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AMA submission to the Department of Health on the Amendment of the Australian Immunisation Register Legislation

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Responses to survey questions:

1. **What is your name?**

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2. **What is your email address?**

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3. **Which State or Territory do you live in?**

Australian Capital Territory

4. **Submission type**

Organisation

5. **Organisation type**

Non Government

6. **Organisation sub-type**

Medical professional
Peak Body

7. **Do you support the proposed amendment to the AIR Act to mandate reporting of vaccinations to the AIR?**

Yes, with some qualifications and caveats.

Comments:

The AMA has long supported a central register of all vaccinations received and to which all immunisation providers can report. The expansion of the Australian Childhood Immunisation Register (ACIR) in 2016 to the Australian Immunisation Register went a long way towards the whole of life register the AMA had strongly advocated for. Requiring immunisation providers to record all immunisations provided will complete the AMA's vision on this issue, ensuring:

- an accurate record of vaccinations received across a lifetime;
- better preventive care – enabling providers to check on immunisations due; and
- reducing wastage of vaccines and healthcare resources by preventing duplication of immunisation services.

However, this must be backed up with appropriate support to cover the administrative work involved in providing this data.

GPs are the predominant provider of vaccination services in Australia and it is vital that they are supported in this role. Financial incentives have previously been available to support practitioners in ensuring patients are informed about vaccinations, understand the role of immunisation in protecting individuals and communities from preventable disease, complete their course of vaccinations and have a record of vaccinations received.

Australia's strong performance over the years on childhood immunisation rates, for example, has been linked to the availability of GP incentives that supported the immunisation service and recognised efforts that kept immunisation rates heading towards the aspirational target of 95%. Results from an analysis of the effect of GP financial incentives on immunisation show that the removal of the General Practice Immunisation Service Incentive Payment and the associated Outcomes Bonus Payment in 2008 and 2013 respectively saw an immediate and statistically significant drop in immunisation coverage. A drop that remained persistent even after data was remodelled to take account of the effects of the 'No Jab No Pay' policy[1].

A catch-up incentive funded for four years in the 2015-16 Federal Budget effectively supported GPs and other vaccination providers for following-up and vaccinating children who were overdue on their childhood vaccinations. During this period catch-up rates for the third dose of diphtheria–tetanus–pertussis vaccine (DTPa3) and measles–mumps–rubella vaccine second dose (MMR2) increased[2].

[1] Hallinan, CM. 2019. *Does the removal of financial incentives from Australian general practices affect immunisation rates?* (Doctoral dissertation, Department of General Practice, Melbourne Medical School, The University of Melbourne. Retrieved from: https://minerva-access.unimelb.edu.au/bitstream/handle/11343/233864/4431a215-f6e3-e911-94ad-0050568d7800_Thesis_Chapter_1-8_Christine_Hallinan.pdf?sequence=1&isAllowed=y

2 Hull BP, Beard FH, Hendry, AJ, Dey A and Macartney K. 2020. No jab, no pay": catch-up vaccination activity during its first two years. Med J Aust 2020; 213 (8): 364-369. Retrieved from: https://www.mja.com.au/journal/2020/213/8/no-jab-no-pay-catch-vaccination-activity-during-its-first-two-years

GPs report that accessing and uploading to the AIR can be a time consuming and duplicative process (if no direct upload from their clinical software system). The impact of problems such as this, the AMA would suggest, are reflected in the failures to upload. In circumstances where Government is mandating uploading to the AIR, it is only reasonable to suggest that practices should be compensated for this. This also recognises the societal benefit of this work being undertaken by GPs and their practices.

This could be in the form of a Service Incentive Payment or as part of an overarching payment tied to patient enrolment with a practice.

8. Do you foresee any challenges in implementing these changes?

Comments:

Our GP members have reported that accessing the AIR can be time consuming, with logins sometimes requiring several attempts, system time outs, receipt of verification codes dependent on data speed, system settings and connectivity, and then identifying the correct patient within the AIR.

If GPs and other vaccination providers are to be required to report vaccines administered at the time of vaccination there must be a streamlined mechanism for this. For GPs there should be an ability to directly upload from the practice clinical software to the AIR so as to minimise any disruption in the clinical flow of the service.

Inconsistent internet connectivity or slow data speeds will impact providers ability to always upload at the time of vaccination and consideration must be given to defining a reasonable timeframe for upload. Our rural and remote GPs regularly report issues with connectivity and Broadband speeds. Providers should not be held to account for any failings of clinical software or communication systems that prevent timely updating of the immunisation register.

Those providing vaccination services in residential aged care facilities have also advised that variable conditions in terms of access to computers and the internet, and no inter-connectivity with clinical software impacts providers capacity for point of care uploads. Part of the accreditation requirements for aged care facilities should include system capacity and capability for GPs to remotely access and update their own clinical records, from which the RACFs record can be seamless updated.

While practitioners have an obligation to maintain contemporaneous clinical records, uploading to the AIR is an administrative process not a clinical one. As such steps must be taken to either remove or compensate for the administrative burden. Automated uploading to the AIR from the clinical record for example would streamline the process and ensure an accurate record of immunisation and largely eliminate the need from compliance measures.

Ideally, automatic uploading of vaccinations through clinical software could be done in a similar way to the electronic submission of MBS claims. Or, alternatively via an upload mechanism similar to that for uploading Shared Health Summaries or Event Summaries to the My Health Record.

No compliance action outside of education and support should be taken before a fit for purpose software solution has been enabled and implemented that provides a streamlined mechanism for accessing and uploading to the AIR.

9. Indicate the proposed compliance options listed below that you support. Do you have suggestions for other compliance measures?

Education and Support

Comments:

The AMA first and foremost supports an educative and support process that equips GPs and other vaccination providers with the mechanisms that will facilitate timely uploads to the AIR.

As mentioned in our response to the previous question a mechanism that enables automatic uploads from GPs clinical software would largely eliminate the need from compliance measures.

With regards to public disclosure as a compliance option the AMA considers that this would likely have perverse consequences such as discouraging providers from offering this service and reducing patient access to care.

Suspending the provision of NIP vaccines not only creates an additional bureaucratic process it fails to recognise that there will be times where the number of vaccines provided and delivered may differ, particularly where demand has lowered or there has been a catastrophic event that may have resulted in a disruption to the cold chain or caused the destruction of supplied vaccines. It will also negatively impact patient access to immunisations.

Just as it is proposed exemptions may be considered for providers in remote regions there should be a fair and reasonable process for practices/providers to show cause for any substantial mismatch in vaccines supplied and vaccines delivered. Denying providers supply could similarly have perverse consequences in the form of limiting patient access to vaccination services. The AMA considers that this measure should only be used where providers remain recidivist after repeated education and technical support targeted to the provider's learning needs has been provided.

The impact of education and support should be evaluated after the first year of implementation to confirm the benefits of this approach with any identified modifications or improvements implemented and subsequently reviewed before any more stringent compliance options are considered.

10. Do you have any additional feedback or concerns on the proposal?

No.

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