Health Misinformation in Primary and Community Care – Vaccination

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Background and purpose

Health misinformation presents a significant risk to population health outcomes and health system performance. It shapes treatment decisions, undermines adherence to evidence-based care, erodes trust in clinicians and institutions, and contributes to both unnecessary service use and dangerous delays in seeking care.

This paper is intended to support discussion with primary and community care partners on health misinformation, using immunisation as a practical case example. The Strategy Workshop seeks to identify opportunities for collective action. The intent of this session is to understand what is being experienced locally, why it is happening, and what could realistically help.

For frontline providers, health misinformation is also an escalating practical challenge: GPs, nurses, pharmacists and community providers are increasingly expected to navigate emotionally charged narratives and online “health influencers” within short consultations, often without shared tools, consistent messaging, or clear escalation pathways.

Immunisation demonstrates how misinformation can translate into real-world harm, but the same dynamics apply across screening, chronic disease management, mental health, medicines and claims of “miracle cures”. A constructive discussion can help CESPHN, and partners address misinformation.

National and international context

The establishment of Australia’s new Centre for Disease Control (CDC) from 1 January 2026, is intended to strengthen trusted, evidence-based advice and national preparedness. This reflects a broader lesson from the COVID-19 period: in a fast-moving crisis, confusion and competing narratives can materially undermine public confidence and the effectiveness of health responses.

This national context matters because it reinforces that misinformation is not just a “communications problem.” It is closely linked to trust, service navigation, equity, and the lived experience people have when they encounter the health system — especially when advice feels inconsistent or hard to access. International research has advanced our understanding of why health misinformation is so persistent and difficult to counter. Several key insights are now well established.

People are not passive recipients of information. They evaluate new claims through the lens of prior beliefs, social identity, and emotional stakes. Corrective information is most effective when delivered by trusted in-group messengers, when it affirms rather than threatens identity, and when it offers a clear alternative narrative rather than simply negating a false claim.

The World Health Organization classifies misinformation as a parallel epidemic, an “infodemic” requiring a systematic public health response. It identifies three priority interventions: strengthening trusted communication channels, building population-level health literacy, and training frontline health workers in evidence-based communication techniques.

The Australian Institute of Health and Welfare (AIHW) and the National Centre for Immunisation Research and Surveillance (NCIRS) have documented measurable impacts of vaccine hesitancy on coverage rates, with variation by geography, socioeconomic status, and cultural background. NCIRS research consistently demonstrates that the most effective interventions combine trusted clinician relationships with culturally tailored community engagement, rather than relying on broadcast information campaigns alone.

Social norms matter - when people perceive that “most people like me” accept a health recommendation, uptake improves significantly. This suggests that norm-based messaging making visible what the majority do is often more effective than risk-focused campaigns.

Understanding health misinformation

For this workshop, health misinformation refers to health-related information that is false, misleading, incomplete, or presented without appropriate context, in a way that can influence decisions and increase harm or reduce the effectiveness of care. In practice, misinformation is not always experienced as a single “myth” to correct. It is often experienced as an overload of competing claims that make people unsure what to do and who to trust.

Misinformation is not only about incorrect facts. Often it is a story about trust: who is credible, whether the system is acting in someone’s interests, what risks matter most, and whether personal experience is being respected. This helps explain why simply providing more facts is often insufficient — and why responses that protect dignity and relationships are frequently more effective than “debunking” alone. Not all misinformation is the same. Distinguishing between types helps practitioners calibrate their responses and direct resources appropriately.

- Misinformation is incorrect or misleading health information that is shared without an intent to deceive. A patient sharing an incorrect claim they genuinely believe is spreading misinformation. The appropriate response relies on relationship-based correction and education.

- Disinformation is false information deliberately created and distributed to cause harm or advance an agenda. This includes coordinated campaigns promoting unproven therapies, politically motivated actors seeking to undermine trust in public health systems, or ideologically motivated groups targeting vulnerable communities. Addressing disinformation requires system-level responses including platform accountability, media literacy, and regulatory frameworks, not just individual-level correction.

- Misinformation involves the weaponisation of accurate information in misleading ways — taking real data out of context to support a false conclusion. For example, citing the genuine rate of a rare vaccine adverse event without contextualising the comparative risk of the disease itself. This is particularly challenging to counter because the underlying fact is real. Misinformation calls for respectful education. Disinformation requires systemic countermeasures.

Why responding can be difficult

Responding to misinformation is difficult for reasons other than the views of the individual. Misinformation is frequently simple, confident, and designed to travel; evidence-based advice is often nuanced, conditional requiring discussion of probabilities and trade-offs.

Uncertainty is also routinely exploited. When guidance evolves as it often must when evidence updates shifts can be framed as incompetence or hidden motives. This can make people reluctant to engage with official advice, even when the intent is transparency.

For many people, misinformation is bound up with identity, belonging, or previous experiences with the health system. In these situations, preserving the relationship and making it safe to return for follow-up is often more important than “winning” a single conversation. Another practical challenge is that rebuttal can inadvertently amplify a false claim. In some contexts, repeating a myth — even to correct it — can increase familiarity and make it feel more plausible. This means responses need to be thoughtful: prioritising clear recommendations, plain language, and trusted messengers, rather than becoming trapped in point-by-point argument.

The burden cannot sit with individual clinicians alone. If messages and pathways are inconsistent, clinicians face an impossible task: correcting misinformation in a consult while the person continues to receive competing narratives elsewhere. This is why local alignment between general practice, allied health, community organisations and others matters so much.

Why it matters for the CESPHN region

Health misinformation matters because it changes decisions and therefore outcomes. It can reduce uptake of preventive care, delay screening or treatment, and increase the likelihood that people present later and sicker. It can also increase demand for unnecessary tests or ineffective interventions and contribute to service churn as people move between providers seeking reassurance or validation.

It also has a significant workforce and service impact. When consultations become dominated by emotionally charged misinformation narratives, less time remains for preventive care, chronic disease management, and relationship-building. Over time, repeated high-friction interactions can contribute to staff strain, complaints, and erosion of trust.

How misinformation compounds inequity

Misinformation rarely operates in a vacuum. It interacts with existing barriers and, in doing so, magnifies them. The burden does not fall evenly. People with less access to trusted care, fewer supports, language barriers, lower health literacy, limited digital access, or prior experiences of discrimination are more likely to be exposed to misleading claims, more likely to have difficulty checking them, and less likely to have a safe, trusted relationship where concerns can be explored over time.

For some communities, mistrust is not irrational; it is shaped by lived experience of exclusion or poor care. In that context, misinformation can feel like an explanation that “fits,” and it can be adopted as a protective stance rather than a simple misunderstanding. The result is that misinformation can widen gaps in two ways at once: reducing uptake of preventive and early intervention care and increasing friction in accessing services.

These patterns tend to concentrate in communities already carrying higher burden, including people with low income, insecure housing, trauma exposure, disability, new migrants and refugees, and those who do not feel the health system was built for them. In other words, misinformation can shift risk and workload onto the very groups least able to absorb it, widening the inequities we are trying to close.

High cultural and linguistic diversity means information needs to be available in the right language, tone and channel. Where this is not the case, misinformation can fill the gap — especially when it travels through messaging apps and tightly connected community networks.

Strong community networks can be an asset for health promotion and community mobilisation. However, they can also mean that a persuasive story — especially one framed around fear, identity, or mistrust — can spread rapidly within and across groups, long before a formal response is prepared. Pockets of disadvantage, housing insecurity, and competing life pressures can reduce people’s capacity to verify information, seek longer consultations, or navigate complex pathways.

Finally, system complexity itself can amplify misinformation. Where pathways are fragmented, advice is inconsistent, or out-of-pocket costs are unclear, misleading narratives can attach easily to genuine frustrations. Improving clarity, cultural safety and consistency is therefore not only good service design; it can also strengthen resilience to misinformation.

Immunisation as a case example

Immunisation provides a clear pathway from misinformation to harm: confidence shifts can lead to delayed or declined vaccination, which increases the risk of preventable illness and outbreaks and places additional pressure on families, primary care and hospitals. It is also an area where misconceptions can spread quickly through social networks, particularly when stories focus on fear, identity, or mistrust.

Today is not intended to become a “vaccine debate.” The value of the immunisation example is that it helps us explore broader questions: how trust is built or lost, how people navigate competing advice, and how the health system can respond in ways that are respectful, practical and equitable. Those lessons apply equally to screening, chronic disease, mental health, medicines and other areas of care.

The NCIRS Vaccine Confidence in Australia report shows that vaccine hesitancy is not uniform. It clusters along lines of prior healthcare experience, cultural background, and exposure to online health communities. Importantly, hesitancy is not the same as refusal: most hesitant parents and adults remain open to conversations with trusted clinicians, and a single respectful conversation can improve uptake rates.

Real-world consequences and behavioural patterns

In practice, misinformation often presents less as dramatic confrontation and more as a steady build-up of friction and delay. People may postpone prevention, screening, or treatment while anxiety grows rather than resolves. Some may substitute unproven approaches for effective care. Others may disengage from mainstream services entirely or move between providers seeking validation.

Common patterns across settings

Delay with uncertainty. A person may not reject care outright but postpones a decision while seeking more information online. In the meantime, anxiety increases, the volume of conflicting advice grows, and the eventual conversation becomes harder. In immunisation, this can mean missing time-sensitive protection; in screening, it can mean later detection; in chronic disease, it can mean delayed treatment and preventable deterioration.

Substitution. People may adopt unproven interventions as a first step — sometimes because they feel more in control, sometimes because the claims are framed as ‘natural’ or ‘risk-free.’ Substitution can delay effective care, increase cost, and create a false sense of security.

Disengagement. Quietly stepping away from mainstream services after a negative interaction or after repeated exposure to distrust narratives. When this happens, people often re-enter the system later, with higher complexity and fewer options.

Service churn. Moving between providers seeking reassurance or validation, which fragments continuity of care and makes coordinated management more difficult for all involved.

These patterns have practical impacts across the system. Frontline services can experience longer and harder consultations, repeated cycles of the same narratives, increased conflict that spills beyond the consult, and reduced continuity. Over time, small shifts accumulate: a missed vaccine, a delayed screening test, a medication never started, a follow-up never booked. The system can fail quietly.

Implications for primary and community care providers

Primary and community care providers occupy a critical and paradoxical position in the misinformation landscape. They are simultaneously the health system’s most trusted interface with patients and communities, and the point most directly exposed to the operational consequences of misinformation. Understanding what this means in practice — and what realistic, proportionate responses look like — is essential for designing a sustainable local response.

The clinical consultation: Challenges and opportunities

The clinical consultation is where misinformation most directly intersects with care. International evidence and local experience consistently highlight several dynamics that practitioners should recognise.

Time pressure is real and consequential. A standard general practice consultation of 10–15 minutes is rarely sufficient to unpick a deeply held belief informed by months of online content consumption. Attempting to “win” the argument in a single consultation is both unlikely to succeed and potentially counterproductive. What is achievable is maintaining the relationship, providing a clear and brief recommendation, and creating a pathway for the person to return.

Motivational interviewing techniques, adapted for clinical settings, offer a structured framework for navigating these conversations. The core principle is that ambivalence is normal, and that the clinician's role is to gently explore and amplify the person's own motivations for healthy behaviour rather than to impose external authority. Key techniques include rolling with resistance rather than confronting it directly, reflecting the person's stated values and concerns, and eliciting change talk by asking open questions about what the person wants for their health.

The "Assume, Acknowledge, Ask" framework developed by the Australian Government Department of Health Disability and Ageing and endorsed by RACGP provides a practical three-step structure: assume positive intent (the person has concerns, not bad faith), acknowledge the concern genuinely before introducing evidence, and ask a focused question to invite reflection. This approach preserves dignity and keeps the consultation productive without requiring clinicians to spend 45 minutes on a 15-minute appointment.

Clinicians should also be aware of the specific challenge of "boosted uncertainty" where online content deliberately exaggerates scientific disagreement or mines historical controversies to suggest that "experts don't agree." A useful response is to anchor on areas of strong consensus, acknowledge genuine areas of ongoing research transparently, and reframe scientific updating as a strength rather than a weakness. Saying "the evidence has strengthened over time" is more effective than defending every prior iteration of guidance.

Workforce wellbeing and service resilience

Repeated high-friction consultations carry a real workforce cost. Distressing encounters including those involving misinformation, refusal of care, and conflict are a significant contributor to practitioner burnout and early exit from the workforce.

Service resilience requires both individual coping strategies and system-level support. Brief structured debriefing after difficult consultations (even informal peer check-ins), conscious boundary-setting around the scope of what is achievable in a single encounter, and explicit acknowledgement within practices that these encounters are genuinely difficult is required.

Team based responses within the practice

There is strong evidence that misinformation responses are more sustainable when distributed across the practice team, rather than sitting entirely with the treating clinician. Practice nurses, Aboriginal health workers, health educators, and reception staff can all play a role in normalising questions, providing consistent messaging, and identifying patients who may benefit from a longer conversation.

A team-based approach might involve practice nurses providing brief educational touchpoints at the beginning of consultations or during vaccine appointments, reception staff trained to respond to common questions with consistent language, and a designated "misinformation champion" within the practice who maintains awareness of current local narratives and available resources. Aboriginal and culturally specific services, Aboriginal and Torres Strait Islander health workers and cultural liaison officers are frequently the most trusted and effective interlocutors. Their role should be recognised and resourced explicitly, not treated as an add-on to other responsibilities.

Allied health and community based providers

Allied health professionals often see patients across extended engagement periods and in different emotional registers than the acute GP consultation. This creates distinct opportunities.

Allied health professionals may encounter misinformation in specific domain areas relevant to their practice — nutrition pseudoscience in dietetics, "natural healing" claims in physiotherapy and musculoskeletal care, anti-medication narratives in psychology. Having accessible, profession-specific resources and communication approaches adapted to these contexts is more useful than generic misinformation training that does not reflect the specific claims practitioners actually encounter.

Community health workers that operate in complex and disadvantaged settings face a particular version of this challenge. They often work with people for whom mistrust of the health system is strongly founded and historically grounded. Directly challenging misinformation can be experienced as dismissive or disrespectful. Approaches that centre curiosity, acknowledge complexity, and connect people to community-embedded trusted sources may be more effective.

Community pharmacy is often underutilised as a strategic partner in the misinformation response. Pharmacists interact with large numbers of community members — including people who may not have a regular GP — and they do so in a setting that is perceived as relatively accessible and non-threatening. Pharmacists are regularly asked about complementary medicines, unproven treatments, and vaccine concerns.

Enhancing the pharmacist's role in misinformation response requires both professional development and system-level alignment. Pharmacists need current, accurate information about the most common misleading claims in their local area, brief communication frameworks that allow productive responses without requiring extended consultations, and clear referral pathways to primary care for patients who need longer conversations.

The Pharmaceutical Society of Australia has resources on therapeutic misinformation that can be adapted locally, and consistent messaging across pharmacy and general practice helps reinforce trust.

Coordination, consistency, and local alignment

Perhaps the most important structural insight from the evidence is that the effectiveness of any individual clinician's response depends substantially on whether the surrounding system is consistent. If a patient receives one message from their GP, a different message from their pharmacist, and a third message from a community health worker, the inconsistency itself becomes a source of doubt — and misinformation attaches most readily to genuine uncertainty.

Local alignment means shared access to current, endorsed resources; agreed communication frameworks across settings; clear escalation pathways for cases where misinformation is causing acute harm; and regular — even brief — cross-sector communication about what is being seen locally. It does not require a large program. It requires a modest investment in coordination infrastructure and a shared commitment to consistency.

CESPHN is well positioned to play a coordinating role: publishing and distributing current local "misinformation alerts" that identify newly circulating claims, convening brief quarterly updates for primary care providers, maintaining an endorsed resource library accessible to practices and allied health, and supporting pharmacy and allied health to be part of the same messaging ecosystem as general practice.

Implications for community members, local leaders and health care providers

Misinformation is produced and amplified in many places, but its consequences are felt locally. That means local action is less about controlling the source and more about strengthening the conditions that support good decisions: trust, clarity, cultural safety, and access to timely advice. Community members and local leaders shape norms and trust. Many people do not begin by seeking official advice; they begin by asking someone they know. Trusted messengers — parents' networks, cultural and faith leaders, educators, community organisations and sporting clubs — can help by normalising questions, encouraging help-seeking, and reducing stigma. In practice, this is often less about 'correcting' and more about making it safe to return to a GP, pharmacist or service for a calm conversation.

Health care providers are often the most trusted source of health information, but the consultation environment is constrained. Providers are balancing clinical care with high demand, short appointment times, and growing complexity. What makes the difference in many encounters is not a perfect rebuttal, but a relationship-based approach: listening first, acknowledging the concern, offering a clear recommendation, and providing a next step that keeps the person connected to care.

Implications for system partners and service pathways

As system partners we can influence the conditions that make misinformation more or less ‘sticky’. Consistency across entry points reduces confusion, while fragmented advice creates space for doubt to grow. Practical alignment might include shared local messages during outbreaks or seasonal campaigns, clear referral and follow-up options, and making reliable information easier to access in the right language and format.

What progress might look like

Progress is often best understood through practical measures rather than perfect targets. It might look like people feeling more comfortable raising questions with trusted clinicians; fewer consultations that shut down due to conflict; improved follow-through for preventive care in targeted settings; and greater consistency of advice across services.

It may also look like reduced navigation load for families — clearer pathways, clearer expectations, and less need to rely on informal online advice to fill gaps. From a workforce perspective, progress can include frontline teams feeling more equipped and less isolated when they encounter recurring narratives, because they have shared resources, shared language, and clear options for follow-up or escalation.

Conversely what would signal that certain approaches are not helping? Well-intended responses could lead to increasing polarisation, increasing avoidance of care, or increased misinformation amplification.

Summary

Health misinformation is not something any one organisation can solve. But it is something we can influence locally through steady, respectful efforts that protect trust, reduce confusion, support frontline teams, and make reliable pathways easier to access — especially for those most at risk of being left behind.
For primary and community care providers, the ask is not heroic. It is to maintain trusted relationships, use evidence-informed communication frameworks, share the load across the care team, and connect with partners to ensure people receive consistent and clear messages.
For system partners, the ask is to provide the coordination infrastructure that makes this possible: shared resources, aligned messaging, and brief but regular cross-sector communication.

Discussion Questions

This workshop will move through four steps.
We will start with lived experience, then explore why it is persuasive, then identify where we have influence locally, and finally propose actions that worth trying together.

- What are we seeing? What does misinformation look like in day-to-day practice and community settings in our region?
- Why is it sticking? What makes particular narratives persuasive, and what system conditions make them harder to counter?
- Where are the leverage points? What could reduce confusion, strengthen trust, and support frontline care?
- What’s one small thing we could try together? A feasible step over the next 6–12 months that has meaningful impact with minimal burden.

Key Questions

1. In your setting, what misinformation themes are most common (immunisation and beyond), and how do they present as delay, refusal, substitution, conflict, disengagement, or service churn?
2. Are there particular communities, settings, or life stages where misinformation is more visible or more harmful?
3. What makes the narratives persuasive locally fear, identity, lived experience, social networks, or frustration with the system?
4. What approaches preserve trust and keep consultations workable especially when conversations are emotive or identity-linked?
5. In different communities, who do people listen to and what supports culturally safe engagement that normalises questions and help-seeking?
6. What is one small thing we could try together over the next 6–12 months with meaningful impact and minimal burden?
7. What kinds of responses risk amplifying misinformation or worsening distrust, even if well-intended?
8. What practical signals would indicate stronger trust, better follow-through, and reduced friction?