

No Jab, No Pay — no planning for migrant children

Migration should be considered by immunisation policy

The *Social Services Legislation Amendment (No Jab, No Pay) Act 2015* (Cwlth) was passed in November 2015, closing the conscientious objection exemption to immunisation requirements for family assistance payments. The intention was to reinforce the importance of immunisation and protect public health, especially for children.^{1,2} While these aims are sound, there are far-reaching, presumably unintended, consequences for migrant and refugee children.

The legislative changes (which took effect in January 2016) require children and young people under 20 years of age to be up to date for their early childhood immunisations in order to qualify for the Child Care Benefit, Child Care Rebate and Family Tax Benefit Part A supplement (Box).³ These Centrelink payments are available for Australian citizens and people holding a permanent visa (including offshore humanitarian entrants), special category visa or certain temporary visas (including temporary protection visas). Immunisation status is assessed through the Australian Childhood Immunisation Register (ACIR), which is linked to Medicare.

Medical contraindications (including immunosuppression and anaphylaxis) and natural immunity are still grounds for vaccination exemption. However, the legislation now specifies that only general practitioners can certify exemptions, with the expectation that specialists will refer back to GPs.² The legislation is paired with a number of supporting measures, including funded catch-up immunisations (time-limited for people aged 10–19 years), expansion of the ACIR to include all people under 20 years of age,⁴ and provider incentive payments for catch-up vaccination in children aged less than 7 years.⁵

There are multiple issues arising for refugee and migrant children. First, any child arriving and receiving catch-up vaccination in Australia after the age of 7 years who is eligible for these Centrelink payments will lose them until their ACIR record is updated, even if he



or she is fully immunised. Before 1 January 2016, the upper age limit for data entry into the ACIR was 7 years — overseas and catch-up vaccinations could not be recorded on the register for older children. Australia's Humanitarian Programme intake has been 13 750 people annually, with around 50% aged less than 18 years on arrival.⁶ Therefore, up to 35 000 refugee children and young people (those who have arrived at the age of 7 years or older and are currently under 20 years of age) will need their vaccination status assessed and ACIR records entered. This number will increase when other migrant children meeting the residency requirements for Centrelink payments are included.

The workforce challenges regarding the No Jab, No Pay measures are substantial. Immunisation providers across Victoria report that refugee families have received (multiple) letters from Centrelink. This has resulted in large numbers of people presenting to services, and an increased demand for providers to clarify previous vaccination history, notify the ACIR of these details, and provide catch-up vaccines where needed. Providers report being inundated, under-prepared and inadequately resourced to meet demand.

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Family assistance payments affected by the No Jab, No Pay measures

- Family Tax Benefit Part A (FTB-A) is a two-part payment supporting disadvantaged families with dependent children or secondary students younger than 20 years of age, consisting of an adjusted base rate and a supplement of up to \$726.35 per child at the end of the financial year. The maximum adjusted taxable income limits for FTB-A are over \$100 000, and it is likely most refugee background families will be eligible for this payment.
- The Child Care Benefit supports costs of registered/approved childcare and outside-school-hour care, with current rates of \$4.17 per hour or \$208.50 per week (85% for school-aged children), which is income-tested and adjusted for family size, service type and hours attended.
- The Child Care Rebate (non-income-tested) covers 50% of out-of-pocket expenses for childcare to an annual limit for each child, in addition to other childcare assistance.
- Together, these benefits are a substantial support for families with children. For further information, go to <https://www.humanservices.gov.au/customer/subjects/payments-families>. ♦

Establishing prior vaccination is difficult, time consuming, and may not be possible. Refugee-background families tend to be mobile in the early years of settlement, and often see multiple providers for health care, which may (or may not) include immunisation. Children may receive vaccinations in different parts of the health system — from GPs, from specialists, at school, and, particularly in Victoria, through local government areas (LGAs).⁷ However, comprehensive records are rare, and information about past vaccinations is often unavailable.

Reporting to the ACIR is time consuming, and there is variation in how information is handled. Providers estimate it takes 20 minutes to enter a full vaccine history into the ACIR online, and longer if overseas vaccinations are recorded. They report delays between submission and registration of data on the ACIR. While on-site vaccines are usually registered within 24 hours, prior vaccines (administered in Australia or overseas) take 1–3 weeks, and individual errors can result in batches of ACIR entries being rejected, affecting ACIR registration for multiple individuals. Many services are now faxing records to the ACIR due to inadequate capacity to enter information directly; these are taking up to 8 weeks to register and delays appear to be increasing. Providers report discrepancies between Centrelink and the ACIR, and cases where families have been sent Centrelink letters, despite children being registered as fully immunised on the ACIR. Paediatricians are the key workforce in childhood immunisation; however, unlike, GPs, they are not automatically registered with the ACIR and the process to obtain or activate specialist ACIR registration is complicated. While specialists may have prescribed catch-up vaccines, they are usually not able to enter this information onto the ACIR, which reduces the opportunity to disseminate the workload and enhance ACIR recording.

Catch-up immunisation generally requires three visits over at least 4 months (four visits over 10 months for children aged 4–9 years), with several vaccines on each visit. Calculating catch-up schedules for migrant children is complex and far more difficult than providing a missed schedule point for an Australian-born child. Primary Health Networks and LGAs report that many GPs feel poorly equipped to deal with this complexity and the time requirements and, in Victoria, are deferring this work to LGAs.

The increase in workload is not reflected in funding arrangements, and the new provider catch-up incentive payments are not structured to support best practice immunisation. Catch-up incentive payments (\$6 additional to ACIR notification payments) are only available for children aged less than 7 years, and for vaccines given after 1 January 2016 that are more than 2 months overdue. Thus, if an immunisation provider gives the first doses of a catch-up schedule and recalls the child 1 month later (the minimum interval and best practice), the second vaccinations will not trigger a catch-up incentive payment, as they are not considered to be overdue in relation to the first. Further, the national due and overdue rules in relation to hepatitis B⁸ are not consistent with the minimum catch-up dosing intervals recommended by the *Australian*

immunisation handbook.⁹ Hepatitis B vaccination at 0, 1 and 4 months (minimum intervals) will register the child as overdue at the time of the final dose (3 months from previous dose), risking loss of Centrelink payments.

Finally, there is complexity concerning medical contraindications and natural immunity, in that the new legislation specifies that only GPs can provide this information. Many refugee children do not require hepatitis B (or other) immunisations, on the basis of natural immunity from infection or immunity from (undocumented) overseas vaccination. Hepatitis B serology is part of the routine post-arrival refugee health assessment, detecting both infection and immunity. Available Australian data suggest that around 30% of East African and 50% of Karen refugee children have immunity to hepatitis B,^{10,11} and 2–5% of African children are infected with hepatitis B.¹² Many children have thus completed catch-up vaccination without needing hepatitis B (or other) vaccines, but will not be regarded as up to date on the ACIR. They will need a medical exemption form completed by a GP; however, many families have changed GPs in the years after settlement and/or were initially managed and immunised at specialist or nurse-led clinics. GPs will likely be asked to enter historical information on behalf of other providers (which will be almost impossible to verify) and there may be considerable reluctance to do so.

These issues are likely to create duplications within the health system in:

- appointments — where children had specialist refugee health screening, it is feasible that an LGA may refer children to GPs who may refer them to specialists to clarify immunisation history and serology, who will then refer children back to the GPs for the medical exemption form, who in turn refer them back to the LGA for vaccine delivery;
- serology — where there is no documentation, GPs and specialists (and families) may choose repeat hepatitis B serology instead of undertaking three immunisation visits; or
- vaccines — where vaccination history or natural immunity cannot be established.

All these options incur additional costs and represent inefficiencies in the health system.

While the No Job, No Pay policy offers an opportunity to improve immunisation coverage rates, the legislation will exclude thousands of Australia's most disadvantaged families from Centrelink payments as a result of system issues rather than any form of conscientious objection. Clinical experience suggests that refugee background families are extremely pro-immunisation, which is consistent with the large numbers presenting to clarify their children's immunisation status and access catch-up vaccinations. Unfortunately, the legislative and policy changes presume continuity of care, administration of early childhood vaccines during early childhood, prior use of the ACIR, and centralised immunisation delivery, which is not the reality for migrant families.

There are several strategies that could reduce the impact of the No Job, No Pay measures on migrant children. There is a strong argument to apply the legislation prospectively (to children born 2009 onwards) or to extend the period before Centrelink payments are affected, allowing adequate lead time for entering data into the ACIR and obtain catch-up vaccination if needed. Due and overdue rules and catch-up incentive payments should be structured to support best practice, including removal of the payment age limit. Funding for catch-up vaccinations in those aged 10 years and older should be ongoing, and better resources to support providers, including a whole-of-life calculator and information on refugee immunisation, would increase efficiency and remove barriers to service delivery. Extending the

ACIR across the lifespan offers an opportunity to address usability issues and capture relevant demography to monitor immunisation in this group. Finally, authority to document medical exemptions, specialist ACIR registration and workforce pressures require urgent attention. Fundamentally, good policy development should recognise that migration is part of the fabric of Australia, and it is not clear this has been adequately considered in the implementation of No Job, No Pay.

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