Mandatory COVID vaccines for aged- and health-care workers could increase uptake, but it's not the first option

June 2 2021, by Holly Seale

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Federal Health Minister Greg Hunt has asked the Australian Health Protection Principal Committee to revisit whether COVID vaccinations

should be mandatory for aged-care workers and provide fresh advice to national cabinet.

In January, the committee said aged-care workers should be "strongly encouraged" to get vaccinated, but given there was little data about the effectiveness of vaccines in preventing the spread of COVID-19, it stopped short of mandating the jabs.

The Victorian government said it expects all front-line aged-care and health workers to be vaccinated against COVID-19. In an attempt to increase coverage, from Wednesday it will allow aged-care and disability-care workers to jump the queue in state-run mass vaccination clinics.

Data from places which have made influenza vaccination mandatory in the past suggests it's clear vaccine coverage will increase after a mandate.

However, before moving forward we need to make sure we have exhausted the other options. The Victorian government is making a good start by reducing the barriers to access.

However to really understand whether mandates are needed it's critical we get a good handle on the number of health and aged-care workers who have received the vaccine, and whether we are getting equity in coverage across and within organizations.

It's important to remember the term "health workers" includes clinical and non-clinical staff. Tracking vaccine uptake for health workers can be challenging for a range of reasons, including that staff can receive their vaccine onsite or at other locations.

We already have various vaccine requirements for health workers

Australian hospital staff are required to show evidence they're protected from a range of vaccine preventable diseases.

The list of diseases differs slightly depending on the state or territory. In New South Wales, for example, front-line staff must show evidence they're vaccinated against measles, diphtheria, tetanus, pertussis (whooping cough), and varicella (chickenpox).

Annual flu vaccines are highly recommended for health-care workers in NSW, but not required. It's currently only mandatory for those in high-risk situations for example intensive care and oncology ward staff.

Internationally, mandates for influenza are more common in parts of the United States, while countries in Europe often require health workers to show evidence of protection from other vaccine preventable diseases.

What happens when voluntary programs fail?

In an attempt to support flu vaccine uptake, staff members running vaccine clinics in Australia would tell me they offered extended opening hours, had mobile clinics, offered raffles and lollipops, had education sessions with influenza experts, and used declination forms (a legal document that signals an individual's intent to refuse a recommended treatment)—but coverage remained the same. One staff member I spoke to likened it to banging her head on the wall. Nothing she did increased coverage at her hospital.

At this point, organizations or governments often shift away from voluntary based programs and introduce mandatory requirements.

While vaccine requirements in Australia for influenza are still in their infancy, they have been in place in some settings in the United States for much longer and have been shown to work.

One study from the United States looked at flu vaccine uptake in health-care workers at University of California Irvine Healthcare. It found that after introducing measures and incentives like the ones above, coverage rose from 44% of staff to 62.9%. But it was only after the vaccine became mandatory that coverage reached over 85%.

What's more, in 2016–2017, influenza vaccination was highest among US hospital workers who were required by their employer to be vaccinated (98.3%). When vaccination wasn't required, promoted, or offered on-site, rates were as low as 45.8%.

What are the pros and cons of mandating vaccination?

Multiple arguments are used to support mandatory vaccination but the focus tends to be the obligation for staff to "do no harm" and patients' and residents' (and staff members') right to a safe environment, free from the risk of infection from a staff member. This right is both an ethical and a legal requirement.

Those who oppose mandates often draw on the rights of health workers to autonomy, question the data supporting the rationale for the mandate, or criticize the level of effect the vaccine has in reducing transmission from staff members to patients. Others suggest adding a mandate will drive staff to quit their jobs. But research shows that isn't the case.

For COVID-19, what should we try first?

We urgently need to reduce the chance of COVID-19 transmission in health- and aged-care organizations to patients and staff members. But are we at that tipping point of needing to mandate a COVID-19 vaccine?

In attempt to answer that question, we need to consider the following:

- have we ensured there are no physical barriers to vaccination? Have we overcome logistical issues impacting on staff getting vaccinated?
- have we tried other options to nudge health workers to get vaccinated? Have we considered incentives or reimbursements such as a coffee voucher or free parking? Or could we introduce a competition with a prize for the department with the highest uptake?
- do we understand the reasons some staff members may be indecisive about receiving a COVID-19 vaccine? Have we developed purpose-built instruments to measure changes in vaccine hesitancy that focus on understanding the attitudes of staff towards issues such as safety, efficacy, and trust? Based on this knowledge, have we modified our communication approaches?
- do we have strategies in place to help those staff who are having trouble reaching a decision about whether to have a COVID-19 vaccine? Could we offer decision aids or guides (which account for variations in health literacy) to assist people to balance up the benefits and risks?

And if that doesn't work?

When we've tried these strategies and haven't seen improved coverage, we need to accept voluntary approaches probably won't cut it. Every study on influenza vaccination of health workers points to a ceiling effect that will not be broken unless the vaccine gets mandated.

If we accept the same situation will occur for COVID-19 vaccination, mandatory policies may be the only way forward in ensuring high coverage of staff.

However, in moving forward with a mandate, it's critical we work with the health workers at the receiving end of the policy, as well as those staff members tasked with introducing and enforcing it.

More information: Holly Seale et al, Examining the role of a decision aid in reducing decisional conflict amongst hospital healthcare workers towards receiving the influenza vaccine, *BMC Health Services Research* (2016). DOI: 10.1186/s12913-016-1339-0