Government of **Western Australia**
Department of **Health**

Decision Regulatory Impact Statement

Public Health Amendment (Immunisation Requirements for Enrolment) Bill 2019

Recommendations for strengthening immunisation requirements for enrolment into child care services and kindergarten programs in Western Australia

Public Health Act 2016 (WA)

School Education Act 1999 (WA)

April 2019

better health ▪ better care ▪ better value

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Disclaimer

The views expressed in this document may not, in any circumstances, be interpreted as stating an official position of the Department of Health.

This document is intended to serve as the basis for further discussion with interested stakeholders.

Contents

1 Executive Summary

The Western Australian (WA) Government is proposing that immunisation requirements for children enrolling into child care services, community kindergartens, and schools, before the compulsory education period, are strengthened through the Public Health Amendment (Immunisation Requirements for Enrolment) Bill 2019 ('the Bill').

During March 2019, public consultation was undertaken by the Department of Health (DoH) to obtain feedback and opinions from stakeholders on the Bill. The *Consultation Regulatory Impact Statement, Public Health Amendment (Immunisation Requirements for Enrolment) Bill 2019* (the 'CRIS'), was the discussion paper developed and released with the Bill to facilitate this public comment. Two options were proposed in the CRIS; Option A, to monitor the impacts of changes to the *Public Health Regulations* that were introduced in January 2019, which provide for the reporting and following up of under-vaccinated children; and Option B, to introduce the Bill to require a child's immunisation status to be 'up to date' as a condition of enrolment into child care services, community kindergartens, and schools, before the compulsory education period. The CRIS also detailed the objectives, provisions, and potential impacts of the Proposals within Option B on the early education and care industry, families, and State Government, for which stakeholders were invited to provide comment.

A total of 547 submissions were received during the three week public consultation. The majority (73%) exclusively identified themselves as a Parent/Guardian (325/547, 59%), or a Member of the Public (77/547, 14%), with further submissions from those representing Health (69/547, 13%), Education (29/547, 5%), Government (14/547, 3%), Child Care (10/547, 2%) or Other (23/547, 4%).

Of the respondents who indicated a preference for Option A, to fully implement recently introduced immunisation regulations, the majority of these were Parents/Guardians or Members of the Public. The basis of this preference was primarily the perceived detriments of Option B, rather than the perceived benefits of Option A. Respondents raised concerns that Option B may disrupt a child's right to early education, removed personal choice on vaccination, and would further marginalise vaccine-refuser families. Additionally, Option A would allow under-vaccinated children to attend early childhood education, and provide a supportive manner to improve immunisation rates, through the referral pathway. Option A supporters also referred to systemic problems i.e. known errors in the Australian Immunisation Register (AIR), which make the implementation of Option B difficult.

Of the respondents who indicated a preference for Option B, to introduce the Bill, around half of these were Parents/Guardians or Members of the Public, and a third were from the Health sector. The basis of this preference was the need to achieve herd immunity as a means to protect those in the community who are most vulnerable to VPDs, the need to provide a strong stance on vaccination as a shared responsibility, and that it will likely lead to improved immunisation rates among those undecided on vaccines or those who 'haven't got round to it'. Option B supporters also suggested this policy provided a flexible approach, as demonstrated by the provision of exemptions for children on a catch up schedule, and those identified as vulnerable and/disadvantaged.

Of those who supported Option B, the vast majority agreed that, with rare exception, there should be a requirement for a child's immunisation status to be 'up to date' as a condition of enrolment into child care services and kindergarten programs. A third of these respondents were not in support of permitting children on a catch up schedule to enrol, as it was believed this decision should be at the discretion of the service, or follow up should be undertaken to ensure catch up is adhered to. Notably, only 37% of Option B supporters agreed with the

provision of exemptions for vulnerable and/disadvantaged children, believing that these children are a priority for vaccination. Such responses demonstrated a misunderstanding of the Proposal, in that it is the full intention of the DoH to ensure these exempt children are in fact supported to be fully immunised, and highlighted the need for clarity across all DoH communications related to the policy.

Importantly, the impact analysis identified a number of matters which will provide valuable guidance to the DoH during implementation of the proposed Bill, to ensure its effective implementation. These matters for consideration by the DoH represent costs to implementation, and are related to communications, enforcement, evaluation and policy.

Should the Bill be passed in Parliament, effective implementation of No Jab No Play is contingent upon activities under the Communications Plan to ensure all stakeholders i.e. parents/guardians, persons in charge of schools, are aware of how the new immunisation enrolment requirements impact them in a practical sense. Consultation identified additional resources that could be provided to these stakeholder groups.

2 Issue Statement

Although the immunisations recommended in the Australian childhood immunisation schedule are provided at no cost under the National Immunisation Program[1] (NIP), and the DoH's immunisation program continues to deliver diverse initiatives which aim to increase access to immunisation services across the state under the *WA Immunisation Strategy 2016-2020*[2], according to data in the Australian Immunisation Register (AIR), WA has lower childhood immunisation rates compared to other jurisdictions, and continues to experience the ongoing incidence of vaccine-preventable notifiable infectious diseases (VPDs).

2.1 Immunisation rates in WA

At least 95% of children should be fully immunised to effectively prevent outbreaks of highly infectious diseases like measles. Known as herd immunity, the 95% immunisation rate is important to protect others in our community, including those who are too young to be vaccinated and those who are unable to be vaccinated for medical reasons, including pregnant women, children with immune disorders and some cancer patients.

However, WA is below the target of 95% immunisation coverage for each age group reported in AIR, and immunisation coverage rates in WA have lagged behind those for other Australian states and territories. In data extracted on 31 December 2018, WA had the second lowest immunisation rates compared to other jurisdictions for 12 ≤15 months (93.4%) and 24 ≤ 27 month old children (90.0%), and the lowest immunisation coverage for children aged 60 ≤ 63 months (93.6%) (Figure 1).

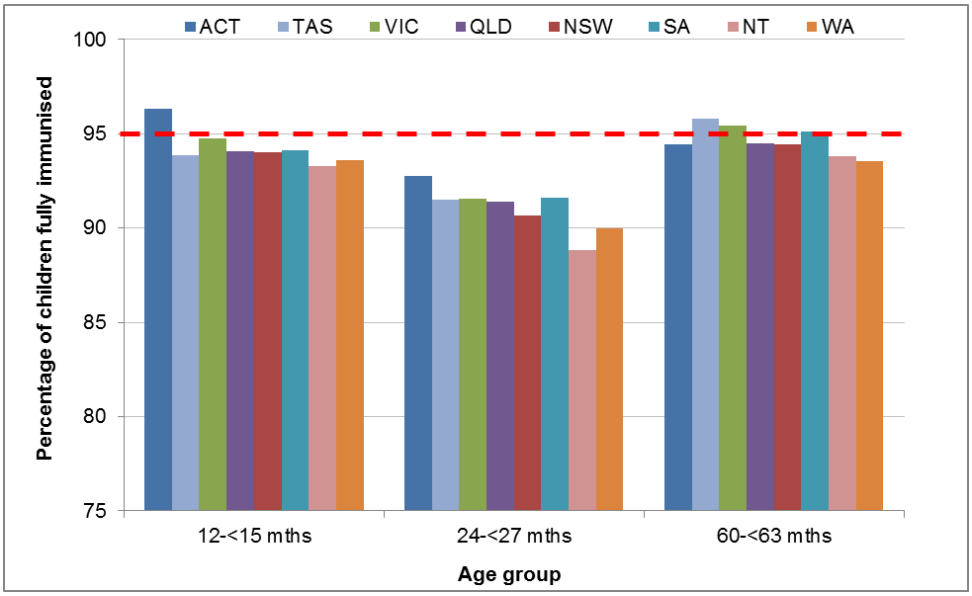

Figure 1 **Percentage of children aged one, two and five years old who are fully immunised across all Australian states and territories, as of December 2018**

From 2010 onwards, immunisation coverage in WA has improved as shown by the proportion of children fully vaccinated, by quarter and age group in Figure 2. (NB: the precipitous decline in 2

[1] *National Immunisation Program*; Department of Health, Commonwealth of Australia. Available at: https://beta.health.gov.au/initiatives-and-programs/national-immunisation-program

[2] *Western Australian Immunisation Strategy*; Department of Health, Government of Western Australia. Available at: https://ww2.health.wa.gov.au/Articles/F_I/Immunisation-strategy-2016

year olds was the result of changes to the definition of 'fully vaccinated' at that age-point, a data artifact observed nation-wide.)

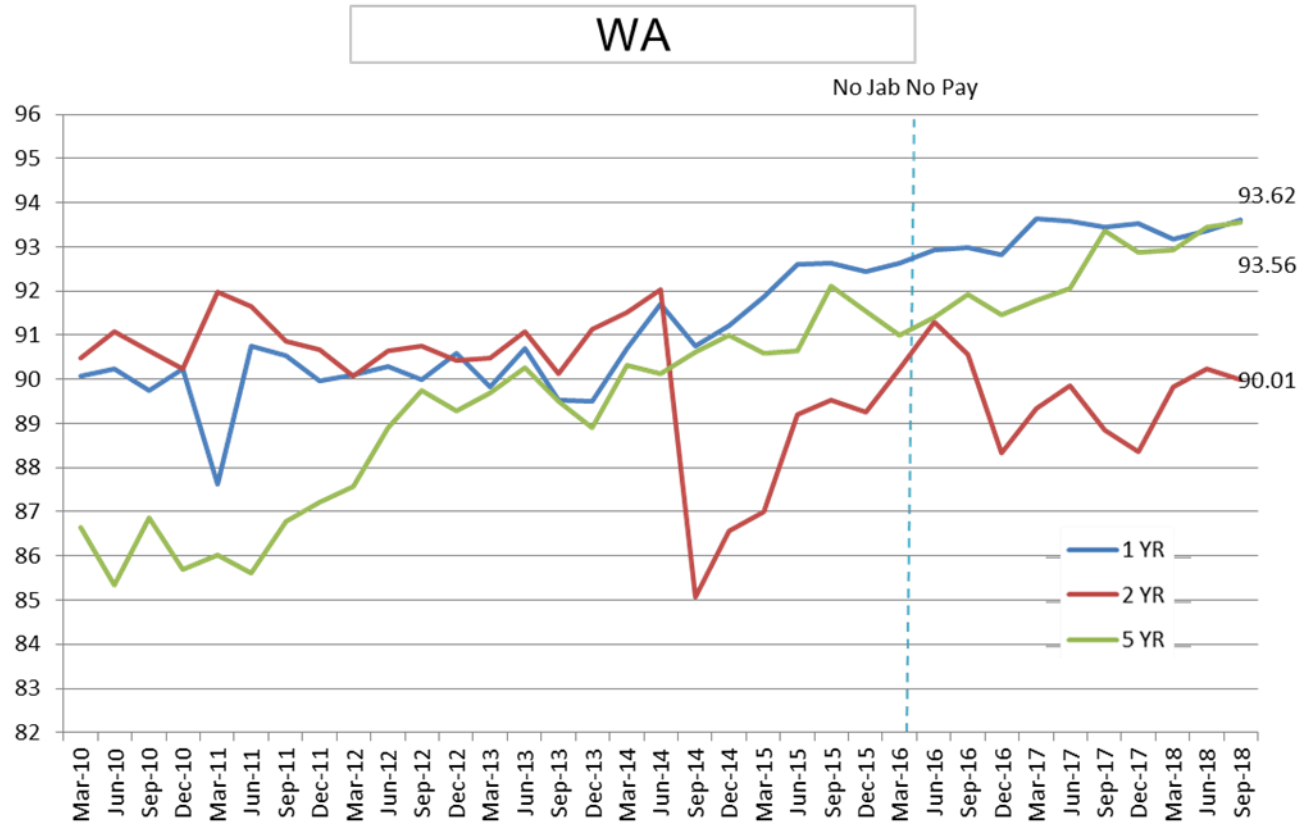

Figure 2 **Immunisation rates for children aged one, two and five years in Western Australia, March 2010 – September 2018**

2.2 Cases of vaccine-preventable diseases in WA

Vaccine-preventable disease (VPD) continues to occur within the WA population (Table 1). Children under five years have some of the highest disease rates for a number of VPDs. Individuals who are not fully immunised are at risk of acquiring VPDs and transmitting them to others individuals, including those who cannot be immunised for medical reasons, and those who are too young to receive certain vaccines. Immunisation helps to prevent individuals from acquiring VPDs, and also helps to protect other members of the population by reducing exposure to disease.

Table 1 Number of notifications of selected vaccine-preventable diseases in WA by year, 2014-2018

Disease	Year				
	2014	2015	2016	2017	2018
Population	2,557,046	2,590,259	2,668,628	2,714,687	2,762,238
Measles	43	7	11	17	36
Meningococcal	17	17	21	45	40
Mumps	23	454	481	23	18
Pertussis (whopping cough)	1,747	1,866	1,521	1,506	1,313
Pneumococcal infection	205	166	200	197	205
Rubella	1	2	1	2	1
Varicella (chicken pox)	424	483	611	692	647

NB: Data sourced from the Immunisation, Surveillance and Disease Control Program, Communicable Disease Control Directorate, Department of Health WA.

Pertussis is the most commonly notified VPD in WA. From 2016 to 2018, the notification rate was highest in those aged 14 years or younger (average: 110 per 100,000 population), although the rate among this age group decreased by 34% from 2017 to 2018 (131 to 81 per 100,000 population).

There were 973 cases of invasive pneumococcal disease notified from 2014 to 2018, with children aged less than 14 years comprising 18% of cases. During this time period, 888 (91%) of the cases were hospitalised, and 103 (11%) died. The majority of the cases presented with pneumonia (65%) or bacteraemia (31%), with a smaller number presenting with meningitis (7%).

There were 140 cases of invasive meningococcal disease (IPD) cases from 2014 to 2018. Children under five years old comprised 45% (18 cases) of all meningococcal notifications in 2018. The notification rate for this age group was seven-times higher than the overall rate that year (9.7 and 1.4 per 100,000 respectively). There were no deaths caused by meningococcal disease during 2018. The number of meningococcal notifications increased from 2016 to 2018 due to an increase in the number of serogroup W cases. Half of all meningococcal W cases in 2018 were in children aged less than 5 years of age. In 2018, WA introduced a program to provide free meningococcal ACWY vaccination to children less than 5 years of age, following which the meningococcal ACWY vaccination became part of the NIP in July 2018.

Measles cases notified in WA from 2014 to 2018 were associated with importations from overseas (49%) and subsequent local transmissions (51%). The age groups with the highest number of measles cases were children under 5 years (16 cases), teenagers 15 to 19 years (15 cases), and adults aged 20 to 39 years (62 cases). All of the young children infected with measles had not received a measles vaccination.

2.3 Factors contributing towards low immunisation rates

The reasons that some young children are not fully vaccinated for age are multi-factorial. The DoH has identified specific circumstances which result in the delayed or non-vaccination of a child. These circumstances include:

- children whose parents have limited access to immunisation services
- children whose parents have not got around to vaccinating their child
- children whose parents have concerns about vaccine safety and/or the timing of childhood immunisations i.e. 'vaccine hesitant' parents
- children whose parents are vaccine-refusers
- children who may be vulnerable or disadvantaged and therefore have irregular contact with preventive health services such as
    - children in emergency care e.g. in foster care or crisis accommodation
    - children in the care of an adult who is not their parent
    - Aboriginal and Torres Strait Islander (ATIS) children
    - children who are refugees or asylum seekers
    - children in need of protection under the *Children and Community Services Act 2004* (Department of Communities); and
    - children of parents/guardians with an income support payment card from the Federal government, such as a Health Care Card, Pension Concession Card, Veterans Affairs Gold or White Card.

Additionally, there are medical reasons why a child may be not be vaccinated and these children are considered to have a 'medical exemption' to vaccination. Medical exemptions to vaccination include persons who:

- had anaphylaxis after a previous dose of a vaccine
- had anaphylaxis after exposure to any component of a vaccine
- have a significant immunocompromising condition – for live vaccines only
- have natural immunity through prior infection for hepatitis B, measles, mumps, rubella and chickenpox only.[3]

Persons may have a serious allergy to a specific vaccine, or be immunocompromised due to illness (e.g. leukaemia, cancer, HIV/AIDS) or medical treatments (e.g. high-dose steroids or chemotherapy). Medical exemption from immunisation, however, is rare and as of December 2018, of the 8,944 children in WA aged between 60 ≤ 63 months registered on the AIR, only 24 had an approved medical exemption.[4] Of those, seven were recorded as having a medical contraindication to vaccination (e.g. immunocompromised, anaphylaxis after a previous dose of a vaccine), 18 were recorded as having natural immunity to a VPD, and one child had both a medical contraindication and natural immunity for two different vaccines.

2.4 Need for additional immunisation regulation and promotion of equity

Decades of experience from industrialised countries, including Australia, has demonstrated that standard community health initiatives, which promote the benefits of immunisation and provide vaccination reminders to both parents and health care providers, can improve childhood

[3] *Immunisation medical exemptions*; Department of Human Services, Commonwealth Government. Available at: https://www.humanservices.gov.au/individuals/enablers/immunisation-medical-exemptions/40531

[4] '*Unpublished data'* from the Australian Immunisation Register; Department of Human Services, Commonwealth Government; accessed 13 February, 2019.

immunisation rates, however these strategies are insufficient to achieve and maintain 95% immunisation coverage in large, diverse populations, for reasons outlined in Section 2.3.

More can be done to reduce the incidence of VPDs in WA, and the government has a responsibility to take measures, beyond those referred to above, to protect individuals and the community from serious infectious disease. Currently, the WA Government is proposing to strengthen immunisation regulations pertaining to child care services and kindergarten programs as a means to mitigate the risk of illness and death from VPDs.

In 2016, the Federal Government initiated a No Jab No Pay policy which excludes families of under-vaccinated children from receiving a Child Care Subsidy. Because this policy only applies to families who are eligible to receive these Federal benefits, it disproportionately affects those from lower socio-economic groups. In contrast, the WA Government is proposing a policy that is socially equitable and acknowledges the shared responsibility of the whole community for achieving and maintaining higher immunisation rates across WA, regardless of a family's financial situation. The proposed policy will apply to all children irrespective of income and means-tested benefits. In this regard, proposed WA regulation will extend immunisation requirements beyond children already covered by the Commonwealth's No Jab No Pay regulations, to also include under-vaccinated children in child care services who do not qualify for Child Care Subsidy payments because of means-testing protocols.

For children who do not attend child care services, kindergarten programs are usually their first entry point into the school system. In this regard, enrolment into kindergarten programs offers an additional check point, occurring at a critical age for a child to receive the recommended vaccinations on the NIP's childhood schedule (birth to four years). This policy aims to promote the recommended childhood immunisation schedule, by ensuring that by the time children reach kindergarten or during the year they turn 4, they should have completed their immunisations.

While under-vaccinated children who fall within a prescribed class of exemption will not be excluded from enrolling in child care services, community kindergartens and schools before the compulsory education period, under the proposed No Jab No Play policy in WA, the DoH intends to provide effective referral pathways for these families (as well as families of under-vaccinated children enrolled in pre-primary) to ensure their children are able to access immunisation services so they can be fully protected through vaccinations.

The key role for government in improving immunisation rates in young children was demonstrated by a request from former Prime Minister Malcolm Turnbull in March 2017 that all jurisdictions implement No Jab No Play policies, as part of a nationally consistent approach to stop under-vaccinated children from attending child care services and pre-schools (noting that 'pre-schools in New South Wales refers to the years prior to compulsory schooling i.e. kindergarten programs in WA). This request was met with strong support from jurisdictions, including WA. The Council of Australian Governments (COAG) developed options for this national approach; these options were noted out of session, however there was no agreement on how to progress the policy further. In September 2017, Premier McGowan directed the state to progress a No Jab No Play policy with similar underlying objectives to those already implemented in other states.

2.5 Immunisation regulation in WA

Until recently, minimal immunisation related regulation existed in Western Australia; however in 2019 new immunisation regulations were introduced under the *Public Health Act 2016* which serve to strengthen the Department of Health's capacity to monitor immunisation rates, as well as limit or prevent the spread of a VPD in an education and care setting.

2.5.1 Prior to 2019

Prior to 2019, no immunisation related regulations had been introduced under the *Public Health Act 2016*. Under the *School Education Act 1999*, there was one existing immunisation-related requirement. Specifically:

- Division 2, 16(1):

  A person who wishes to make an application for enrolment at a school is to provide the following information to the extent that he or she is asked to do so –

  (f) the vaccination status of the enrolee.

Similarly, the *Education and Care Services National Regulations 2012* and *Child Care Services (Child Care) Regulations 2006* required services to keep the immunisation status of a child enrolled at a service.

The *School Education Act 1999* also contains a provision to support the principal to limit or prevent the spread of an infectious disease. Specifically:

- Division 3, 27(1):

  The principal of a school may require that a student –

  (a) not attend the school; or
  (b) not participate in an educational programme of the school,

  during any day on which the student or any other student at the school is suffering from a medical condition to which this section applies.

2.5.2 From 2019 onwards

As of 1 January 2019, new Regulations came into effect under the *Public Health Act 2016* that strengthen immunisation requirements around the collection and reporting of immunisation information by child care services, community kindergartens and schools (Table 2). The development of these regulations followed a Regulatory Impact Assessment (RIA) process, whereby a Preliminary Impact Assessment was undertaken. The Better Regulation Unit (Department of Treasury) deemed these amendments were unlikely to have significant adverse impacts on WA consumers, business or the economy, and that no further RIA activities were required.

Table 2 Immunisation related regulations under the *Public Health Regulations 2017,* in effect 1 January 2019

Regulations 10B – 10G	
10B.	If a child is being enrolled at a child care service, community kindergarten or school, the responsible person for the child is required to give to the person in charge of the child care service, community kindergarten or school the immunisation status of the child as recorded on the child's current immunisation status certificate.
10C.	The CHO may direct the person in charge of a child care service, community kindergarten or school to give to the CHO a report, in an approved form, in respect of the immunisation status of a child or children enrolled at the school.
10D.	The CHO may direct the person in charge of a child care service, community kindergarten or school to give to the CHO a report, in an approved form, in respect of a child enrolled at the child care service, community kindergarten or school who has, or who is reasonably believed to have, contracted a VPD.
10E.	The CHO may direct the person in charge of a child care service, community kindergarten or school not

	to permit any child to attend the facility who does not have immunity against a VPD; in this instance, the person in charge is required to write to the child's parent/guardian specifying the VPD that the child does not have immunity from, and the period of time during which the child must not attend, as advised by the CHO
10F.	The CHO may direct the person in charge of a school to close the whole, or a part, of the school if the CHO considers it reasonably necessary to limit or prevent the spread of a VPD.
10G.	If the CHO requests from a person in charge of a child care service, community kindergarten or school to give a report to the CHO in respect of a child who has not, or children who have not, been immunised against a VPD, the CHO may request further information necessary to assist in preventing, controlling and abating the public health risk that might foreseeably arise from the child or children not being immunised against the VPD e.g. name and other identifying information of the child; name and contact details of the responsible person of the child.

To support these changes, complementary amendments were also made to the *School Education Regulations 2000* (WA) to require schools to keep the vaccination status of an enrolee on the school's enrolment register, while amendments to the *Child Care Services (Child Care) Regulations 2006* (WA) are planned to come at a later stage.

While these regulations have created new authorities for the Department of Health which may in turn help increase immunisation rates among children, further regulation is proposed that will strengthen immunisation enrolment requirements, as a means to have greater impact on immunisation rates among children enrolling into child care services and kindergarten programs.

2.6 Stakeholder viewpoints on the CRIS

A number of respondents disagreed with the Department of Health's summary of information and viewpoint presented in the CRIS. There were two main reasons presented for their alternative viewpoints, being:

Claim 1: Other determinants of childhood health are relevant

A criticism was that the policy focuses on vaccination rates, while ignoring (1) overall health outcomes in children in terms of chronic disease and disability, and (2) important social determinants of health such as inclusion, socialisation and early childhood education.

Response from DoH

Chronic diseases are often associated with non-communicable diseases, and are outside of the scope of the current public health issues, which concerns communicable diseases. Social determinants of health are addressed by Proposal 3 of the Bill, which acknowledges the importance of access to early education in accordance with the *2018-2019 National Partnership Agreement on Universal Access to Early Childhood Education*. It is particularly important that vulnerable and disadvantaged children are supported to attend early education and care services. For this reason, it is proposed that these children will be exempt from the requirement to be fully vaccinated for age as a condition of enrolment in child care services and kindergartens. Exemptions will also be made for children who have a medical contraindication to vaccination as well as children on an approved immunisation catch up schedule. Both exemptions would require approval by an eligible health professional and recording on the AIR.

Claim 2: Data is misrepresented in the CRIS

Proponents of the view that the CRIS misrepresented data suggested that:

- “The vaccination rate in Western Australia may already be at the aspirational target of 95%, but this information has not been provided in the discussion paper (CRIS).”
- AIR data issues and errors are significant, resulting in an underreporting of true vaccination rates.
- “(the data) creates an incorrect perception and false sense of security that the exclusion of incompletely vaccinated children will prevent disease outbreaks, even though large numbers of fully vaccinated children are being notified with diseases such as Whooping Cough, Mumps, and Chickenpox. Increasing already high vaccination rates will not change this state of affairs. For example, the mumps outbreaks in large numbers of fully vaccinated children in Western Australia.”

Response from DoH

The Department of Health acknowledges that no vaccine is 100% effective and therefore makes no claim that higher vaccination rates will completely eliminate VPDs from child care services, kindergartens and schools. That said, achieving higher vaccination coverage in these cohorts will increase the number of children who are directly protected against vaccine preventable illness and reduce opportunities for disease transmission within child care settings. In addition, although some individuals may still acquire a VPD for which they have been vaccinated, prior vaccination often mitigates the severity of the illness they experience.

While 95% vaccination coverage is proposed as the minimum level required to prevent sustained transmission of measles, achieving higher immunisation rates is desirable because it means a greater number of individual children will be immune and no longer at-risk if exposed, either in a child care or community setting. Additionally, while WA’s overall immunisation rate may be relatively high, immunisation coverage varies across local government areas, as demonstrated by Figure 3.

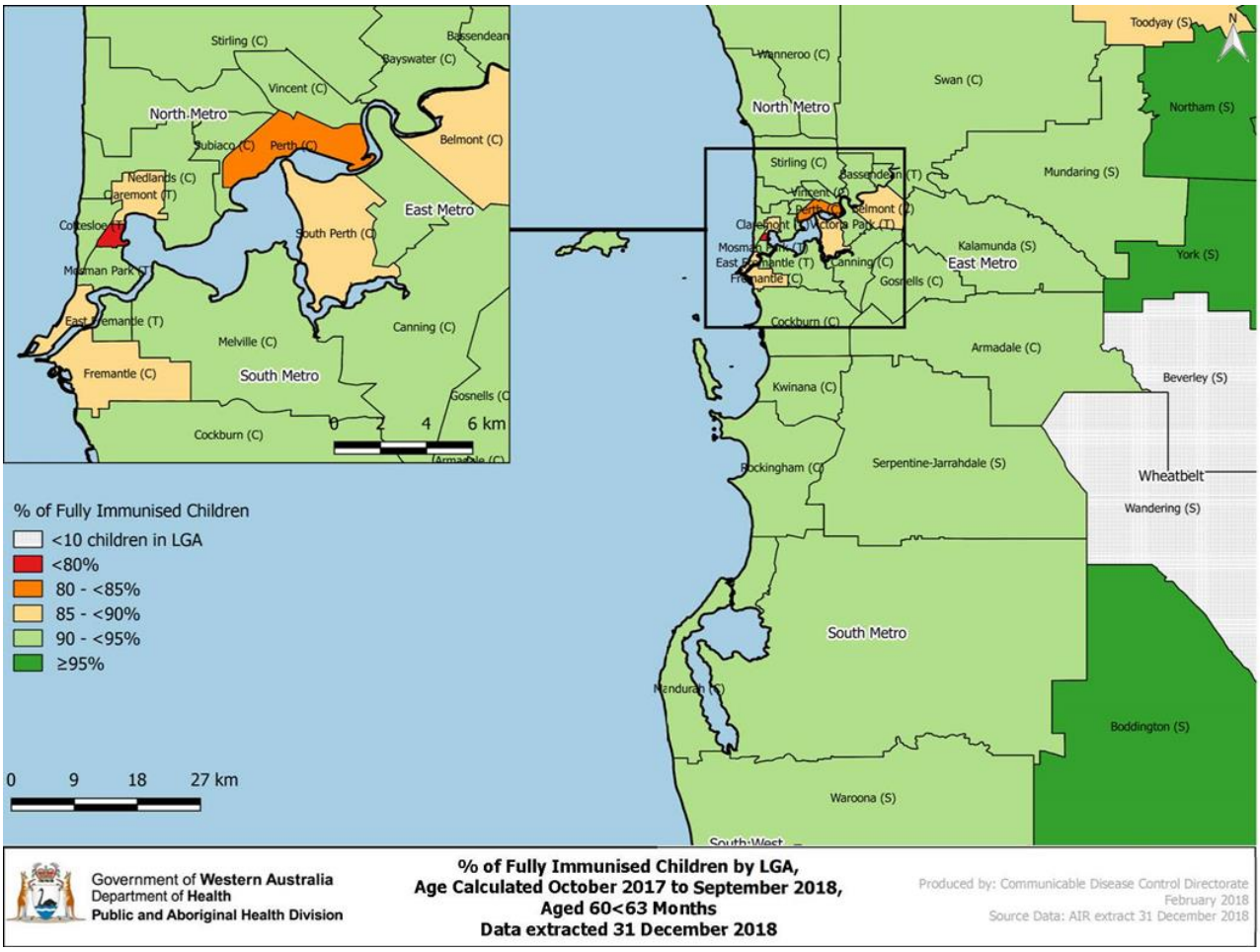

Figure 3 **Percentage of children fully vaccinated at 60 ≤ 63 months of age in WA, by metropolitan local government area, data extracted 31 December 2018**

In light of the above, the Department of Health maintains the issue statement (Section 2) to be a correct evaluation and that higher vaccination rates will reduce the number of individuals at-risk and help minimise opportunities for disease transmission. Appropriate messaging regarding the expected benefits, and their limitations, while implementing Option B should be sufficient to address any incorrect perceptions held by some members of the public.

3 Policy objectives

In March 2017, former Prime Minister Malcolm Turnbull requested that all jurisdictions implement No Jab No Play policies, as part of a nationally consistent approach to stop under-vaccinated children from attending child care services and pre-schools (noting that 'pre-schools in New South Wales refers to the years prior to compulsory schooling i.e. kindergarten programs in WA). This request was met with strong support from jurisdictions, including WA. Although COAG developed options for this national approach, there was no agreement on how to progress the policy further. In September 2017, Premier McGowan directed the state to progress a No Jab No Play policy, to introduce immunisation requirements for children enrolling in child care services and kindergarten programs in WA. Legislative amendments, which provide for similar underlying objectives to those already implemented in other states, would be required across the *Public Health Act 2016* and *School Education Act 1999.*

Amendments are proposed to both these Acts to require that, with rare exception, children in WA need to be fully vaccinated for age as a condition of enrolment into child care services, community kindergartens, and schools, before the compulsory education period, unless the

child has an approved medical exemption, is on an approved catch-up schedule, or is identified as being vulnerable and/or disadvantaged under prescribed exemption categories. Queensland, Victoria and New South Wales have already introduced legislation with similar underlying policy objectives, and South Australia is planning to do so in the near future.

Immunisation is a safe and effective way of protecting individuals against serious infectious disease.[5] Immunisation not only protects individuals from life-threatening diseases, but can also reduce the spread of disease within a community, a phenomena often referred to as indirect protection or 'herd immunity.' The higher the proportion of people who are immune to a disease through vaccination, the fewer opportunities a disease has to spread.[5] Creating 'herd immunity' is important for protecting individuals who cannot be directly immunised themselves, often because they are too young to receive the vaccine or because they have a medical contra-indication.

A working group consisting of representatives from the Department of the Premier and Cabinet (DPC), DoH, Department of Education (DoE) and Department of Communities (DoC) developed an approach for implementing a No Jab No Play (NJNP) policy in WA (Table 3).

Table 3 Approach to strengthening immunisation enrolment requirements for children in WA

No Jab No Play in WA
Description ▪ Introduce the proposed Bill to require that, with rare exception, children in WA are fully vaccinated for age as a condition of enrolment into child care services, community kindergartens and schools, before the compulsory education period commences. ▪ In most instances, in order to enrol, a child's immunisation status will be required to be recorded as 'up to date' on an AIR Immunisation History Statement issued within 2 months of the proposed enrolment. ▪ Children with an approved medical exemption to a vaccine or natural immunity to a specific disease are 'up to date' for the relevant vaccine according to their AIR Immunisation History Statement. ▪ Exemptions to the child care and kindergarten immunisation requirements will apply to children who are: - on an approved immunisation catch-up schedule; or - identified as being an exempt child. ▪ This proposed WA NJNP immunisation policy acknowledges the importance of access to early education as enunciated in the *2018-2019 National Partnership Agreement on Universal Access to Early Childhood Education.*[6] Early education services can be particularly important for vulnerable and disadvantaged children, who should be supported to ensure their participation in early education services. It is proposed that under this policy vulnerable and disadvantaged children who are under-vaccinated will be exempt from the requirement to be fully vaccinated for age, as a condition of enrolment into child care services and kindergarten programs. ▪ Under-vaccinated children who are enrolled in child care services, community kindergartens and schools, before compulsory education period, on an exemption, and children who are enrolled on an approved immunisation catch-up schedule, will be reported to the DoH. ▪ The DoH will follow up with the families of these under-vaccinated children to provide support in accessing local immunisation services.

[5] *National Immunisation Program;* Department of Health, Commonwealth of Australia. Available at: https://beta.health.gov.au/initiatives-and-programs/national-immunisation-program

[6] *2018-2019 National Partnership on Universal Access to Early Education*, Department of Education and Training, Commonwealth Government. Available at: https://www.education.gov.au/national-partnership-agreements

The objectives of the proposed amendments to the *Public Health Act 2016* and *School Education Act 1999* are to mitigate the risk of VPDs occurring among children attending child care services, community kindergartens, schools and the wider community, by ensuring that, with rare exception, all children enrolled in these services are fully vaccinated for their age. The proposed legislative changes will not apply to compulsory schooling which commences with pre-primary school in WA.

The rationale for the immunisation policy is that, if young children do not receive their recommended vaccinations, they are at increased risk of serious illness. If a substantial number of children are unvaccinated, there is an increased risk of VPDs spreading within early education and care settings, and potentially, the wider community. While the Commonwealth's existing No Jab No Pay scheme aims to achieve high immunisation rates among children attending child care services, for children who do not attend a child care service, kindergarten programs are usually their first entry point into early education and care and the broader school system. In this regard, enrolment into kindergarten programs offer an additional check point, occurring at a critical age for a child to receive the recommended vaccinations on the NIP's childhood schedule (birth to four years). This policy aims to promote the recommendations of the childhood schedule, by ensuring that by the time children reach kindergarten or during the year they turn 4, they have completed their childhood immunisation schedule.

The proposed immunisation enrolment requirements will apply to children enrolling in a child care service (other than a child care service that operates on a temporary, casual or ad hoc basis). It will also apply to enrolments in a pre-kindergarten program and kindergarten program in a government school, non-government school or community kindergarten.

The proposed WA No Jab No Play policy is fully supported by the WA Premier who has directed the policy is to be expedited with a goal to implement it in time for 2020 kindergarten enrolments, which commences in July 2019.

In September 2018, the DoH engaged with the Better Regulation Unit (Department of Treasury) to develop this legislation under the guidance of the RIA process. In October 2018, a Preliminary Impact Assessment was undertaken for which the Better Regulation Unit considered the proposal may have significant adverse impacts on WA businesses. Consequently, a Consultation Regulatory Impact Statement (CRIS) was required in addition to this Decision Regulatory Impact Statement. The Better Regulation Unit also requested that the Small Business Development Corporation was invited to participate in the public consultation (Appendix A). Following approval by Cabinet in December 2018, and under instruction from the working group, the Public Health Amendment (Immunisation Requirements for Enrolment) Bill 2019 was drafted.

4 Consultation

4.1 Objectives

Under the requirements of the RIA process, and guided by the Better Regulation Unit, the DoH sought stakeholder feedback on the seven Proposals of the Bill, as outlined in the Consultation Regulatory Impact Statement (CRIS). The aim of the consultation was to gather information from stakeholders that would enable:

i. identification of the range of viewpoints within each Option and Proposal, and
ii. development of any additional options or proposals for reform not already identified.

The process of community consultation is designed to ensure that stakeholders from a range of sectors are able to express support or concern regarding a proposed policy. The views of

respondents are acknowledged to reflect the key issues relating to a proposed policy, however they are not necessarily exhaustive, nor necessarily representative of the views held by the majority of individuals from within that sector. They do, however, indicate sentiment from a cross-section of individuals, and are useful for soliciting alternative approaches to the issues being addressed.

4.2 Methodology

Public consultation on the Bill was held over a three week period; consultation commenced Tuesday 5 March, and closed Tuesday 26 March, 2019.

The consultation was located online on the Department of Health's Consultation Hub (https://consultation.health.wa.gov.au/) and was hosted by Citizen Space, the Department's preferred consultation software.

The use of Citizen Space for consultation purposes is compliant with the Department of Health's *Research Policy Framework* and *Information Management Policy Framework*, both which are underpinned by the *Privacy Act 1988*.

Stakeholders across various sectors were advised by the Department of Health when the consultation was open and were invited to participate (Appendix A). Targeted communications to these stakeholder groups were made in the following ways:

- an email from immunisation@health.wa.gov.au on Tuesday 5 March 2019; recipients were also encouraged to forward the email through their networks; and
- a post on the HealthyWA Facebook page, published Wednesday 6 March 2019.

The intent of the HealthyWA Facebook post was to engage with parents and parent groups to elicit their participation in the consultation, and the post provided a direct link to the Consultation Hub. Additionally, a news article on the Department of Health's consumer website, HealthyWA, was published on Wednesday 6 March 2019. Titled *'Immunisation requirements for enrolment: Have your say,'* the article invited participation and provided a direct link to the Consultation Hub.

Consultation documentation comprised of three documents:

i. The Public Health Amendment (Immunisation Requirements for Enrolment) Bill 2019

Proposed amendments to the *Public Health Act 2016* (WA) to strengthen immunisation enrolment requirements, comprising seven Proposals.

ii. Consultation Regulatory Impact Statement: Public Health Amendment (Immunisation Requirements for Enrolment) Bill 2019

The CRIS (discussion paper) outlined the public health issue to be addressed, the current provision of childhood immunisation programs in WA under the National Immunisation Program, the newly introduced immunisation-related regulations, and the experience of the implementation of similar No Jab No Play legislation in other Australian jurisdictions. The primary purpose of the CRIS was to facilitate public comment on the Options and Proposals within the Bill, by detailing their objectives, proposals, and potential impacts on the early education and care industry, families, and State Government.

iii. Guiding Questions

The Guiding Questions (Appendix B) comprised 25 questions largely based on the Options, and Proposals 1 to 5 within the Bill. Proposals 6 and 7 referred to minor technical or consequential

amendments relating to the preceding Proposals, and therefore did not require stakeholder comment. The Guiding Questions provided a structure for analysis of the Options and Proposals and where appropriate, open questions were used to provide respondents the opportunity to suggest alternative options or proposals. As such, the majority of data collected was qualitative.

Respondents were provided three ways in which they could respond to the Guiding Questions:

Online	https://consultation.health.wa.gov.au/
Email	Complete the Guiding Questions and email to: immunisation@health.wa.gov.au
Post	Complete the Guiding Questions and post to: Immunisation Consultation Communicable Disease Control Directorate Public and Aboriginal Health Division Department of Health PO Box 8172 Perth Business Centre WA 6849

Analysis of the submission data was undertaken by the DoH. NVivo software was used to code the qualitative (free-text) responses into broad categories prior to review. Free-text responses were categorised by the reviewer under thematic groups, designed to capture the major issues and reasons identified across all respondents, and within each unique sector. All responses were individually reviewed and analysed, with comments categorised under thematic headings, with unique themes and categories added until saturation was reached.

Given an objective of the consultation was to identify the range of views of respondents with regards to the Options and Proposals, the results of the consultation are less focussed on how many respondents were of certain viewpoints, and more focussed on identifying all viewpoints from the various stakeholder groups.

4.3 Profile of respondents

A total of 547 unique responses to the public consultation were received; 545 submissions were submitted online via the Consultation Hub, and two submissions were emailed. Respondents could choose more than one sector to represent, and in order to conduct meaningful analysis, a primary sector was chosen for each respondent. Respondents designated from the same sector were grouped together, as presented in Table 4. A hierarchical approach was taken, with occupation (health, school or child care) given priority (i.e. those who indicated they worked in one of these fields were assigned this sector as their primary classification). Those who indicated they worked in government with no indication of primary occupation were classified under the government category, and those who indicated they represented parents/guardians with no indication of occupation or sector were classified as such. These designations were selected in this manner as it was felt that a participant's occupation lent unique significance to the submission, as the views provided insight into sector-specific issues.

Table 4 Respondents' identified sector and their allocated primary sector

Respondents' identified sector	Allocated primary sector
State Government	Government
Local Government	Government
Child care service provider	Child care
Child care advocacy group	Child care
Children's welfare group	Child care
Non-government school	School
Government school	School
Teachers' association	School
Health service provider	Health
Clinical association	Health
Regulation agency	Government
Parent/guardian	Parent/Guardian
Member of the public	Member of the Public
Prefer not to say	Other
Other	Other

The majority (73%) exclusively identified themselves as a Parent/Guardian (325/547, 59%), or a Member of the Public (77/547, 14%), with further submissions from those representing Health (69/547, 13%), Education (29/547, 5%), Government (14/547, 3%), Child Care (10/547, 2%) or Other (23/547, 4%). Finally, those who identified purely as Members of the Public or Other retained this classification. Respondents who selected Other identified as grandparents, not-for-profit representatives, researchers, indigenous health staff, or media. Figure 4 presents the respondents' primary representation across sectors.

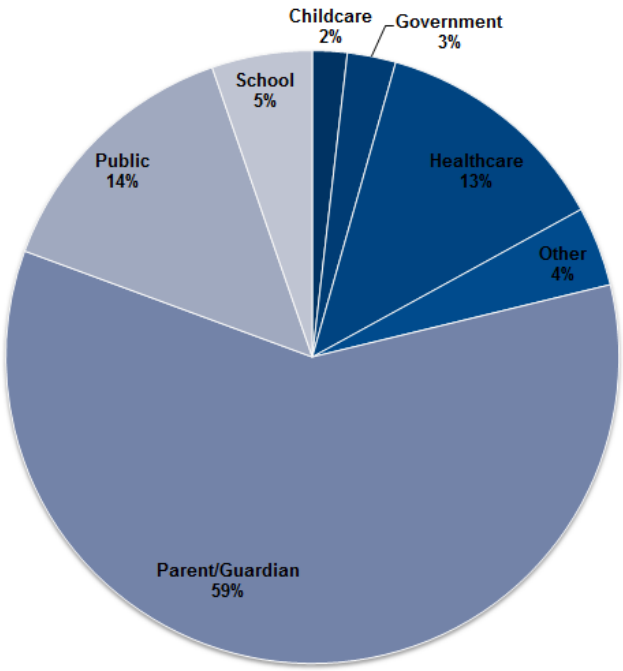

Figure 4 Respondents' primary sector representation

Based on the number of responses received, and the spread of sector representation, the consultation appeared to have demonstrated genuine engagement with the community, and it is expected that responses represented a range of opinions.

It was observed that some respondents did not fully understand the provisions of the Bill, which may have influenced their responses. For example, some respondents indicated they did not support Option B as it would further disadvantage already vulnerable children should they be excluded from early education and care. However these comments preceded the explanation of Proposal 3 which provides that these vulnerable and disadvantaged children will be exempt from these enrolment requirements.

If these respondents were aware of the proposed exemption, this may have meant that they would support Option B. As another example, respondents stated that under Proposal 3 children who would qualify for an exemption category should not be exempt from vaccination itself. However, as the CRIS outlines, it is the intention for these children to be caught up with their outstanding vaccinations through supportive referral pathways provided by the DoH, and this is a major focus for the DoH.

For the purposes of analysis of submission data, where a respondent's comments demonstrated misunderstandings, as above, this was managed on a case-by-case basis, to ensure the general viewpoint of their response was maintained.

A significant proportion of submissions were found to have similar text responses. Upon further investigation, it appeared that the Australian Vaccination-risks Network Inc. had developed a guide for its members on how to make a submission in this consultation. The majority of these respondents identified as a Parent/Guardian or Member of the Public, and some also purported to represented schools and health agencies.

4.4 Limitations

Due to the relatively high vaccination rates in WA among children of the target age group, the implementation of this policy has significant impacts for a minority of the wider population.

Therefore, people who will respond are likely to be those who feel they will be most impacted by the policy. This includes parents who decline vaccine for their children, people working in the early education sector, people working in communicable disease prevention, and parents of children with a medical contraindication for immunisation, who are concerned about the risks of their child being exposed to a VPD. It was also apparent that a proportion of responses were guided by a representative group, founded by a concern for the lack of scientifically-based information on vaccination. Submissions guided by this group were uniform in theme and content.

In light of the volume of submissions received, it has been necessary to summarise and group these responses together under common thematic headings, designed to cut across the essence of all submissions. Every effort has been made by the DoH to ensure that this document presents a true representation of the various opinions across the multiple stakeholder groups. Any inadvertent omission of any issues or reasons raised by respondents is unintentional.

Among Child Care and Education sector responses, the submissions generally appeared to be from the opinion of the individual making the submission, rather than representing the views of the named organisation. Such respondents also identified as a 'Parents/Guardian', and this highlighted a weakness in Guiding Question 5, which is 'Which sector do you represent?' Respondents could identify as representing more than one sector, however the question should have asked respondents to nominate their primary sector only.

5 Impact Analysis

The WA Government is currently investigating the introduction of legislation intended to increase childhood immunisation rates by strengthening immunisation enrolment requirements. Two regulatory Options to address this issue were identified and outlined in detail in the CRIS. Public consultation asked respondents for their comment on these Options, with some respondents also suggesting alternative regulatory options, and comment on the Proposals which make up the key components of Option B.

This part of the DRIS presents the results of the consultation and importantly impact analysis, which will inform implementation. In Section 5.1, the basis of respondents' support for Option A and B are outlined, and a feasibility assessment of these themes from the DoH perspective provides an impact analysis. Similarly, the alternative options as suggested by respondents are outlined, including a feasibility analysis of each. Option B is the recommended approach for increasing childhood immunisation rates in WA, and consultation results on the five Proposals which make up the key components of Option B are then presented in Section 5.2. Where appropriate, the DoH has undertaken an impact analysis, the results of which will provide valuable implementation guidance for the DoH, should the legislation be passed by Parliament.

Option A: Fully implement recently introduced regulations

Option A proposes to enact recently introduced regulations requiring the collection and reporting of immunisation information by child care services, community kindergartens and schools at the time of enrolment, and monitor any impact on immunisation rates before changing the status quo.

Recent amendments to the *Public Health Regulations 2017* introduced new requirements (effective 1 January 2019) which mandate universal immunisation records checks for children when they enrol into a child care service, community kindergarten and school, and allow the

Chief Health Officer (CHO) to request reports on the immunisation status of any child or children enrolled.[7] Families of under-vaccinated children who are reported to the DoH under the regulations will be offered assistance with obtaining vaccinations but there is no exclusion of these children from attending or enrolling into child care, community kindergarten or school, before the child's compulsory education period.

These regulations also provide a framework for action to be taken to limit and prevent the spread of an outbreak of a VPD in a child care service, community kindergarten and school.

Option B: Amend the Public Health Act 2016

Option B proposes to amend the *Public Health Act 2016* (WA) ('the Act') to require, with rare exception, children in WA to be fully vaccinated for age as a condition of enrolment into child care services, community kindergartens and schools, before the compulsory education period. Regulation proposed in this option would work alongside and in addition to the regulation proposed Option A.

This option follows a direction from the WA Premier to implement an immunisation policy with the same underlying policy objectives to those already implemented in Victoria and New South Wales. This proposed WA No Jab No Play policy aims to further strengthen immunisation requirements for children enrolling into child care services, and kindergarten programs, and is supported by the Australian Medical Association of WA.

This proposed legislation would also operate in conjunction with the *Public Health Regulations 2017*[8] immunisation requirements outlined in Section 2.4, and amendments to the *School Education Act 1999* would also be required to achieve alignment with these requirements within the *Public Health Act 2016*.

The proposed immunisation requirements will apply to children enrolling in a child care service (other than a child care service that operates on a temporary, casual or ad hoc basis). Requirements will also apply to enrolments in a pre-kindergarten program and kindergarten program in a government school, non-government school, and community kindergarten ('kindergarten programs').

5.1 Options: key observations and findings

This section presents the main reasons why respondents preferred Option A, Option B, or suggested an alternative option. These alternative options are also assessed for their feasibility to address the issue statement.

5.1.1 Basis of respondents' preference for Option A

The major themes identified by those who supported Option A are presented below in Table 5. These results summarise the reasons that Option A was preferred. The majority of responses focused on the perceived detriments of Option B, rather than the perceived benefits of Option A, therefore many of the themes are framed within this context. Where a theme was raised by one sector only, this is also indicated by a (*) in the table under 'Theme'. Table 5 also contains the DoH feasibility assessment of themes, where appropriate.

[7] *Immunisation enrolment requirements for child care services, kindergarten and schools;* Department of Health, Government of Western Australia. Available at: https://ww2.health.wa.gov.au/immunisationenrolment

[8] *Public Health Regulations 2017*, Western Australian Legislation. Available at: https://www.legislation.wa.gov.au/legislation/statutes.nsf/law_s49088.html

Of those who supported Option A, 80% identified as a Parent/Guardian or Member of the Public. As this group comprised the majority of responses in support of Option A, Table 5 contains an exhaustive summary of their themes, with no additional sector-specific issues raised by this group. It must also be noted that a significant proportion of these responses contained identical or similar text (as provided by the Australian Vaccination-risks Network Inc.), meaning the issues raised were relatively uniform across this group.

A total of 20 respondents reported representing the Health sector and indicated they were in support of Option A. These respondents provided an interesting viewpoint: they represent the health sector, are generally supportive of vaccination programs, and for various reasons supported Option A. The unique themes these respondents raised are presented in Table 5.

A total of 22 respondents reported representing the Education sector and indicated they were in support of Option A. The unique themes these respondents raised are also presented in the table below. Child Care sector, Government and Other respondents did not raise any unique themes.

Table 5 Summary of themes for preference of Option A

Themes	Description	DoH feasibility assessment
Option B disrupts a child's right to access early education	There was concern that the proposed policy (Options B) was punitive in nature towards children, with early childhood education viewed as important for all children in terms of socialisation and educational attainment, regardless of vaccination status. Prohibiting a child's access to early childhood education based on the decisions of parents was seen as detrimental, and could potentially be harmful for a child's development. This view was supported by respondents across multiple sectors. It was also noted that for parents whose children could not access early childhood education, these people may be unable to return to the workforce or study, which may cause financial hardship, limit professional development opportunities, and negatively impact the mental health of carers.	The DoH acknowledges the importance of access to early education and care, so to minimise impact, the DoH is proposing exemptions for children on a catch up schedule, and those identified as vulnerable and disadvantaged.
Option B removes personal choice to decide on whether to vaccinate	Personal choice and autonomy over decision-making was a concern, with Option B viewed as a means to remove autonomy for parents to make their own decisions regarding the vaccination of their children. This proposed policy was viewed as a means to coerce parents into vaccinating, rather than allowing them informed consent. There was mention of 'mandatory vaccination' and exclusion from 'compulsory education', which may imply that some respondents understood the proposed changes would prevent under-immunised children from attending school; this misconception may need to be addressed. Personal choice also encompassed an expressed desire for parents to use alternatives to vaccination e.g. 'homeoprophylaxis.'	Vaccination will always remain the choice of the individual or parent. There is no scientific evidence to support the efficacy or safety of homeoprophylaxis.
Option A allows for refusal of vaccination for ethical or medical	A number of respondents raised issues of vaccine refusal on the basis of medical or religious/ethical/philosophical grounds, which Option A accommodates for.	Perceived medical contraindications to vaccination were cited as reasons that a child

Themes	Description	DoH feasibility assessment
reasons	It was also noted that some religious practices prevent people from vaccinating on ethical/religious grounds.	would be unfairly excluded from early education and care. As persons with a medical contraindication to vaccination that is recorded in the AIR have an immunisation status that is 'up to date', it could be assumed that these concerns relate to medical issues which have not been recognised by a primary care provider as being legitimate contraindications to vaccination.
Need to assess the impact of Option B in other jurisdictions	It was suggested that there is insufficient evidence from other jurisdictions that Option B would be effective in raising childhood immunisation rates, and that data supporting this policy from other jurisdictions should be reviewed.	Data from Victoria (Figure 5) indicates that since early 2016, an increase in immunisation rates has been experienced.
Option B marginalises children and families	Concern was expressed that vaccine-refuser families may feel further isolated/discriminated against by the proposed legislation in Option B. This approach may further contribute to the perceived divide between people who choose not to vaccinate, and their access to 'mainstream' health and education services. The issue of social exclusion and the associated detrimental effects were highlighted, with suggestions that families would face further marginalisation, and seek alternative care outside of mainstream channels. Further, it was suggested that disadvantaged/vulnerable families who may have access issues could be inequitably affected. Option B was felt to disproportionately affect people from lower socioeconomic brackets who could not afford to go without child care, while Option A was perceived to be a more balanced approach.	Social exclusion of these families is not the intent of the policy.
General rejection of vaccination safety and efficacy	This theme encompasses a range of comments that questioned the efficacy and effectiveness of one or more vaccinations. Doubts were expressed about herd immunity and the impact of vaccinations on disease control. Distrust for the safety of one of more vaccines was consistently raised as a reason for parents to decline vaccinations for their children. A lack of a compensation scheme was discussed, with a view that it is unreasonable for parents to assume the risks of vaccination by vaccinating their child, in order to comply with government policy.	An extensive body of scientific research demonstrates that routine Australian childhood immunisation programs are safe and highly effective in preventing serious illnesses and death.
Option A is a supportive way to increase immunisation	Under Option A, reminders will be sent to parents/guardians to offer support for these children to be caught up with any missed vaccinations. In doing so, this provides a supportive	Planned follow up activities are a major

Themes	Description	DoH feasibility assessment
rates *Health	manner to get children caught up, without excluding them from early childhood education and care services. These vaccine reminders need to help parents to overcome practical barriers to immunisation, as well as overcome vaccine hesitancy by forming trusted relationships with service providers, and providing information.	focus for the DoH.
AIR data collection issues *Health	The Australian Immunisation Register (AIR) was noted to have issues with data capture and there was a concern that immunisation records in AIR may not reflect the true vaccination status of some children. This may be due to data entry omissions or errors. It would therefore be unfair to exclude children from enrolling into child care services and kindergarten programs, based on a database with a low but appreciable error rate. Option A would address these errors in AIR whereby data cleaning activities would be undertaken by the DoH as part of the reporting and follow up of under-vaccinated children.	The current planned activities under Option A (reporting of under-vaccinated children) and broader program activities will contribute towards improving the quality of AIR data.
Onus rightly sits with Department of Health to monitor vaccination rates, and notifications, and follow up with families of under-vaccinated children *Health	Under Option A, the DoH can monitor vaccination rates, in particular, identify any geographical areas which experience lower rates. Respondents stated that the data collected under Option A will allow research and reporting on communicable disease rates in vaccinated and unvaccinated children, and assessments of vaccine safety. Option A favourably allocated responsibility on the DoH to contact and manage under-immunised children and their families, and this proposal better aligned with this mandate.	These are ongoing surveillance and monitoring activities undertaken by CDCD, and the addition of collecting reports of under-vaccinated children is a natural progression.
Option B poses a negative potential impact on the Education sector *Education	Potential impact on enrolment numbers (and the flow on effects in terms of employment and ongoing financial sustainability of classes) under Option B.	Such potential impacts will be monitored as part of evaluation activities (Section 7).

Advantages (benefits) and disadvantages (costs) of Option A

Table 6 outlines a summary of the major additional advantages and disadvantages identified by those who supported Option A and which differ from the themes identified above. As mentioned previously, a significant proportion of responses in support of this option were identical or used similar wording, and therefore there is minimal variation across many responses. As these questions were specifically designed to capture information on additional perceived advantages and disadvantages, any statements that were not related to either Option are not captured, as they do not represent either a perceived advantage or disadvantage.

Table 6 Additional perceived advantages and disadvantages of Option A

Option A
Advantages (benefits)
• Equity of access to child care services for all children, regardless of vaccination status, which is advantageous due to documented benefits of early education and care for the child. • Allows public reporting of immunisation rates at centres, giving parents a choice as to whether or not to send their children to a facility. • Avoids coercive measures. • Will increase immunisation rates – ACT and Tasmania cited as jurisdiction with a similar Option in place, who have high immunisation rates. • Less costly (cost-benefit ratio). • Less 'stress' for parents and educators. • Allows centres/schools to quickly identify, notify and exclude (if required) under-immunised children, in the event of an outbreak. • May be helpful for tracking vaccine adverse reactions. • Allows schools to have knowledge of a child's immunisation record/status if they change schools.
Disadvantages (costs)
• Increased administrative workload for clerical staff of schools. • May create a perception that vaccination is a mandatory requirement for enrolment. • The Chief Health Officer has powers to exclude children who do not pose a risk. • Economic burden on families who will need to stay home with children who are excluded during outbreaks. • Creates an opportunity for parents of under-immunised children to be marginalised. • Contacting parents identified via this reporting may be seen as intrusive or 'harassment.' • This option will not change the behaviour of vaccine-refusers. • Less effective than Option B. • Potential for misuse of medical information.

5.1.2 Basis of respondents' preference for Option B

The major themes identified by those who supported Option B are presented below in Table 7. These results summarise the reasons that Option B was preferred. Where a theme was raised by one sector only, this is also indicated by a (*) in the table under 'Theme'. Table 7 also contains the DoH feasibility assessment of themes, where appropriate.

Of those who supported Option B, 53% identified as a Parent/Guardian or Member of the Public, with a further 34% purportedly representing the Health sector. Two respondents who identified as representing the Education sector supported Option B, and raised a unique theme. Respondents representing Child Care, Government and Other did not raise any unique themes.

Table 7 Summary of themes for preference of Option B

Themes	Description	DoH feasibility assessment
Needed to achieve and maintain herd immunity	The need to maintain high immunisation coverage, and thus promote herd immunity was viewed as a major reason to support Option B. Concerns were raised that children in early education and care services were being put at risk by allowing under-immunised children to enrol. This option was viewed as a means to ensure high vaccination rates are maintained within this population.	DoH agrees.

Themes	Description	DoH feasibility assessment
Protects vulnerable children	Related to herd immunity, the protection of vulnerable children was viewed as a strength of Option B, with respondents noting that some children in these environments may be too young to be vaccinated, and thus represented a vulnerable group that requires protection. In addition, children who were immune-compromised, or had a medical contraindication for vaccination were viewed as a group who would also be protected by Option B.	DoH agrees.
Provides a strong and clear stance on vaccination	It was suggested that Option A would have minimal impacts on vaccination rates, and therefore a stronger stance was required to ensure higher vaccination rates were achieved and maintained. Supporters of Option B felt that this set a clearer expectation for parents/guardians of the social responsibility to protect other children from VPD.	DoH agrees.
Counters anti-vaccination messages	Respondents highlighted Option B was a means to counter 'misleading' information provided to parents regarding immunisation. Respondents indicated that community protection against VPD was being eroded due to parents being provided incorrect immunisation information, and that this Option represented an opportunity for the Government to demonstrate a strong commitment for the public vaccination program.	The DoH will consider developing communications which address misinformation around vaccines.
Delivers equality across socio-economic groups	Respondents felt that current financial incentives to vaccinate (under No Jab No Pay) resulted in high vaccination rates among families of lower socioeconomic status, only. It was perceived that the immunisation enrolment requirements of Option B would apply to a wider sector of the population, regardless of income.	DoH agrees.
Onus is on the parents/guardians	Supporters of Option B felt that this approach rightly places the onus on parents/guardians to ensure their children are fully vaccinated, and the policy approach is particularly helpful for those who may be intending to vaccinate, but have unintentionally fallen behind on the schedule.	DoH agrees.
Government responsibility to protect those most vulnerable to VPDs *Health	This theme encompassed views that the Government has a duty of care to its citizens to maintain high vaccination rates, particularly in the context of children with a medical contraindication, those too young to be immunised and those who are immuno-compromised.	DoH agrees.
Will lead to improved vaccination rates among those who are undecided about vaccines or those who 'haven't got round to it' *Health	Parents who are on the fence are more likely to get their child vaccinated if it is an enrolment requirement. For example, following media reports in December 2018 about the NJNP regulations (Option A) there was an observed 'rush' on childhood immunisations, with many parents under the impressions these immunisation enrolment requirements had already become a legal requirement. Many of these parents had previously either forgotten to or lacked capacity to arrange their children to be vaccinated. Respondents suggested Option B would send a strong	DoH agrees.

Themes	Description	DoH feasibility assessment
	message on the importance of vaccination.	
Supports parental responsibility to vaccinate their children *Education	A sentiment was expressed that parents/guardians whose children are attending early education and care have a responsibility to ensure their children are not posing a risk to others.	DoH agrees.
Provides a flexible of approach *Government	The available exemptions for children who are unable to be vaccinated due to medical issues, on a catch up schedule or identified as vulnerable/disadvantaged, was seen as a positive attribute of this Option.	DoH agrees.

Advantages (benefits) and disadvantages (costs) of Option B

Table 8 outlines a summary of the major additional advantages and disadvantages identified by those who supported Option B and which differ from the themes identified above.

Table 8 Additional perceived advantages and disadvantages of Option B

Option B
Advantages (benefits)
• Increasing immunisation rates and achieving herd immunity. • Gives parents confidence that their children are protected from diseases while attending these institutions. • Acts as a 'deadline' to ensure timely immunisations. • Protects siblings of children who attend child care who may be too young to be vaccinated. • Reduces costs associated with treatment of communicable disease, including hospitalisation and ongoing management due to disability. • Ensures protection of the wider community who may be vulnerable to diseases (e.g. cancer patients, pregnant women). • Promotes discussion between parents and providers regarding immunisation. • Prevents unimmunised children who pose a 'risk' or 'threat' from attending child care. • Reinforces the responsibilities of parents to not place others at harm. • Benefits of protecting children and others at risk outweigh the costs.
Disadvantages (costs)
• There will be educational disadvantages to for children who are not able to attend early education and care, and this may increase the burden on the pre-primary sector when these children start attending compulsory school • Loss of revenue for child care services. • Loss of employment to guardians of unvaccinated children with flow on economic impacts and tax revenue implications. • Creating a false sense of risk reduction related to communicable diseases among parents of vaccinated children. • Government may have legally liability to provide compensation to people who experience adverse events following vaccination. • This option will not change the behaviour of genuine vaccine-refusers. • Appropriate exemptions are must be available.

Option B
• Pro-vaccination health officials oppose this policy. • Increased workload for Health officials. • Unvaccinated children will still pose a risk when they reach school-age. • Doctors will need to face consequences for false declarations regarding exemptions. • Costs of implementation and administration for child care services. • Political polarisation / erosion of public trust.

5.1.3 Alternative regulatory options identified by respondents

One hundred and twelve submissions (20%) did not support Option A or B, and instead indicated they had an alternative option for consideration. Unique reasons for suggesting an alternative that have not been suggested previously are presented in Table 9.

Table 9 Unique reasons in support of alternative options

Theme	Description
Removal of all encumbrances for non-vaccination	Respondents suggested that there should not be any financial or other penalties for parents/guardians of children who are under-immunised. Further, it was suggested there should be no requirement to report vaccination status to the Government, nor for these families to be contacted by the DoH.
Duplication of existing data collection	It was suggested that given the AIR already comprises data of under-immunised children, this represents a duplication of existing systems, which is an inappropriate use of resources.

Those who selected an alternate option were asked for further details of their suggested alternative approach to increasing childhood immunisation rates in WA. Several respondents did not suggest a true alternative option that addresses the issue statement, but rather provided reasons they were opposed to Options A and B, or provided an unrelated answer. Table 10 lists and describes the main alternative options suggested by these respondents, with a feasibility assessment of each alternative option provided by the DoH. None of the alternative options suggested were deemed to be feasible and in need of further investigation, except for the matter of a national vaccine injury compensation scheme.

Table 10 Suggested alternative options and DoH feasibility assessment

No.	Alternative options	DoH feasibility assessment
1	Option A, but with a safeguard to never exclude unvaccinated children except in circumstances of outbreaks.	The DoH would only take action to exclude under-vaccinated children from attending child care, kindergarten or school, in the instance where doing so would provide protection to these children. This alternative option represents Option A. **Not a feasible alternative option.**
2	Expansion of the criteria for medical exemptions.	Circumstances for medical exemptions are prescribed by the Commonwealth's National Immunisation Program, and are therefore not a decision of the state. However, under Option B, Proposal 2, and in the event of a special circumstance, the CHO will have the discretionary authority to issue a certificate for a child who might otherwise meet the immunisation requirements, but for

No.	Alternative options	DoH feasibility assessment
		that circumstance the child's immunisation would be up to date. A special circumstance could be medical related. This alternative option represents a provision under Option B. **Not a feasible alternative option.**
3	Allow exemptions for vaccine refusal based on personal, philosophical or religious grounds.	This option does not promote the shared responsibility of increasing immunisation rates. Furthermore, this option does not address low immunisation rates in WA. **Not a feasible alternative option.**
4	Allow alternative immunisations.	As there is no evidence in the medical literature for either the efficacy or safety of homeophrophylaxis, the Commonwealth cannot consider its inclusion on the NIP. **Not a feasible alternative option.**
5	Allow for specific schools to require attendees to be fully immunised and others that do not.	Through the creation of heterogeneous regulation, this option would create complex administrative activities for the DoH. This option does not address low immunisation rates in WA. **Not a feasible alternative option.**
6	Remove any financial penalties or regulation by DoH for under-immunised children.	The Child Care Subsidy program is a Commonwealth program and is therefore out of scope of any state policy, while the DoH has a responsibility to ensure high immunisation rates are achieved through the introduction of immunisation regulation. **Not a feasible alternative option.**
7	Create a vaccine injury compensation scheme to pay for the costs of care and loss of potential future earnings, in the event of an adverse reaction to a vaccine.	This option does not address how to improve immunisation rates in WA but it raises the need for a no-fault vaccine-injury compensation program in Australia. No-fault vaccine-injury compensation programs are based on the premise that adverse events attributable to vaccination can occur as a rare, individualised reaction to a vaccine that is otherwise safe for the vast majority of the population. As the benefits of immunisation are critical for protecting the health of our population, there is a strong case for compensation for the small, but predictable, number of individuals who may be injured as a consequence of immunisation. The ethical argument for establishing no-fault vaccine injury compensation programs is based on the concept that as government augments mechanisms to ensure parents vaccinate their children, there is a reciprocal strengthening of the government's obligation to compensate for the rare instance when injuries are directly attributable vaccination. Advocates for no-fault vaccine-injury compensation programs maintain that a person who is injured while helping to protect the community - by contributing to herd immunity - should not bear the consequences of injury alone, and that the community owes a duty of care to an individual injured by a vaccine, offered and accepted in good faith. No-fault vaccine-injury compensation programs improve consumer and provider confidence in vaccination programs. **Not a feasible alternative option for increasing immunisation rates in WA but an issue for Commonwealth consideration.**

5.1.4 Preferred Option

Following a request from former Prime Minister Malcolm Turnbull in March 2017 for a nationally consistent approach to immunisation enrolment requirements, the WA Government responded in support of legislative amendments to enact this policy, the purpose of which is to increase immunisation rates. Option B will best address this request by introducing immunisation enrolment requirements for non-compulsory early education and care, through implementation of the Bill.

Additional reasons why Option B is the recommended approach for increasing childhood immunisation rates in WA are outlined below:

Aligns with the request from the Prime Minister and direction of the WA Premier

In March 2017, the Prime Minister requested that all jurisdictions implement No Jab No Play type policies, to stop under-vaccinated children from attending child care services and pre-schools, noting that 'pre-schools' in New South Wales refers to the years prior to compulsory schooling i.e. kindergarten programs in WA. Although COAG developed options for this national approach, there was no agreement on how to progress the policy further.

Subsequent to this request, in September 2017 the WA Premier directed that a NJNP immunisation policy with similar underlying policy objectives to that already introduced in other states be implemented. The NJNP policy is currently on the Ministerial Legislative Agenda under the *Department of Health Corporate Plan 2018-19*[9] (refer to section 3.2.4 within the Corporate Plan). Legislative amendments would need to be expedited to ensure implementation in time for 2020 kindergarten enrolments, which occurs in July 2019.

Demonstrates the high importance placed by the State Government on improving childhood immunisation rates

Prior to 2019, only minor immunisation regulation existed in the *School Education Act 1999,* however, the government has recognised the valuable opportunity of merging education and health regulation where possible, as a means to improve health outcomes for children. In addition to the new immunisation regulations, the proposed legislative amendments reinforce the government's message that immunisation is highly important for the community's wellbeing and as such, is a shared responsibility of the whole community to achieve and maintain higher immunisation rates (herd immunity) in order to better protect those who can't be vaccinated. This viewpoint is consistent with respondents who supported Option B.

Strengthen newly introduced immunisation regulations

The proposed legislative changes to the *Public Health Act 2016* will strengthen recent amendments to the *Public Health Regulations 2017* and the *School Education Regulations 2000.*

Recent amendments to the *Public Health Regulations 2017* introduced new requirements for the collection and reporting of immunisation information by child care services, community kindergartens and schools. From 1 January 2019, regulations:

i. require the responsible person for a child enrolling into a child care service, community kindergarten or school, is to give to the person in charge of the child care service,

[9] *Department of Health Corporate Plan 2018-19,* Department of Health, WA. Available at: https://doh-healthpoint.hdwa.health.wa.gov.au/workingatdoh/About-us/Documents/Corporate-plan-2018-19-v2.pdf

community kindergarten or school the immunisation status of their child as recorded on the child's current AIR Immunisation History Statement (Regulation 10B); and

ii. make provision for the CHO to direct the person in charge of a child care service, community kindergarten or school to share this information with the Department by giving to the CHO a report, in an approved form, on the immunisation status of any child or children enrolled (Regulation 10C).

To support these changes, complementary amendments were also made to the *School Education Regulations 2000* to require schools to keep the vaccination status of an enrolee on the school's enrolment register, while complementary amendments to the *Child Care Services (Child Care) Regulations 2006* (WA) are currently planned to come at a later stage.

The proposed NJNP *Public Health Act 2016* amendments will act to readily complement these regulations and further strengthen immunisation requirements in early education and care. NJNP legislation is largely contingent on existing Regulation 10B, whereby parents/guardians must provide their child's AIR Immunisation History Statement upon enrolment.

To provide consistency with the Act, minor consequential amendments are also required to the *Public Health Regulations 2017*, *School Education Regulations 2000* and *Child Care Services (Child Care) Regulations 2006*, and at a later stage in 2019, the *Education and Care Services National Regulations 2012*.

Will likely increase immunisation rates among children enrolled in child care services and kindergarten programs

Since the implementation of Victoria's NJNP legislation which was implemented around the same time as the Commonwealth's No Jab No Pay in early 2016, an increase in immunisation rates among children under five years has been experienced, as shown by the proportion of children fully vaccinated, by quarter and age group in Figure 5.

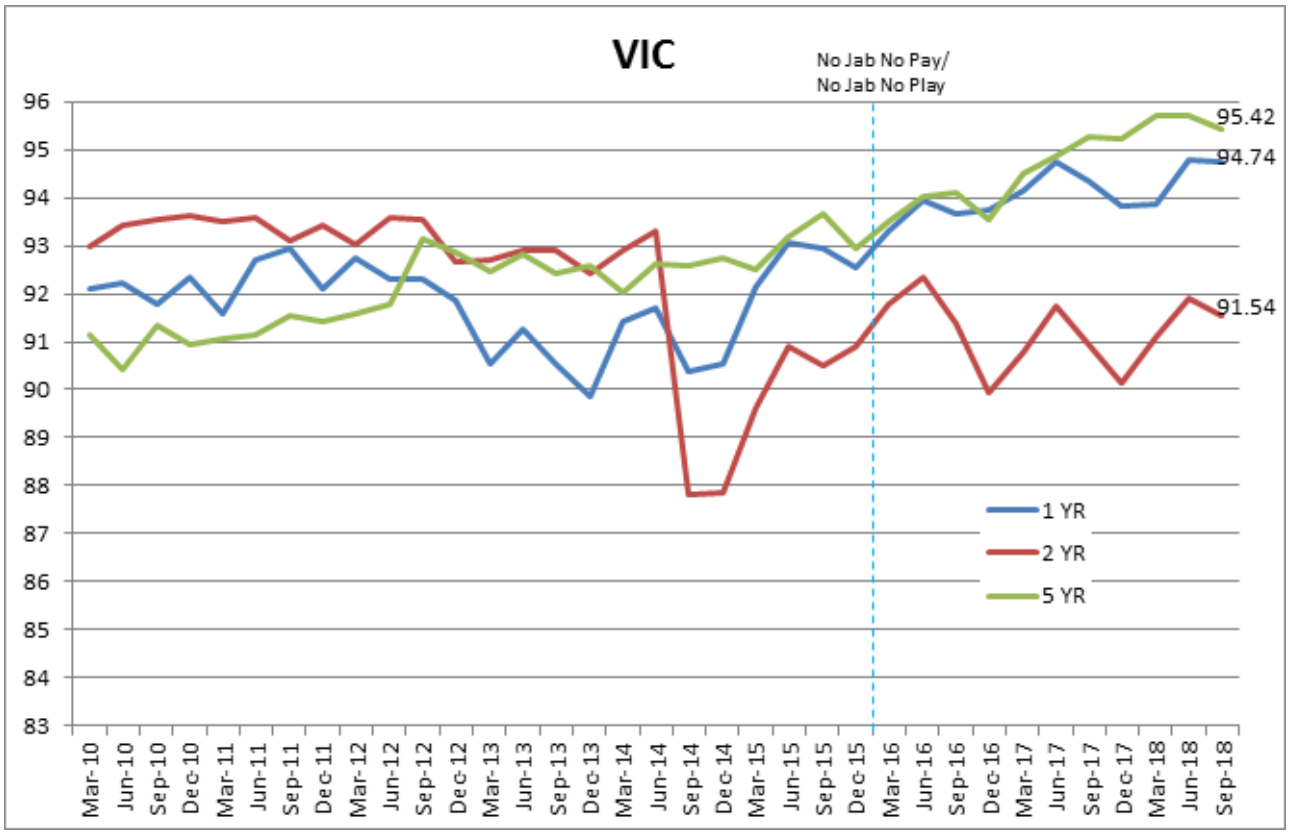

Figure 5 Immunisation rates for children aged one, two and five years in Victoria, March 2010 – September 2018[10]

WA would expect to see similar improvements in immunisation rates among this age group, should NJNP legislation be implemented. Similarly to what has occurred in Victoria, NJNP legislation in WA is expected to have a lower impact on immunisation rates for younger children, as a smaller proportion of children access child care services as compared to kindergarten programs.

Is supported by the Australian Medical Association of WA (AMAWA)

The AMAWA suggests that the NJNP policy will likely improve vaccination rates and send a message to families that it is a shared responsibility to contribute to the eradication of serious VPDs.[11] The AMAWA believes that for the most part, families of under-vaccinated children do not object to vaccination, but are more likely to be too busy, unaware of the vital importance of vaccination, or may simply not have gotten around to keeping on top of their children's' vaccination schedules. It is anticipated that this policy will provide the motivation for these families to get their children's immunisation status 'up to date.' This viewpoint is also consistent with respondents who supported Option B.

Helps protect those in the community who are most at risk of VPDs

Individuals who are not fully immunised are at risk of acquiring VPDs and transmitting them to others individuals s. Achieving a 95% immunisation rate (called 'herd immunity') is important to protect members of our community that are too young to be vaccinated and those who are unable to be vaccinated for medical reasons, including pregnant women, children with immune

[10] Source: Australian Immunisation Register Quarterly Data
[11] *Do not underestimate influenza: AMA (WA);* Australian Medical Association of WA, October 2017; Available at: https://www.amawa.com.au/not-underestimate-influenza-ama-wa/

disorders and some cancer patients. This viewpoint is consistent with respondents who supported Option B.

Minimises administrative requirements for persons in charge of child care services and kindergarten programs

Additional administrative requirements required to be undertaken by persons in charge of child care services and kindergartens to ensure compliance with the proposed legislation, is anticipated to be minimal. Persons in charge are already collecting every child's AIR Immunisation History Statement upon their enrolment. The legislation will only require persons in charge to check the child's immunisation status on this statement, and where required, determine if a child qualifies for an exemption category through a discussion with the parents/guardians.

Provides exemptions that will minimise negative impacts

The NJNP policy acknowledges the importance of access to early education in accordance with the *2018-2019 National Partnership Agreement on Universal Access to Early Childhood Education*. It is particularly important that vulnerable and disadvantaged children are supported to attend early education and care services. For this reason, it is proposed that these children will be exempt from the requirement to be fully vaccinated for age as a condition of enrolment in child care services and kindergartens. Exemptions will also be made for children who have a medical contraindication to vaccination as well as children on an approved immunisation catch up schedule. Both exemptions would require approval by an eligible health professional and recording on the Australian Immunisation Register.

The provision of exemptions will ensure there is minimal market impact and that this policy does not create further health and social problems. For example, by providing exemptions for children who are disadvantaged and vulnerable, this ensures that these children do not experience further disadvantage that could arise from them being under-vaccinated and therefore excluded from enrolling into child care services and kindergarten programs. The majority of respondents who support Option B supported these children to be fully vaccinated, rather than exempt, but this reflected a misunderstanding of Proposal 3, as a major focus of this policy is for the DoH to follow up with the families of these exempt children, to ensure they are offered support to catch up on missed vaccinations.

Provides for unforeseen circumstances

The NJNP policy acknowledges that an unforeseen circumstance may apply to a child and but for that circumstance, the child's immunisation status would be up to date. The proposed legislation provides a mechanism for the Department of Health's Chief Health Officer to make an assessment, and if the Chief Health Officer is satisfied that a special circumstance is applicable to the child, and that the Chief Health Officer is satisfied that, but for that circumstance, the child's immunisation status would be up to date, the Chief Health Officer may issue an immunisation certificate that can be used for enrolment purposes. Assessments in this regard would be made on a case-by-case basis and the process would be managed by the Department of Health.

5.2 Proposals: key observations and findings

Under Option B, there are seven Proposals which constitute the key components of the Bill, and these were outlined in detail in the CRIS. An impact analysis of Proposals 1 - 5 was conducted, through an analysis of the qualitative data collected during consultation. Proposals 6 and 7 referred to minor technical or consequential amendments relating to the preceding Proposals,

and therefore did not require stakeholder comment. This section presents the key themes, issues and concerns raised by respondents under Proposals 1 – 5, and the Closing Questions.

This impact analysis was largely focussed on respondents who were supported of Option B, as it was deemed that respondents who supported Option A or an alternative option, could not necessarily provide a detailed analysis of the Proposals under Option B. The submissions from all respondents (regardless of their support for either option) were subsequently reviewed, to include any additional suggested alternatives, and capture any perceived advantages and disadvantages of individual proposals.

Advantages and disadvantages already identified in Section 5.1 are not repeated in this section, with the results below applying to Proposal-specific comments that are unique from other general commentary on the Options. The results for each Proposal are discussed in further detail below.

5.2.1 Proposal 1

Description

Require, with rare exception, a child's immunisation status to be 'up to date' as a condition of enrolment into child care services and kindergarten programs

Objective

To improve immunisation coverage among children in child care services, community kindergartens and schools, before the compulsory education period, by restricting enrolment to children who are fully vaccinated for age.

Impact analysis

The majority (97%) of those who indicated support for Option B responded that they agreed that, with rare exception, a child's immunisation status is required to be 'up to date' as a condition of enrolment into child care services and kindergarten programs. Those that supported Option B but indicated they did not support this element did not offer any alternative suggestions. From the remaining submissions (i.e. respondents who supported Option A), the following alternatives to being fully immunised as a condition of enrolment were identified, of which none were deemed feasible:

Proposal 1: alternatives to being fully immunised as a condition of enrolment	DoH feasibility assessment
Accept alternate forms of medicine as immunisation	Homeoprophylaxis is not considered a legitimate vaccine under the NIP, as there is no scientific evidence to prove the safety or efficacy of these alternatives. **Not a feasible alternative option.**
Allow parents to vaccinate on an alternative schedule	Under certain circumstances, children can be put on an approved catch up schedule. Already exists. **Not a feasible alternative option.**
Provide information and education to parents at the time of enrolment	Both Department of Education and Health provide information to parents/guardians at enrolment times.

Proposal 1: alternatives to being fully immunised as a condition of enrolment	DoH feasibility assessment
	Not a feasible alternative option.
Remove certain vaccines from the requirements	The Commonwealth sets the NIP schedule. **Not a feasible alternative option.**
Test children's titers, and exclude those who do not demonstrate immunity	Cost impact would be large; vaccination a cheaper option. **Not a feasible alternative option.**
Exclude under-immunised children during outbreaks	This is currently provided for under current regulations. **Not a feasible alternative option.**
Fine or tax parents who do not meet immunisation requirements	As vaccination is a choice, this is unreasonable. **Not a feasible alternative option.**
Allowing some centres to operate who exclusively enrol under-immunised children	From a public health perspective, allowing for pockets of under-immunised children to congregate increases their risks of illness from a VPD. **Not a feasible alternative option.**

The majority (78%) of respondents who supported Option B also agreed with prescribing an offence with penalty $10,000 for persons in charge of child care services and kindergarten programs, who fail to comply with the proposed immunisation enrolment requirement. For those who did not agree or who were unsure, the following alternatives to penalty for non-compliance were identified, of which only the last was deemed feasible and is noted for implementation:

Proposal 1: alternatives to a penalty for non-compliance	DoH feasibility assessment
Revoke licences of child care services with repeat breaches	It would never be the intention of the DoH to obstruct a small business in such a manner. **Not a feasible alternative option.**
Higher/lower penalties than the one proposed	The rate was determined on consideration of other existing penalties in the Public Health Act. **Not a feasible alternative option.**
The child care/early education parent company (or chain) should face the penalty	This would be a matter between the service and their parent company. **Not a feasible alternative option.**
Publication of the details of child care centres that have enrolled under-immunised children	Doing so would potentially assist those families who refuse to vaccinate. **Not a feasible alternative option.**
Fines for parents rather than or instead of, providers	Fines for providers will ensure compliance to

Proposal 1: alternatives to a penalty for non-compliance	DoH feasibility assessment
	enrolment requirements. **Not a feasible alternative option.**
Incremental fines, rather than a one-off large sum, including warnings as a first step	**For consideration.**

Further, the majority (67%) of respondents who supported Option B agreed that children on an approved catch-up schedule should be permitted to enrol. For those who did not agree or who were unsure, the following concerns were raised, of which none were deemed consequential:

Proposal 1: concern for allowing children on a catch up schedule to enrol	DoH feasibility assessment
Should limit the catch-up period to a pre-defined timeframe	Catch up schedules recorded in AIR are allocated only once per person, and allow a 6 month period to be caught up. **Not feasible.**
Allowing this decision to be at the discretion of the service	May be confusing for parents to find a child care service or kindergarten who will accept their child's enrolment. **Not feasible.**
Additional requirements for follow up, to ensure the catch-up schedule is being adhered to, with suspension of enrolment if this does not occur	Would impose an additional administrative requirement for persons in charge to follow up. Additionally, the power of the proposed legislation is at the point of enrolment and there would be no mechanism to compel the de-enrolment of a child. **Not feasible.**

The table below outlines the suggestions for additional resources that the DoH could provide to support those impacted by the proposed changes to immunisation enrolment requirements. These have been grouped under common thematic headings, with details provided for each. These suggestions provide valuable insight on the information and guidance materials required by early education and care providers and parents, and will be considered in the context of the Communications Plan (Section 6.2).

Proposal 1: suggested additional support and resources for implementation
For early education and care providers
• Online resources of standardised factsheets and forms that can be downloaded and printed • Guidance on the reading and understanding of AIR immunisation history statements (various formats suggested) • Provision of a referral pathway for aggressive parents who wish to enrol under-immunised children to prevent frontline staff from confrontations • Information on the benefits of immunisation including immunisation for staff members
For parents/guardians

Proposal 1: suggested additional support and resources for implementation
• Educational resources for parents/guardians regarding the requirement for childhood immunisations, in multiple languages • Information for parents/guardians on how to access immunisation records online • Educational materials on the importance of immunisation • Easy access to immunisation services close to child cares, community kindergartens and schools • Provision of on-site vaccination clinics at child cares, community kindergartens and schools • Access to immunisation providers for advice and support • Ensuring all immunisation appointments at GPs are free • The introduction of a vaccine adverse event compensation scheme

The advantages and disadvantages of the proposed legislation for Proposal 1 were listed in the CRIS, with 86% of respondents in agreement with these. Of those who disagreed; statements around impacts of parents unable to return to work, marginalisation, and the detrimental effects of being denied access to child care (previously captured in Table 5) were repeated. In addition, it was suggested that the burden on education is overstated as they already check immunisation status as part of enrolment.

Additional benefits of Proposal 1 were that it would 'save lives' and that the 'cost-benefit ratio' with this proposal suggested to offer more benefits in reducing costs associated with the treatment of communicable disease than it would cost to implement. Additional disadvantages of Proposal 1 that were identified by respondents are presented below, with two potential impacts to be monitored:

Proposal 1: additional disadvantages	DoH assessment
Excluded under-vaccinated children are more likely to form enclaves outside of mainstream care, increasing the risk of outbreaks in these pockets and spread to the community.	This is not the intent of the policy but will be monitored as part of the evaluation (Section 7.2). **To be monitored**
The inability to confirm enrolment lists; this is usually done months ahead, but will not be able to be confirmed until immunisation checks have occurred much closer to commencement.	Adverse impacts to the enrolment process will be monitored as part of the evaluation and in collaboration with the DoE (Section 7.2). **To be monitored**
Increased demand for home-schooling	Proposed legislation does not impact compulsory schooling.
Children being unable to enter private schooling, as enrolment requires kindergarten attendance	These are choices of parents/guardians.
Grandparents needing to help with child care	This is an alternative to enrolling into early education and care.

5.2.2 Proposal 2

Description

In specified circumstances, allow for documentation other than a child's AIR Immunisation History Statement to be used to satisfy immunisation requirements for enrolment into child care services and kindergarten programs.

Description
Objective
Provide flexibility to address situations where a child's AIR Immunisation History Statement cannot be used as evidence of their immunisation status, when determining their eligibility for enrolment into a child care service or kindergarten program.

Impact analysis

The majority (82%) of respondents who supported Option B agreed that the CHO should have the flexibility to issue an alternative immunisation certificate in the event the child is experiencing an atypical or unforeseen circumstance, but for which they would otherwise be fully vaccinated for age. Those who disagreed expressed that it should be a parental responsibility to ensure a child's immunisations are up to date, and that an alternative certificate was open to potential fraud.

Additional special circumstances a child may experience, but for which they would otherwise be fully vaccinated for age, that might warrant issuing an alternative immunisation certificate that were identified by respondents below. Several respondents identified circumstances already proposed under Proposal 2, and other suggestions were not deemed feasible by the DoH for various reasons, also presented in the table.

Additional special circumstances	DoH feasibility assessment
A range of medical conditions (allergies, illness, phobias, genetics)	Under Proposal 2, the CHO will have the discretion to exempt any medical conditions beyond those prescribed by the NIP, following investigation on a case-by-case basis. **Already captured.**
Children with a previous vaccine injury	Under Proposal 2, the CHO will have the discretion to exempt any medical conditions beyond those prescribed by the NIP, following investigation on a case-by-case basis. **Already captured.**
Siblings/relatives of children who have had a reaction, and therefore may be at increased risk of a reaction	Under Proposal 2, the CHO will have the discretion to exempt any medical conditions beyond those prescribed by the NIP, following investigation on a case-by-case basis. **Already captured.**
Children who have naturally acquired immunity for an infectious disease (including those for which there is no available titre test)	Naturally acquired immunity must be scientifically proven through a titre test. **Does not warrant a special CHO certificate.**

Additional special circumstances	DoH feasibility assessment
Religious/personal beliefs of parents/guardians as outlined in Table 5	This option does not promote the shared responsibility of increasing immunisation rates. **Does not warrant a special CHO certificate.**
Children immigrating from a country with a different immunisation schedule	Proposal 2 captures these children. **Already captured.**
Children taken into protective care	These children are exempt under Proposal 3, whereby vulnerable and/or disadvantaged children are exempt from immunisation enrolment requirements. **Does not warrant a special CHO certificate.**
Children who have had alternate immunisations e.g. homeopathy	Homeoprophylaxis is not considered a legitimate vaccine under the NIP, as there is no scientific evidence to prove the safety or efficacy of these alternatives. **Does not warrant a special CHO certificate.**
Fully vaccinated children whose AIR record is incorrect	This is an administrative issue, whereby the child's AIR record needs to be updated. **Does not warrant a special CHO certificate.**
Children who are immunised, but missing a booster	This is considered an outstanding vaccination. **Does not warrant a special CHO certificate.**

In addition, 86% agreed with the listed advantages and disadvantages of this proposal as listed in the CRIS. Notably, it was suggested that for children in these special circumstances, a grace period should be provided, rather than an exemption, however the DoH does not support the use of a grace period as it would likely add to administrative requirements for persons in charge. Rather it is proposed that for children in special circumstance, an indefinite or definite time period is allocated by the CHO, on a case-by-case basis.

Overall, the results and impact analysis for this Proposal did not identify any additional special circumstances which would need to be prescribed in the proposed regulations. However, impact analysis identified the need for the DoH to provide information and guidance material that will support parents/guardians to understand if their child is eligible for a special circumstance, and to support them through the application process. Support will be provided through information and guidance materials, as part of the Communications Plan (Section 6.2).

5.2.3 Proposal 3

Description

Prescribe the categories of children for which exemptions to immunisation requirements for enrolment into child

Description

care services and kindergarten programs apply.

Objective

This proposed immunisation policy acknowledges the importance of access to early education as communicated in the *2018-2019 National Partnership Agreement on Universal Access to Early Childhood Education.*[12] Access to early education services is particularly important for vulnerable and disadvantaged children, whose participation in early education programs should be encouraged and facilitated. It is proposed that under WA's No Jab No Play policy children who are vulnerable and disadvantaged will be exempt from the requirement to be fully vaccinated for age, as a condition of enrolment into child care services and kindergarten programs.

Impact analysis

A minority (37%) of respondents who supported Option B supported the provision of exemptions to the immunisation enrolment requirements for vulnerable and/or disadvantaged children, while 10% were unsure, 49% disagreed, and 4% declined to answer. Reasons for disagreeing or being unsure fell under the following categories, for which the concern around the potential misuse of exemptions will be monitored:

Proposal 3: concerns for provision of exemptions	DoH assessment
There is no valid reason that children enrolled in child care can't be 'up to date.'	DoH acknowledges that being under-immunised is multi-faceted.
*The focus should be on catching these vulnerable children up as a priority, rather than providing exemptions.	This is the intent of the DoH.
*These children still pose a risk if they are under-immunised.	It is the intent of the DoH to support these children to become fully immunised.
There are no means to exclude a child who is enrolled and does not catch up, once the grace period expires.	The power of the proposed legislation is at the point of enrolment and there would be no mechanism to compel the de-enrolment of a child.
Vulnerable/disadvantaged children migrating from countries with higher rates of communicable disease pose an increased risk.	It is the intent of the DoH to support these children to become fully immunised.
*This would only be acceptable if these children were placed on a catch-up schedule.	It is the intent of the DoH to support these children to become fully immunised.
Such exemptions are open to abuse, and could be granted in situations they are not warranted.	The use of the exemptions will be monitored (Section 7.2). **To be monitored**

Some reasons above (*) demonstrate that respondents did not understand that the full intention of the DoH is to ensure these exempt children are in fact supported to be fully immunised. The DoH wants to recognise the importance of access to early education and care for these

[12] *2018-2019 National Partnership on Universal Access to Early Education*, Department of Education and Training, Commonwealth Government. Available at: https://www.education.gov.au/national-partnership-agreements

vulnerable and disadvantaged children, by not requiring them to meet immunisation enrolment requirements. However, a major focus of the NJNP policy is to have these children reported to the DoH as under-immunised, with the plan to follow up with these families to ensure improved access to immunisation services.

A minority (36%) of respondents who supported Option B also agreed that the proposed categories of vulnerable and disadvantaged children which should be exempt from the immunisation enrolment requirements were appropriate, while 11% were unsure, 48% disagreed, and 6% declined to answer. Those who disagreed or who were unsure cited reasons that fell under the following categories, noting that any responses captured above are not duplicated here, and that no impacts to the Bill were identified:

Proposal 3: concerns for appropriateness of exemption categories	DoH assessment
Children in state care should be vaccinated, and therefore should not require exemptions.	Under state care, these children are vaccinated.
Several categories should be removed, as they should be a priority for catch up rather than being exempted.	It is the intent of the DoH to support these children to become fully immunised.
All ATSI children should not be included, without taking into consideration individual circumstances.	The policy acknowledges the national Closing the Gap strategy.
Low income should not be grounds for an exemption, as immunisations are free.	Low income families may also experience accessibility disadvantage e.g. transport.
Parent or guardian with a government income support payment seems too broad.	Four categories of income support are prescribed.
Intercountry adoption should be a prescribed category.	These children should be supported to become fully vaccinated on a catch up schedule managed by an immunisation provider.
Premature children should be considered vulnerable.	These children are not deemed vulnerable/disadvantaged.
There should be no exemptions outside of medical exemptions.	The policy acknowledges there are some children which may experience barriers to being fully immunised, and that it is important for such children to access early education and care.
Any child flagged to be at risk by any community or social services professionals or that is eligible for or has received the Special Child Care Benefit should be added.	These children are already captured.

A total of 43% of respondents who supported Option B agreed with the proposed process to determine if a child qualifies for an exemption category, with 32% disagreeing, and a significant proportion unsure (18%) or declining to answer. Suggested alternatives are outlined below, with the suggestion of wider discretionary powers for child care services to be taken into consideration post-evaluation:

Proposal 3: alternatives to exemption process	DoH assessment
Assessment for eligibility of an exemption should be	This is not practical and the DoH proposes it is a

Proposal 3: alternatives to exemption process	DoH assessment
performed by a medical professional (GP, Immunisation Clinic), Centrelink or AIR, as child care services are not in a position to accurately make these assessments	simple and clear process to follow, for which guidance material will be provided.
Provision of supporting evidence e.g. letter from the Department of Communities	Self-reporting will be largely used to identify as vulnerable/disadvantaged, noting that monitoring of the use of exemptions will be undertaken to mitigate abuse.
Reviewing the social determinants of health during assessment	Not practical.
Wider discretionary powers for child care services, with legal protections	Following evaluation of the policy implementation, consultation with the sector could be undertaken to identify further areas of reform in relation to immunisation. **For consideration**
Allowing a grace period, but no long-term exemptions.	Not feasible as a grace period would likely add to administrative requirements for persons in charge

While 63% of respondents who supported Option B agreed with the listed advantages and disadvantages of this proposal in the CRIS, some respondents identified additional disadvantages, of which two require consideration during implementation:

Proposal 3: additional disadvantages of exemption process	DoH assessment
Underestimated cost impacts on Education sector	Impacts on the Education sector to be monitored as part of monitoring activities (Section 7.2). **For consideration**
Potential for not identifying children who qualify for an exemption category, and their subsequent incorrect exclusion.	DoH to work with DoE to identify any occurrence of this. **For consideration**
Parents who are choosing not to vaccinate for reasons of personal choice attempting to exploit these exemptions.	The use of the exemptions will be monitored (Section 7.2).

Within the proposed process for assigning exemptions, the latter disadvantage will be monitored by the DoH and therefore any misuse will be readily identifiable.

5.2.4 Proposal 4

Description

Enable updated information about a child's immunisation status to be provided at times other than enrolment.

Objective

To enable updated information regarding an enrolled child's immunisation status to be provided to the person in

Description
charge of a child care service, community kindergarten or school at times other than enrolment.

Impact analysis

The majority (75%) of respondents who supported Option B supported the provision that the DoH could prescribe another time or times at which a child's updated immunisation certificate needs to be provided by the parent/guardian to the person in charge of the child care service, community kindergarten or school, and a further 78% agreed with the listed advantages and disadvantages of this proposal.

For those who did not support this Proposal, the following concerns were raised:

Proposal 4: concerns for prescribing additional times to provide AIR Statement	DoH assessment
People may not fulfil the requirements for future vaccinations as prescribed after this requirement has been met.	As an additional check point, the DoH currently plans to target pre-primary children, to ensure childhood schedule is met, which is a major focus for the DoH.
Parents are already given adequate reminders, and this is not required.	As the only additional check point, the DoH currently plans to target pre-primary children.
Perceived potential misuse in future to suspend or cancel the enrolment of under-immunised children.	The power of the proposed legislation is at the point of enrolment and there would be no mechanism to compel the de-enrolment of a child.

Alternative suggestions centred around obtaining this information directly from AIR or immunisation providers, rather than following up through child care services, community kindergartens and schools. While this approach is currently available to the DoH, it is not viable due to the lack of contact information of parents/guardians (i.e. phone number, email) that exists in AIR.

Overall, the results and impact analysis for this Proposal highlighted a need for the DoH to provide supporting information and guidance material which clarifies the reporting requirements and the reasons for these, as a means to assist persons in charge to comply with the proposed regulation. This support will be provided through information and guidance materials, as part of the Communications Plan (Section 6.2).

5.2.5 Proposal 5

Description
Offences for which penalties may be issued.

Objective
To provide for penalties for non-compliance with the legislation.

Impact analysis

The majority (86%) of those who supported Option B supported the offences for non-compliance outlined under Proposal 5, and 87% agreed with the listed advantages and disadvantages of this Proposal. Those who disagreed described the penalties as 'too harsh', and that they placed an unfair burden of responsibility on persons in charge of child care services. It was further suggested that penalties may be passed on to parents/guardians via increases in enrolment fees, but this would not be a feasible approach. Additionally, one respondent felt this should solely be the responsibility of the parent/guardian and that child care services and schools should not be penalised.

An additional benefit of the proposed penalties was that they created consequences for non-compliance, without which it was thought that some services may choose to ignore the requirements.

Overall, the results and impact analysis for this Proposal highlighted a need for the DoH to support persons in charge of child care services and kindergarten programs to comply with the proposed legislation. This support will be provided through information and guidance materials, as part of the Communications Plan (Section 6.2).

5.2.6 Closing Questions

The final Guiding Questions asked respondents to i) identify additional regulatory proposals to be considered or any other way of achieving higher immunisation rates, and ii) provide final comment on the Bill. The results of these questions were grouped first by respondents who supported either Option A or an alternative option, and those who supported Option B, and then responses were grouped into themes. Themes which have not been raised previously are listed below.

Additional regulatory proposals to be considered

Suggestions from supporters of Option A and alternative option	DoH assessment
WA already has a number of strategies in place for increasing vaccination rates	The DoH must continually maintain and improve immunisation rates through various strategies.
Further regulation to promote vaccination would not be justified.	Prior to 2019, immunisation regulation was scant. However given other strategies are not achieving aspirational immunisation rates, the government is turning to regulation.
Need for increased transparency of involvement with pharmaceutical companies and government	There is only a commercial relationship between the government and pharmaceutical.
GPs should have a no appointment approach to immunisations.	This is contingent on the private practice.
Department of Health's website difficult to navigate and find information	**For consideration**
Non-government schools should be able to choose whether to comply	Would not be practical to apply differential regulations to different schools.
Public health campaign based on evidence based science from independent researchers	Existing information, resources and recommendations are based on scientific evidence.

Suggestions from supporters of Option A and alternative option	DoH assessment
Suggestions from supporters of Option B	DoH assessment
Increase number of immunisation clinics e.g. mobile vaccination providers at child cares and kindergartens.	As part of ongoing activities, the DoH is continually investigating other means of accessing immunisation services e.g. pharmacies.
More emphasis on immunisation services through Child Health Community Centres.	Although these services are available, the majority of parents/guardians are choosing to take their children to GPs for immunisation services.
Migrants and refugees should be fully immunised upon entry to Australia	The existing Humanitarian Entrant Health Service provides for this.
Apply the same immunisation enrolment requirements to playgroups, mothers groups, primary school and secondary school.	This policy cannot impact compulsory school years, while unregulated playgroups cannot be regulated under this requirement.

Final comments on the Bill

Final comments from supporters of Option A and alternative option	DoH assessment
Individuals should support building their own immunity through lifestyle	DoH agrees with keeping healthy through lifestyle, but also acknowledges that some communicable diseases can be life threatening and are best avoided for many reasons.
Families will lose faith in the health and political systems, and be forced into an underground unregulated environment	This is not the intent of the policy and will be monitored.
This policy embodies discrimination and oppression	This is not the intent of the policy.
To exclude children from an early education is not fair and will cost the government more later on	This policy has been developed in collaboration with the DoE, DoC and DoH.
The policy does not acknowledge children who have had sever adverse reactions.	Medical exemptions are provided.
Women will be forced to leave the workforce to care for their children.	The policy does not intend to adversely affect women; alternative care arrangements are a choice of parents/guardians.
Double-blind placebo controlled studies required	An extensive body of scientific research demonstrates that routine Australian childhood immunisation programs are safe and highly effective in preventing serious illnesses and death within the community.

Final comments from supporters of Option B	DoH assessment
Families who don't vaccinate often home-school; government needs to address vaccination rates of home-school children	This strategy would not be practical to implement.
Evaluation of the policy is important	The DoH has developed an evaluation plan (Section 7).
This policy is about saving lives	DoH agrees

5.3 Summary

Proposals 1, 2, 4 and 5 received majority support for all elements from those who indicated they were in favour of Option B. Proposal 3, which relates to exemptions for vulnerable children, was the most polarising proposal, with a significant proportion disagreeing or being unsure about elements of this proposal. The major concerns stem from the sentiment that the focus should be on catching up disadvantaged children, rather than providing exemptions. The categories were also felt by many to be too broad, and potentially open for abuse. Further, the methods for providing exemptions were not supported by a significant proportion of respondents.

Importantly, the impact analysis identified a number of matters which will provide valuable guidance during implementation of the proposed Bill, to ensure its effective implementation. These matters for consideration by the DoH represent costs to implementation, and include:

Communications

- Develop communications which address misinformation around vaccine safety and efficacy.
- Develop resources to clarify the penalties and legal requirements for persons in charge.
- Develop resources to clarify the reporting requirements of under-vaccinated children and reasons for this activity.
- Develop guidance material that will support parents/guardians to understand if their child is eligible for a special circumstance, and to support them through the application process.
- Develop additional resources to support parents/guardians, and persons in charge of early education and care services.
- Ensure immunisation webpages are easier to navigate and more user-friendly

Enforcement

- Provide for incremental fines, rather than a one-off large sum, including warnings as a first step.

Evaluation

- Monitor potential impact on enrolment numbers on early education and care, and other flow on impacts
- Monitor the use of any unregulated early education and care services which accept enrolment of under-immunised children
- Monitor any adverse impacts to the enrolment process, in collaboration with the DoE.
- Monitor the use of exemptions for children identified as vulnerable / disadvantaged.

- Monitor any instances whereby a child is not identified as qualifying for an exemption category, but should, and is subsequently incorrectly excluded from early education and care.

Policy

- The need for a national vaccine injury compensation scheme was previously raised by the State Government at the COAG Health Council in 2014, but without commitment from COAG for further consideration; CDCD to keep this initiative on the agenda and to seek future opportunities for its promotion at a Commonwealth level.
- Following evaluation of the policy, consultation with the child care sector could be undertaken to identify further areas of reform in relation to immunisation, and in terms of wider discretionary powers.

In spite of these additional costs to implementation, significant benefits of implementing the Bill are expected to become apparent within 1-2 years. Following an anticipated increase in immunisation rates among WA children, this will result in a reduction in the incidence of VPD, which means cost savings for both government and families across primary health care (e.g. GP visits), secondary health care (e.g. allied health consultations), tertiary health care (e.g. hospitalisation), and death. Other expected flow on cost savings include less time spent away from work for parents looking after children who have contracted a VPD, and less government spending required to provide ongoing care for such children.

For further information on evaluation activities in relation to indicators of impact, see Section 7.

6 Implementation

Implementation of the NJNP policy is being led by the DoH, in collaboration with the DoE, DoC and DPC.

Essentially, implementation comprises three main processes occurring concurrently:

i) legislative process

ii) communications; and

iii) development of processes for reporting children whose immunisation status is 'not up-to-date' to the DoH, and subsequent follow up by the DoH with these families to ensure these children are caught up on missing vaccinations.

6.1 Legislative process

Following Cabinet's consideration of this DRIS and the Bill, it is expected that the Bill will be introduced into Parliament in May/June 2019, to ensure that the proposed legislative amendments are passed in time for the 2020 school enrolment period, which will occur during July 2019. Communication activities will need to be undertaken in the lead up to enable parents, and persons in charge of child care services and kindergarten programs, to be fully prepared for the legislative changes once they come into effect.

6.2 Communications

Effective implementation of the legislative amendments is contingent upon the provision of clear and far-reaching communications to all stakeholders. As such, a comprehensive NJNP Communications Plan was developed by the DoH Communications Directorate, with input from communications personnel at DoE and DoC; this plan aims to ensure that comprehensive communications are provided to all stakeholder groups in a timely manner and using various mediums. Stakeholder groups include the general public; families; persons in charge of child

care services, community kindergartens and schools with kindergarten programs; and immunisation providers. Messages are created to target these groups using the Department of Health website, HealthyWA Facebook page, email, radio, and press advertising.

The plan commenced in December 2018 with a media statement from the Ministers for Health, and Education announcing the immunisation regulations, as well as advised of the proposed NJNP legislation. It was practical to advise the public of the proposed NJNP legislation, however, emerging from this media in December was some misunderstanding among service providers in the early education and care sector, as to whether NJNP legislation was in fact already in effect. The current and ongoing communications in the lead up to July 2019, need to carefully balance the fact that these proposed legislative changes are only proposed, but that families need to be prepared for the changes, once they are in effect.

Should the proposed legislation be passed in Parliament in July 2019, the changes are effective immediately for child care enrolments, as well as 2020 kindergarten program enrolments which are occurring simultaneously. In light of this tight timeline for implementation for the 2020 school year, and as part of an annual *Starting Schools* campaign occurring every April reminding parents to provide their child's AIR Immunisation History Statement upon enrolment, this year's mail out campaign will include reference to the proposed legislation, as a way to prepare parents/guardians and persons in charge of schools, of these proposed changes.

In light of some respondent's comments in their submissions, it was apparent that there were some common misunderstandings with regards to the Bill's Proposals. This demonstrates there is a great need for the legal requirements and operational implications of the Bill to be explicitly communicated to all stakeholders within the guidance material. For example, the proposed Frequently Asked Questions document will provide information and guidance to the various stakeholder groups on what the legislative changes are, how to meet legal responsibilities, and what to do in various scenarios. In addition, the child care sector identified a need to advise parents/guardians how to access their child's AIR Immunisation History Statements. While this explanatory information is currently available on the Department of Health website[13] (refer to the Guidance document and the Frequently Asked Questions), the DoH recognises this as a critical activity for parents/guardians to undertake not only due to the regulation requirement to do so upon enrolment, but importantly to demonstrate that their child meets immunisation enrolment requirements for child care services and kindergarten programs. As such, the DoH will ensure that further guidance material on how to access AIR records is readily available across all forms of communication.

6.3 Reporting and follow-up of under-vaccinated children

The DoH has developed an online reporting tool for child care services, kindergartens and schools to report children whose immunisation status is 'not up-to-date,' to the DoH. During Term 2 and using CHO authority, the DoH plans to request reports of under-vaccinated children enrolled in child care services, kindergarten programs and pre-primary. With this information, the DoH will provide follow-up and referral pathways to the families of these children, to enable better access to immunisation services. These activities will be delivered in collaboration with health service providers, and aim to support these children to become fully vaccinated.

7 Evaluation

Evaluating implementation and impact of the proposed immunisation policy will take a three part approach:

[13] *Immunisation enrolment requirements for child care services, kindergarten and schools;* Department of Health, Government of Western Australia. Available at: https://ww2.health.wa.gov.au/immunisationenrolment

i) monitoring immunisation rates of children aged 5 years and under both before, during and after policy implementation, as well as number of notifications of VPDs

ii) gathering qualitative data on the impacts to early education and care industry, families and State Government; and

iii) undertaking a statutory review in accordance with section 306 of the Act.

Desired outcomes:

- improved immunisation coverage rates of WA children attending non-compulsory early education and care, to ≥ 95%
- minimal negative impact experienced by stakeholders; and
- reinforcement of the importance of vaccination for children and the wider community.

7.1 Monitor immunisation rates and notifications of VPDs

Currently, records of all childhood vaccines administered since 1 January 1996 are stored in the AIR. Data on immunisation episodes are recorded by the administering health service provider e.g. child health centres, immunisation clinics, GP Medical Centres, Aboriginal medical services.

As part of ongoing business activities, CDCD analyses and disseminates statewide AIR and other immunisation related data.[14] This monitoring activity will be able to measure the impact of the legislative changes across the relevant timeline, including both before and after the proposed amendments come into effect, with the most impact to immunisation rates expected to occur from 2021 onwards.

The following data would be monitored and analysed to determine if immunisation coverage increases to ≥ 95%:

- immunisation rates of WA children at 1, 2, and 5 years of age
- these rates by region, ATSI status; and
- number of exempt children, who are also reported as under-vaccinated, who are subsequently caught up following the provision of referral pathways by WA Health.

CDCD conducts surveillance of notification rates for VPDs occurring within the WA population; analyses of notification rates during the period before and after the implementation of the NJNP legislation will also form part of the evaluation of the NJNP policy.

7.2 Monitor impacts

Given the identified advantages and disadvantages of the Proposals across the industry, families and state government, the proposed evaluation of NJNP will include qualitative and quantitative surveying of stakeholders to measure indicators including, but not limited to:

- awareness of legal requirements of persons in charge of child care services, community kindergartens, and schools with kindergarten programs

[14] *Agreed roles and responsibilities in the control of communicable disease and health care acquired infections, F-AA-49993, 2nd edition*, 2018; Department of Health, Government of Western Australia. Available at: https://ww2.health.wa.gov.au/Articles/N_R/Roles-and-responsibilities-in-control-of-communicable-disease-and-health-care-associated-infections

- operational impact on persons in charge of child care services, community kindergartens, and schools with kindergarten programs
- operational and economic impact on small business
- appropriateness of the prescribed exemption categories and the exemption process; and
- appearance of any unintended consequences

7.3 Statutory review

The amendments are intended to come into operation by July 2019 in time for the commencement of the 2020 enrolment period. Once implemented, the proposals will be subject to the five year statutory review requirement under section 306 of the Act. The first review of the Act is expected to occur in 2021 and be undertaken in accordance with the requirements set by the Public Sector Commission's *Guidelines for the review of legislation.*[15]

[15] *Guidelines for the review of legislation*; Public Sector Commission, Government of Western Australia. Available at: https://publicsector.wa.gov.au/public-administration/public-sector-governance/guidelines-review-legislation

8 Acronyms

Acronym	Definition
AIR	Australian Immunisation Register
AMS	Aboriginal medical service
ATSI	Aboriginal and Torres Strait Islander
CDCD	Communicable Disease Control Directorate
CHO	Chief Health Officer
COAG	Council of Australian Governments
CRIS	Consultation Regulatory Impact Statement
DoC	Department of Communities
DoE	Department of Education
DoH	Department of Health
DPC	Department of the Premier and Cabinet
DRIS	Decision Regulatory Impact Statement
NIP	National Immunisation Program
NJNP	No Jab No Play
PAHD	Public and Aboriginal Health Division
RIA	Regulatory Impact Assessment
VPD	Vaccine-preventable (notifiable infectious) disease
WA	Western Australia

Appendix A – Stakeholder engagement list

Stakeholders in the following sectors were targeted in consultation communications, largely via email, in order to elicit submissions.

State Government	
Department of Education	Better Regulation Unit, Department of Treasury
Department of Communities	South West Public Health Unit
Department of Premier and Cabinet	Great Southern Public Health Unit
Department of Health	Midwest Public Health Unit
Child and Adolescent Community Health	Wheatbelt Public Health Unit
Metropolitan Communicable Disease Control	Goldfields Public Health Unit
North Metropolitan Health Service	Kimberley Public Health Unit
South Metropolitan Health Service	Pilbara Public Health Unit
East Metropolitan Health Service	
Local Government	
WA Local Government Association	Local Government Professionals
Associations and corporations	
Australian Medical Association, WA	Health Consumers' Council
WA Primary Health Alliance	Royal Australian College of General Practitioners
Derbarl Yerrigan Health Service Corporation	Small Business Development Corporation
School and Kindergarten Associations	
Catholic Education Office of WA	WA District High School Administrators' Association
Australian Independent Schools WA	WA Education Support Principals' and Administrators Association
Educational Leaders Association	Western Australian Managers of Corporate Services in Education
WA Primary Principals' Association	WA Education Corporate Services Staff Association Inc
WA Secondary School Executives Association	WA Council of State School Organisations
WA Secondary Teaching Administrators' Association	Community Kindergarten Association of WA
Child Care Service Providers	
City of Kwinana	Jalygurr-Guwan Aboriginal Children's Services Centre
Goodstart Early Learning	Coolabaroo Neighbourhood Centre
YMCA	Wanslea Early Learning & Development (Inc)
Cachet Holdings	Affinity Education Group Limited
Rose Nowers Early Learning Centre	
Child Care Agencies	
Child Care Alliance WA	Outside School Hours Care WA
Community Based Children's Services	Child Australia
Family Day Care WA	Early Childhood Australia WA
Australian Community Children's Services	One Tree Community Services
Family Day Care Educators Association WA	G8 Education Limited
Family Daycare - WA Educator Netwerx Community	The Association of Children's Welfare Agencies (tagged in HealthyWA Facebook post)
Parent Groups	
PlaygroupWA	Ngala (tagged in HealthyWA Facebook post)
Buggybuddys (tagged in HealthyWA Facebook post)	Parenting with Confidence (tagged in HealthyWA Facebook post)
Boab Health Services (tagged in HealthyWA Facebook post)	

Appendix B – Guiding Questions for consultation

Respondent Details

1. Would you like your responses to be confidential?
2. Name
3. Contact email address
4. Name of your organisation
5. Which sector do you represent?

Options

6. Which Option do you support?

   Option A: Fully implement recently introduced regulations

   Option B: Amend the *Public Health Act 2016*

   a. If you support Option A or B, why is this your preferred Option?

   b. If you support Option A or B, can you identify any additional advantages (benefits) or disadvantages (costs) for your preferred Option? Please provide details and supporting evidence where possible.

7. Are there other options you would suggest and why? Please provide supporting evidence.

Proposal 1 - Require, with rare exception, a child's immunisation status to be 'up to date' as a condition of enrolment into child care services and kindergarten programs

8. Do you agree that, with rare exception, children in WA should be fully vaccinated for age as a condition of enrolment into child care services and kindergarten programs?

   a. If 'no' or 'unsure', what do you suggest as an alternative proposal or activity to improve immunisation rates among young children?

9. Do you agree with prescribing an offence with penalty $10,000 for persons in charge of child care services and kindergarten programs, who fail to comply with the proposed immunisation enrolment requirement?

   a. If 'no' or 'unsure', what do you suggest as an alternative penalty, if any?

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

    a. If 'no' or 'unsure', why not?

11. To assist in meeting the proposed immunisation requirements, what resources and/or support should the DoH provide to persons in charge of child care services and kindergarten programs, families and/or immunisation providers?

12. Do you agree with the listed advantages (benefits) and disadvantages (costs)?

    a. Please provide evidence to support your views, including any likely overall financial impacts.

    b. Can you identify any additional advantages (benefits) and disadvantages (costs)? Please include quantitative evidence of any likely impacts.

Proposal 2 - In specified circumstances, allow for documentation other than a child's AIR Immunisation History Statement to be used to satisfy immunisation requirements for enrolment into child care services and kindergarten programs

13. Do you agree that the CHO should have the flexibility to issue an alternative immunisation certificate in the event the child is experiencing an atypical or unforeseen circumstance, but for which they would otherwise be fully vaccinated for age?

    a. If 'no' or 'unsure', why not?

14. Can you identify any other special circumstances a child may experience, but for which they would otherwise be fully vaccinated for age, that might warrant issuing an alternative immunisation certificate?

15. Do you agree with the listed advantages (benefits) and disadvantages (costs)?

    a. Please provide evidence to support your views, including any likely overall financial impacts.

    b. Can you identify any additional advantages (benefits) and disadvantages (costs)? Please include quantitative evidence of any likely impacts.

Proposal 3 - Prescribe the categories of children for which exemptions to immunisation requirements for enrolment into child care services and kindergarten programs apply

16. Do you support the provision of exemptions to the immunisation enrolment requirements for vulnerable and/or disadvantaged children?
    a. If 'no' or 'unsure', why not?
17. Are the proposed categories of vulnerable and disadvantaged children which should be exempt from the immunisation enrolment requirements, appropriate?
    a. If 'no' or 'unsure', what do you suggest?
18. Do you agree with the proposed process to determine if a child qualifies for an exemption category?
    a. If 'no' or 'unsure', what do you suggest as an alternative process?
19. Do you agree with the listed advantages (benefits) and disadvantages (costs)?
    a. Please provide evidence to support your views, including any likely overall financial impacts.
    b. Can you identify any additional advantages (benefits) and disadvantages (costs)? Please include quantitative evidence of any likely impacts.

Proposal 4 - Enable updated information about a child's immunisation status to be provided at times other than enrolment

20. Do you support the provision that the DoH could prescribe another time or times at which a child's updated immunisation certificate needs to be provided by the parent/guardian to the person in charge of the child care service, community kindergarten or school?
    a. If 'no' or 'unsure', what do you suggest as an alternative for the DoH to obtain updated information regarding a child's immunisation status?
21. Do you agree with the listed advantages (benefits) and disadvantages (costs)?
    a. Please provide evidence to support your views, including any likely overall financial impacts.
    b. Can you identify any additional advantages (benefits) and disadvantages (costs)? Please include quantitative evidence of any likely impacts.

Proposal 5 - Offences for which penalties may be issued

22. Do you support the offences for non-compliance?
    a. If 'no' or 'unsure', what do you suggest as an alternative for non-compliance with these requirements?
23. Do you agree with the listed advantages (benefits) and disadvantages (costs)?
    a. Please provide evidence to support your views, including any likely overall financial impacts.
    b. Can you identify any additional advantages (benefits) and disadvantages (costs)? Please include quantitative evidence of any likely impacts.

Closing Questions

24. Can you identify any additional regulatory proposals to be considered or any other way of achieving higher immunisation rates for young children in WA? Please provide details as well as supporting evidence where possible.
25. Do you have any additional comments in relation to the proposed Bill to strengthen immunisation enrolment requirements for child care services and kindergarten programs?

This document can be made available in alternative formats on request for a person with disability.