE Pertussis control in Australia – the current state of play (2014). Epidemiology of pertussis in Australia. Communicable Diseases Intelligence - Volume 38 Number 3 Quarterly report. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-cdi3803-pdf-cnt.htm/$FILE/cdi3803.pdf.

[11] Australian Government Department of Health (2014). Epidemiology of pertussis in Australia. Communicable Diseases Intelligence - Volume 38 Number 3 Quarterly report. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-cdi3803-pdf-cnt.htm/$FILE/cdi3803.pdf.

[12] See https://www.abc.net.au/news/2019-03-31/measles-case-sees-toddler-contract-virus-before-vaccination/10956102

[13] SA Consultation Discussion Paper, p. 36, available at: https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/resources/south+australian+public+health+indicators+discussion+paper.

[14] OECD (2016), "What are the benefits from early childhood education?", *Education Indicators in Focus*, No. 42, OECD Publishing, Paris, Available at: https://doi.org/10.1787/5jlwqvr76dbq-en. (accessed February 2018).

[15] Pascoe S, Brennan D (2017). Lifting our game. Lifting Our Game: Report of the Review to Achieve Educational Excellence in Australian Schools through Early Childhood Interventions. Available at: http://www.education.vic.gov.au/Documents/about/research/LiftingOurGame.PDF (accessed February 2018).

[16] Pearce A, Marshall H, Bedford H, Lynch J. Barriers to childhood immunisation: findings from the Longitudinal Study of Australian Children. Vaccine 2015; 33: 3377-3383.

[17] Home vaccination for children behind in their immunisation schedule: a randomised controlled trial, Med J Aust. 1998 May 18;168(10):487-90 (accessed June 2019).

[18] See Barriers to childhood immunisation: findings from the Longitudinal Study of Australian Children, Anna Pearce, Helen Marshall, Helen Bedford, John Lynch, Vaccine, 2015; 33(29):3377-3383.

[19] Department of Health website (2017). National Immunisation Program Schedule. Available at: https://beta.health.gov.au/topics/immunisation/immunisation-throughout-life/national-immunisation-program-schedule (accessed May 2018).

[20] See Recommendation 32 on p. 38 of the RACP Position Statement *Early Childhood: The Importance of the Early Years*.