Health Misinformation in Primary and Community Care – Vaccination

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An Australian Government Initiative

Overview

Health Misinformation in Primary and Community Care

CESPHN Strategy Day | At-a-glance

What has changed

- **Decline** in vaccination rates.
- **Health misinformation** is **increasingly** recognised as a **system risk** (not only a communications issue), influencing trust, decisions and follow-through.
- Establishment of Australia's new CDC (from 1 January 2026) reflects the growing need for trusted, evidence-based advice and stronger preparedness.

Potential risks

- **Reduced or delayed vaccination increases** the risk of vaccine-preventable illness and outbreaks, with downstream impacts for families, primary care, and hospitals.
- **Frontline impact:** longer consultations reduce capacity for prevention and chronic disease management.
- **Quiet harm:** people may delay, substitute or disengage, then reenter the system later with higher acuity.
- **Equity impact:** harms concentrate among people with less access to trusted care, language barriers, or fewer supports.
- **System impacts:** avoidable escalation (including hospital demand) when prevention and early intervention are missed.

Why it matters

- High cultural and linguistic diversity increases the need for trusted information.
- Population mobility and service complexity can weaken continuity of care and increase reliance on online sources.
- Increased pressures reduce capacity for people to verify claims and get vaccinated.
- If advice is inconsistent across entry points, inconsistency itself becomes a resource for doubt.

Key messages

- **Trust is key:** misinformation often reflects fear, identity and lived experience - not just facts.
- **Consistency reduces doubt:** aligned messages and clear pathways across services make misinformation less 'sticky'.
- **Delay is not neutral:** hesitancy and disengagement can mean missed prevention and later, more complex care.

At a glance: Who is most at risk

- People **without stable access to trusted care** (no regular GP or pharmacy relationship).
- Communities facing **language barriers**, **lower health literacy** or **limited digital access**.
- People with **low income, insecure housing, trauma exposure, disability, or new migrants/refugees**.
- Carers and families carrying the navigation and **decision burden**.

The CESPHN region

- **Childhood immunisation** coverage in **CESPHN** varies significantly in **culturally diverse areas**. In the 12 months to **September 2025**, the proportion of children fully immunised in **CESPHN** was **92.9.% at 1 year, 90.8% at 2 years, and 92.5% at 5 years** this compares to areas like **Canterbury** with rates of **88.8% at one year, 86,2% at 2 years and 89.1% at 5 years.**
- For **influenza**, uptake among people aged **65+** also varies significantly by cultural diversity. In the 12 months to **September 2025** proportion of vaccinated adults was **72%** but was much **lower** in **Canterbury** and **Botany.**
- **COVID** and **shingles** vaccination rates remain **low.**

Discussion questions

- What are we seeing locally?
- Why is vaccine hesitancy sticking—what makes narratives persuasive here, and what system conditions make them harder to counter?
- How is vaccine hesitancy affecting frontline teams and community leaders in practice?
- Where are the leverage points to reduce vaccine hesitancy - what could strengthen trust, reduce confusion, and improve vaccine use?
- What is one small thing we could try together over the next 6–12 months?