



victorian refugee  
health network

# No Jab, No Pay – implications for service providers and refugee background communities

Prepared by the Victorian Refugee Health Network Immunisation Working Group

## Background

The Victorian Refugee Health Network (VRHN) aims to identify and address emerging health issues and build sector capacity to provide accessible and appropriate health care for people from refugee backgrounds, including people seeking asylum.

The VRHN Immunisation Working Group (IWG) was established in late 2015, and brings together key stakeholders to: i) improve access to catch-up vaccinations for refugee background communities in Victoria; ii) monitor the impact of State and Commonwealth immunisation policy on people from refugee backgrounds; and iii) provide advice to the VRHN, and to the Victorian Government as requested.

The IWG comprises representatives from primary health care and specialist services, Refugee Health Nurses (RHN), local government areas (LGA) of high refugee settlement, Primary Health Networks (PHN), settlement and asylum seeker services, the Victorian Department of Health and Human Services (DHHS), and Department of Education and Training (DET) (see appendix 1).

The IWG has identified concerns relating to the Commonwealth 'No Jab No Pay' legislation and the impact on service providers and on refugee-background communities through the effects on Centrelink payments (family tax benefit part A-supplement, childcare benefit, and childcare rebate).

## Scale and context

Prior to 1 January 2016 the upper age limit for data entry into the Australian Childhood Immunisation Register (ACIR) was 7 years. For children over 7 years of age, overseas vaccinations and vaccinations in Australia were not (and could not be) recorded on ACIR.

Victoria receives around 4,000 people of refugee-background each year, with around half aged less than 20 years. The refugee intake will increase going forwards, with the program intake increasing by 2018-19 and the expected intake of Syrian refugees from 2016. Considering all children aged 7 years and older on arrival back to 2003 (i.e. age 7 years in 2003 will be turning 20 years in 2016) provides a quick estimate - **approximately 20,000 ACIR records will need to be updated in refugee-background families in Victoria.**

Asylum seeker children will also face challenges in the future. Currently there are **approximately 2000 asylum seekers aged less than 20 years in Victoria.** There have been longstanding issues with catch-up vaccinations not being entered into ACIR for this group, both in held detention, and also subsequent to their release into the community. For those children who go on to receive a temporary protection visa, the issues with age/ACIR data entry and access to these Centrelink payments will also be relevant.

These issues also apply to migrant children in Australia who meet residency requirements for Centrelink access.

## Summary of issues

### Increased workload in all sectors

There are consistent reports from North (Hume LGA), South (Dandenong LGA), East (EACH), West (Wyndham LGA), and central (Melbourne PHN) regions that families of refugee background have received (multiple) letters from Centrelink advising that their children are not immunised according to ACIR, and are no longer eligible to receive family assistance supplement payments or childcare benefit/rebate payments.

This has resulted in high numbers of families presenting at immunisation service providers with Centrelink documentation and has created increased demand for services to i) clarify previous vaccination history, and ii) notify ACIR of these details.

**Immunisation providers report that they have been inundated with requests for catch-up vaccination, and they are unprepared and under-resourced for the increased demand for clarifying previous immunisation history, catch-up vaccine delivery and ACIR reporting.**

- **Collating previous vaccination information 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 healthcare, which may (or may not) include immunisation. They may receive immunisation within different parts of the health system – e.g. at general practitioners, specialists, LGAs and in schools, but it is rare to see any form of comprehensive catch-up immunisation record, and information may not be available for vaccines given many years previously.
- **Delivering catch-up vaccinations is complicated, and time/resource intensive**
  - Melbourne PHN report private general practitioners (GPs) are struggling with the workload. They are often reluctant to approach catch-up immunisation and may defer this workload to LGAs.
  - Wyndham City Council report that local GPs have contacted council for advice on catch-up immunisation. Others have sent patients to the LGA to develop the catch-up schedule, advising patients then to return to the general practice to have vaccines administered.
  - City of Greater Dandenong (CGD) report that a local GP super clinic (that has the expertise to complete catch-up immunisation and has previously provided this on-site) is currently unable to meet demand and is deferring additional workload to LGAs.
  - CGD reports that:
    - An **additional 20-30 children/adolescents are presenting each week** to get catch-up immunisation and/or their ACIR history updated – this is on top of the usual workload.
    - The CGD immunisation program provides catch-up vaccination to around 300 children each year, and has been running a catch-up program at the English Language School (ELS) for more than two decades. They do not have the resources to retrospectively enter many years of vaccinations into ACIR (at 300 children per year, and considering those aged 7 – 19 years, this could be as many as 2500 individual ACIR records).
    - They are entering historical vaccines as people present to the service with Centrelink letters, but are struggling to meet demand.
- **RCH Immunisation Service reports their demand to develop written catch-up plans for external providers has increased by 70%** since December 2015. They are now providing 60/month, and this number is increasing (this does not include phone advice on

catch-up and catch-up immunisation provided at the hospital). They report many GPs find catch-up immunisation difficult, consistent with the reports from Melbourne PHN and the LGAs.

- There are **challenges delivering catch-up vaccines and recording these vaccinations onto ACIR for large families**. For example, one LGA recently saw two Burmese families with 9 and 10 children respectively, all requiring catch-up vaccines. It required three immunisation nurses to gather previous vaccine records from multiple sources, administer the vaccines, and submit data to ACIR, and the process took nearly one full day.
- **This increase in workload is not reflected in funding arrangements**. There are currently no subsidy payments provided for catch-up vaccines administered after 7 years of age, despite the stated intention to support catch-up immunisation; and there are no incentive payments for calculating catch-up immunisation plans.
- From a systems perspective, there is a **broader risk to the infrastructure for immunisation delivery**, with additional strain on services that are already working at capacity leading to workforce turnover, burnout and the potential for these services to pull out of immunisation delivery altogether.

## Reporting vaccinations to ACIR

- Providers estimate it takes **20 minutes per child to enter a full vaccine history into ACIR** online, and some providers report that it takes longer if overseas vaccinations are recorded as part of the vaccine history.
- A RHN practitioner reported that **community health centres have insufficient workforce capacity to enter vaccines online into ACIR**, and consequently, they are faxing printed vaccine records from the practice software to ACIR (see below).
- Wyndham LGA reported that a senior immunisation nurse is working additional hours to meet the additional administrative demands around vaccine reporting.
- Providers report **significant delays between submitting data to ACIR and these data being registered**. The following timeframes were provided:
  - Catch-up vaccines administered on-site and entered into ACIR are usually registered within 24 hours, although some providers reported delays of up to 2 weeks.
  - Vaccines previously administered (in Australia or overseas) and entered into ACIR appear to take 1-3 weeks to be registered after being entered.
  - Faxed immunisation records are currently registered up to 8 weeks after being sent to ACIR, this delay appears to be increasing.
  - It takes up to 28 days to receive an immunisation history statement by request from ACIR (this information is included in messaging on the ACIR helpline).
- There is complexity with **batches of ACIR entries being rejected due to errors in one or more entries, leading to failure to register the other entries**. Providers may not be aware that the entire batch has been rejected, affecting registration of vaccine for multiple individuals.
- **The process for specialists, nurses, and other agencies to register as a vaccination provider with ACIR is complicated**. GPs are automatically registered with ACIR. Subsequent clarification with ACIR has suggested paediatricians (who are another key workforce in prescribing childhood immunisations) are also automatically registered, although this information is not well known, and individuals need to obtain a password and activate their registration. Other service providers are directed to send their *ACIR Application to Register as a Vaccination Provider form (IM004)* to their state or territory health department for approval, however no contact is provided. The form must be returned to the health provider who then has to post or fax it to Perth. Again, there is no contact provided. In practice, this complexity

effectively prevents specialists accessing and using ACIR; and acts as a barrier to this workforce assisting with catch-up immunisation. Specialists may not be able to check vaccination status, and without access to ACIR, they cannot enter prior vaccination information, including vaccines they have prescribed.

- **The process for families to obtain their own immunisation history statement(s) is complicated and not accessible for people with low English proficiency.** Parents need to create a 'myGov' account, link this to their Medicare, and obtain an immunisation statement from Medicare, OR download a mobile app, OR call ACIR to obtain their child's immunisation history statement. These instructions are only provided in English, they require a significant degree of IT literacy and Internet access, and the instructions on obtaining an ACIR statement from Medicare are unclear. The IWG is uncertain whether the Medicare linkage process would be available for asylum seekers, who have a different category of Medicare cards relating to their migration status.
- Providers reiterated **longstanding concerns at the separation of immunisation reporting systems**, in Victoria, the Immunisation Program System (ImPS) used by LGAs (and others) does not connect with ACIR to record vaccines for children aged 7 years and older.
- There is **complexity for children born in New Zealand (NZ) due to the format of the NZ immunisation history statement**. NZ children are supplied with a statement that they are 'up to date' for immunisation, which does not provide details of individual vaccines. This record format is inadequate to document vaccination history for ACIR.

## Inaccurate Centrelink letters

- There have been **discrepancies between Centrelink and ACIR reporting**, Providers were aware of several cases where families had been sent Centrelink letters stating their children were not up to date with immunisation, despite ACIR recording the children as being up to date. In one case a family lost Centrelink payments for a period despite being fully immunised, and it appeared the onus was on the family to prove the Centrelink mismatch. This may be due to changes in Medicare details; this issue may be of particular relevance to the asylum seeker cohort going forwards, due to the nature of their designated Medicare status.
- **Families frequently receive multiple letters from Centrelink**, which adds to confusion.

## Insufficient provider education

- PHNs and providers reported **discrepancies between GPs knowledge of catch-up immunisation (which may be sound) and their knowledge of the notification process** (which they may be reluctant to engage with). The net outcome is that children may have had catch-up immunisation, but there is no record within ACIR, with the same negative impact for families (also see below). Incentive payments for catch-up immunisation in children aged less than 7 years are a positive reason for GPs to engage in education, although the lack of incentives for those 7 years and older was identified as a significant barrier.
- **Specialists may not know they can become (or might be) an ACIR registered provider and that they can request access to the ACIR secure site.** Specialists and others, including RHNs, are often involved in the long-term care of refugee-background families, and may have been involved in delivering catch-up immunisation. Paediatricians are registered for ACIR, however they need to apply for additional access to the secure ACIR site to record patient vaccines. Enabling specialist involvement has some potential to disperse the workload, although in the absence of incentive payments, and with the additional workload arising, there may be little/no motivation for specialists (or others) to become registered to enter vaccines onto ACIR.
- There is currently **inadequate information for providers** about i) how Centrelink registers a 'catch-up' plan as being in place, ii) the application of the 'due/overdue' rules for catch-up and

Centrelink payments, iii) details on the 'grace period', which the legislation specifies as 63 days, and iv) whether natural immunity is factored into catch-up vaccination and incentive payments.

- **Currently, ACIR helpline information about 'No Jab No Pay' and Centrelink payments is inconsistent** and at times, contradictory. During the course of clarifying information for this briefing we have made many phone calls to ACIR. We have had contradictory information on i) whether catch-up payments apply to children over 7 years (told yes and no), ii) when catch-up incentive payments start (told March 2016 and July 2016) iii) whether providers get both ACIR notification payments and catch-up incentive payments (told yes, but not for same schedule point, which would suggest the reverse), iv) how Centrelink registers that a catch-up plan in place (there were several answers provided), and v) whether there is complexity to the administration of catch-up payments (i.e. where payment for one vaccine may depend on the administration of another (different) vaccine) similar to the ACIR notification payments. We have not been able to identify written information on these areas.

## Insufficient community education

- Refugee service providers reported that **many refugee-background families are confused about what is required when they receive a letters from Centrelink** about their child's immunisation status. Providers reported that initially many families ignored, or were not able to understand these letters. The letters are in English, and people may not have sufficient print literacy to understand the content.
  - **Communities are now disseminating information internally** - A Karen community worker from a Migrant Resource Centre is providing information and education to their community.
  - AMES reported that some clients have proactively sought letters from their GP to take to Centrelink as proof of their immunisation status. These have been rejected and people advised to go back to their GP to request that their records are provided to ACIR. This example highlights that many GPs are unsure of what is required to document immunisation status.

## Medical exemptions

Under the new legislation, only GPs are able to provide certification of vaccine exemption due to a medical contraindication or natural immunity. The reasons for this are outlined in the explanatory memorandum as follows:

*If a diagnosis of medical contraindication is made by a medical specialist, then it is expected the specialist would refer the matter back to the person's general practitioner who could then make the relevant certification (page 3)*

AND

*a child meets the immunisation requirements if a general practitioner has certified in writing that the child does not require immunisation because the child has contracted a disease or diseases and, as a result, has developed a natural immunity. Paragraph 6(3)(b) is similar to current subsection 6(6). However, a general practitioner, not a medical practitioner, would now be required to make the certification in relation to natural immunity (page 4).*

This raises specific challenges for catch-up immunisation in refugee-background communities, and there are a number of (possibly unintended) consequences that pose significant productivity and financial costs.

- **Many people who arrived as refugees or asylum seekers have moved between GPs, and were/are initially treated and immunised at specialist or nurse-led clinics.** People may be many years after their initial post arrival health assessment, and the original vaccination and/or

health assessment history is frequently difficult to identify. Many people move GPs and local area several times in the years after settlement. The legislation presumes relative continuity of care, administration of early childhood vaccines during early childhood, use of ACIR, and centralised immunisation delivery, which is not the reality in many refugee-background families.

- **Many refugee-background children do not need (and will not have had) hepatitis B (or other) immunisations.** All new refugee and asylum seeker arrivals should have hepatitis B serology as part of their post-arrival health assessment, detecting both infection and immunity. Available Australian data suggest 26-60% of African and 40-70% of Karen refugee children have immunity to hepatitis B, through exposure to natural infection or (usually undocumented) vaccination overseas. This proportion is likely to increase, as hepatitis B vaccination has been introduced into a number of humanitarian source country schedules in recent years. This means many children and adolescents will not need (or have had) hepatitis B immunisation as part of catch-up vaccination. This is particularly relevant to adolescents, and those who arrived prior to the introduction of *Infanrixhexa*® in the routine schedule in 2008. In some LGAs, individuals also had mumps, measles and rubella serology, or varicella serology, and may not have had these vaccines for the same reasons.
- **Many refugee-background children will need a medical contraindication form completed,** as they may have completed catch-up vaccination without needing hepatitis B (or other) vaccines, but, if registered, will not be regarded as up to date for age. Alternatively, those with hepatitis B infection also will not need vaccination, and will also need a medical contraindication form completed.
- **Specialists and nurses are no longer able to provide certification of medical contraindications or natural immunity,** although for many refugee-background families in Victoria (and Australia) specialists and nurses may have been responsible for the initial post arrival health screen and catch-up immunisation, and may be the main form of ongoing care. In many circumstances, it is likely GPs will be asked to enter historical information on behalf of other providers, which will be almost impossible to verify, and GPs may be reluctant to do this.
- **There are several scenarios possible, all of which result in increased cost to the health system:**
  - **Duplication in appointments** (i.e. GPs refer to specialists to ascertain the child's immunisation/screening record delivered in specialist care who then refer back to GPs to enter the record) resulting in increased costs through health visits.
  - **Duplication of and/or unnecessary vaccines** resulting in increased costs through both the vaccine components and associated service delivery.
  - **Duplication of serology** – e.g. GPs or specialists (and families) may request testing for hepatitis B immunity rather than progress 2-3 immunisation visits, resulting in increased costs through pathology charges.

These system issues will cause considerable inconvenience (and confusion) for individuals, who may lose access to Centrelink payments in the interim.

- The working group also notes the **information provided in the Department of Social Services (DSS) fact sheet is inconsistent with the legislation on this issue.** The fact sheet 'Extending immunisation requirements for children – frequently asked questions'<sup>1</sup> states "*Children with medical contraindications or natural immunity (certified by an immunisation provider)*" - this is not consistent with the recent legislative changes specifying a GP has to certify natural immunity/medical contraindications, and may cause further confusion.

---

<sup>1</sup> <https://www.dss.gov.au/our-responsibilities/families-and-children/benefits-payments/strengthening-immunisation-for-young-children/strengthening-immunisation-for-children-frequently-asked-questions>

## Other

Two other issues emerged in preparing this background paper, through discussions with ACIR staff, and clarifying incentive payments with the Immunisation Policy section within ACIR.

- **The application of due/overdue rules for hepatitis B vaccine is not clear in relation to catch-up immunisation.** Hepatitis B vaccine becomes overdue at 3 months after dose 2, however, by the Australian Immunisation Handbook, the dosing interval for hepatitis B catch-up vaccination specifies that the interval between dose 2 and 3 must be 2 months, **and**, the dosing interval between dose 1 and 3 must be 4 months. Therefore, a minimum dosing interval for hepatitis B vaccination is 0, 1 and 4 months – i.e. 3 months between dose 2 and 3, so the vaccine can *only* be given as the overdue rule commences. Children still have the 'grace period' where they can have immunisations, however the timing and application of these conditions for hepatitis B is different compared to other vaccines.
- **Catch-up incentive payments do not support best practice catch-up immunisation,** and in fact payments are *higher* for sub-optimal catch-up vaccination with longer intervals between dosing. Catch-up incentive payments are only available for children <7 years, for vaccines given after 1/1/16, that are more than 2 months overdue; thus if an immunisation provider gives the first dose of a catch-up schedule and recalls the child for the next dose of catch-up vaccines 1 month later (which is the minimum interval and best practice), the second dose does *not* trigger a catch-up incentive payment, as it is not considered overdue in relation to the first.

## Summary

The large numbers of refugee-background (and other) families presenting to clarify their immunisation status and access catch-up immunisation is positive, and is in keeping with our collective clinical experience that these families are extremely pro-immunisation. While the No Job No Pay legislation offers an unparalleled opportunity to improve immunisation coverage rates and enhance immunisation service delivery, there are many (presumably unintended) consequences of this legislation and policy for migrants. The legislation will have the effect of excluding thousands of Australia's most disadvantaged families from Centrelink payments, due to systems issues in immunisation service delivery, rather than any form of conscientious objection by these families.

The pre-eminent issue is that anyone arriving in Australia aged over 7 years will not be registered on ACIR, even if they have completed catch-up immunisation, and therefore, will lose Centrelink payments until this is updated. Updating ACIR is complex, time consuming, and may not be possible in many cases, due to prior Australian (and/or overseas) immunisation records not being available. The legislative and policy changes presume relative continuity of care, administration of early childhood vaccines during early childhood, use of ACIR, and centralised immunisation delivery, which is not the reality in many migrant families.

Key issues identified by this working group are: an enormous increase in workload consequent to No Job No Pay, with inadequate resourcing to support this; problems with the structure and application of catch-up incentive payments; and inefficiencies in ACIR in relation to data entry and registration. Other challenges are discrepancies between Centrelink and ACIR records, inadequate information for consumers and providers, and increased costs to the health system through the flow on effects from the specification that only GPs can certify natural medical contraindications and immunity.

## Recommendations

1. Many of these issues could have been avoided if the new changes only applied for children born after 2009 (i.e. those who have had access to ACIR because they were aged <7 years) allowing ACIR to be updated for all ages going forwards, and a more equitable approach to implementation. An alternative would be to extend the period before payments are ceased, which would allow families a greater period to ensure prior vaccines are entered on ACIR, and to complete catch-up where needed. Families have now been notified by Centrelink and are acting on this information. Given the scale of the issues, and considering that it takes 10 months to complete a catch-up regimen for children aged 4-9 years, a 12-24 month lead-time should be strongly considered. This time period would match the funding period for catch-up immunisations.
2. Extend catch-up immunisation incentive payments to cover all children/young people 0-19 years and ensure they are structured to support best practice catch-up immunisation.
3. Ensure there is consistent and accessible information for providers and consumers.
  - a. In addition to existing information, providers need consistent and accessible information on how Centrelink registers a 'catch-up' plan being in place, the application of the 'due/overdue' rules for catch-up immunisation, details on the 'grace period', and details on how natural immunity is considered in relation to Centrelink and incentive payments.
  - b. Consumers need translated and accessible information on accessing catch-up immunisation, obtaining their own ACIR records, and the No Jab, No Pay legislation in relation to Centrelink payments.
4. Amend the due/overdue rules for hepatitis B vaccination to reflect the dosing intervals specified in the Australian Immunisation Handbook.
5. Streamline the process for specialists and others to register with ACIR as 'limited' vaccination providers so they can enter vaccination information and review immunisation status on ACIR.
6. Consider reverting the legislation to allow all medical practitioners to certify medical contraindications and natural immunity, instead of the specification that only GPs can provide this documentation - any avoidable duplications in visits, vaccines, or serology will reduce costs to the health system.
7. Support the development of initiatives to support service providers in delivering catch-up immunisation. This could include directives through PHNs about resources for workforce professional development on 'No Jab No Pay'; an on-line catch-up calculator (for all ages) ideally linked to ACIR; improving the useability of ACIR for data entry; and short-term allocation of resources to ACIR to facilitate data cleaning, and entry of vaccination information.

*Dr Georgie Paxton (Chair)*

*On behalf of the Victorian Refugee Health Network Immunisation Working Group*

*23 March 2016*

*Minor amendments 20 April 2016*

[Georgia.paxton@rch.org.au](mailto:Georgia.paxton@rch.org.au)

## Appendix 1. Immunisation Working Group members

Name	Position	Organisation
Dr Georgia Paxton	(Chair) Head Immigrant Health, Paediatrician	The Royal Children's Hospital and Murdoch Children's Research Institute
Dr Karen Kiang	Paediatric Refugee Health Fellow	The Royal Children's Hospital
Dr Sophie Oldfield	Paediatric Refugee Health Fellow	The Royal Children's Hospital
Dr Margie Danchin	Paediatrician & Senior Research Fellow, Infection & Immunity	The Royal Children's Hospital & Murdoch Children's Research Institute
Kate Russo	Immunisation Nurse & Immunisation Program Consultant	Networking Health Victoria
Lindy Marlow	Statewide Facilitator, Refugee Health Program	cohealth
Merilyn Spratling	Refugee Health Nurse Practitioner	EACH Social and Community Health
Kate Maloney	Refugee Health Nurse	Sunraysia Community Health Service, Mildura
Sahema Saberi	Project Officer, Refugee & Asylum Seeker Health	South Eastern Melbourne Primary Health Network
Sandra Lonergan	Project Officer, Immunisation	South Eastern Melbourne Primary Health Network
Wendy Reid	Program Officer, Immunisation & Quality Improvement Support	North West Melbourne Primary Health Network
Samantha Milford	Program Officer, Refugee & Asylum Seeker Health	North West Melbourne Primary Health Network
Angela Dunn	Immunisation Team Leader	Hume City Council
Lisa Beck	Immunisation Coordinator	City of Greater Dandenong
Lynda Marburg	Immunisation Coordinator	Wyndham City Council
Stephen Pellissier	Manager, Immunisation Section	Department of Health and Human Services
Megan Beasley	Senior Project & Policy	Department of Health and Human Services
Crystal Russell	Senior Policy Adviser, Refugee & Asylum Seeker Health	Department of Health and Human Services
Zoe Smith	Public Health Officer, Western Area	Department of Health and Human Services
Toni Bloodworth	Manager Health Advice and Policy	Department of Education and Training
Sheenagh McShane	Health Program Manager	Asylum Seeker Resource Centre
Victoria Fisher	Settlement Team Leader North West	AMES
Sue Casey	Manager, Sector Development & Partnerships	Foundation House
Lauren Tyrrell	Sector Development & Policy Advisor (meeting minutes + secretariat support)	Victorian Refugee Health Network