

Draft outline:

November 2010

New Zealand National Immunisation Plan: the Six Star Plan

*A New Zealand commitment to having all New Zealand children well protected
against vaccine-preventable disease*

I would put a brief summary of the 6 points of the strategy in here

Background

Every country in the world has a childhood immunisation programme committed to protecting their population against vaccine-preventable diseases. These programmes are based on the best available evidence and, when effectively delivered with high population coverage, they offer very good control against these diseases.

NZ has increased immunisation coverage in the past few years and it is likely with the current improvements seen in service delivery NZ will be able to achieve over 90% of infants fully immunised at the age of 2 years. However to get the best disease control immunisation coverage rates need to be as high as 95%, infants need to receive their immunisations on time at the recommended schedule ages, and immunisation coverage rates for older children at the ages of 4 and 11 years (which lag behind rates for younger children), also need to improve.

The NZ health care system offers free immunisations to all NZ children. This is, in the majority of cases, working well. However further changes and refinements are needed to improve the effectiveness of service delivery.

In the current NZ environment, parents are expected to make an active and informed decision to immunise their children. There are a range of community conversations that negatively affect confidence in the science of vaccination and the immunisation programme. The evidence-base behind the immunisation programme is not at times well understood or well communicated to families and the community. 'Science' is seen as dispassionate, manipulated and uncaring. Equal weighting is often given to personal experience, and anecdote, with these often presented as 'fact' rather than opinion. Many parents find this difficult, and given their perception of disease risk (low), they find it easier to abdicate responsibility and make no decision. The current systems will not necessarily seek to follow up these parents and determine what help they may require to make their decision.

Vaccine-preventable diseases are less visible in the community, due of course to a great extent to immunisation coverage. This perceived absence of risk of disease does lead to more focus on questioning the need for vaccines, and magnifies any perceived concerns regarding vaccine safety. In the absence of disease it is easy to attribute success to other reasons, such as improved hygiene, 'natural' immunity and unproven immunity improvement products. Immunisation is mostly seen as an individual parental choice and relevant to children only, and can miss the broader issue that this is a significant concern for the whole NZ community.

Countries such as the United Kingdom and Australia have shown that with strong national commitment, advocacy and health community leadership high immunisation coverage can be achieved resulting in good disease control, without resorting to mandatory policies. These effective approaches include a mixture of local requirements, incentives and a strong focus on communication strategies. Obligations and incentives are effective both at the health care professional and public level, when well tailored to the local environment.

Basis of the six star plan

- New Zealand is committed to delivering a high quality national immunisation programme.
- All New Zealand health care professionals are committed to advocating the best evidence base behind the national immunisation programme.
- Every family is expected to consider immunisation for their children and make a timely active decision.
- NZ will further enhance its immunisation safety surveillance programme.



Component One Enhanced Business-as-Usual

- All significant political parties endorse the national immunisation programme.
- Introduce targets for on-time immunisation in infancy and for older age groups
 - 95% immunisation rates at 6 months, 16 months and 4 years .

(NB targets for 11 years can be introduced in 5 years time when the NIR data covers this age group)

Improving systems

- Agree that the DHBs are responsible for immunising their populations and that funding and contracting arrangements should be aligned to accountability.
- DHBs responsible for 100% enrolment for all infants at birth (or antenatally) with a general practice.
- DHBs undertaking contractual approaches with PHOs to support general practice being responsible for immunisation coverage of their enrolled populations.
- Continue to improve the functionality of the National Immunisation Register (NIR) at all levels and undertake a review of the NIR functionality.
- Align the PHO performance payments with the NIR reporting.
- Regular publication of DHB targets. Ministry of Health to publish an annual review of immunisation showing changes over time in coverage, disease rates and adverse events.
- Maintaining functioning Immunisation Steering Groups in all DHBs.

Service Delivery

- DHBS to ensure that immunisation services are available to parents/individuals from a wide range of providers at times and locations that suit the parent/individuals and consider using these opportunities to integrate with other services to improve the health of the child/individual.

Cross Sectorial Initiatives

- The Ministry of Health to work closely with Ministry of Education to review health education curriculum in antenatal arena and in schools to include immunisation and vaccine preventable diseases as a core component of health curricula.

Increased focus in the Antenatal Arena

- Review and further development of good immunisation promotional materials and decision-making tools for parents antenatally.
- Improve options for education and resources for childbirth educators.
- Increase amount and availability of education/training for Lead Maternity Caregivers.

Improve Adverse Event notification reporting

- Increased vaccine safety data reporting as per the UK and Canadian systems including regular reporting via the Medicines Adverse Reaction Committee (MARC) and regular publication of adverse events reported to the Centre for Adverse Reaction Monitoring (CARM).

Costs: should be part of current service delivery



Component Two: Contractual/legislative

- All contracts for immunisation service delivery will specify an obligation to promote the evidence-base behind immunisation for NZ children.
- All health care professionals are under a legal obligation to neither promote nor disseminate immunisation information that is not evidence-based and not supported by the national programme.
- Health professionals involved in immunisation service delivery must be committed to offering timely immunisation to all children for best protection (i.e. keeping to the recommended schedule time frames).

A review of all contracts with health providers who promote and/or deliver immunisation services will be undertaken. All contractual language and obligations are to be reviewed to conform to the above and remove any ambiguity. Contracts are to be strengthened to recognise health care professional obligations to promoting the evidence-base.

Costs: should be able to be absorbed into the current structures.



Component Three: Responsibilities/support for Primary Care

- Primary Care services will be supported to ensure all their enrolled population of infants have access to the first immunisation event on time.
- Primary care service providers will support all parents to make an active decision to immunise their infants on time, or to formally choose to decline immunisation.

1. All children in NZ need to be enrolled with a general practice (via PHO enrolment) at birth or prior to birth. This is an obligation for DHBs working with PHOs in all areas.

Costs: should be part of current commitments

2. All general practices need to ensure parents or caregivers of enrolled children are contacted **prior** to 6 weeks of age and offered appropriate immunisation services. At the 6 week check, infants are either immunised or a full decision-making protocol with a completed declination form for those who chose to decline immunisation. Services can either be offered at the practice or elsewhere (e.g. with Outreach Immunisation Services, Well Child providers etc) but the practice is responsible for ensuring this has occurred. Extra funding is provided to recognise the responsibility, extra time and resourcing costs of achieving timely immunisation at the 6 week check.

Estimated costs: an extra \$10 on top of the current Immunisation Benefit Subsidy for the 6 week check to be delivered by 10 weeks of age or a record of a completed declination form. Birth cohort of 55,000 – 90% uptake = \$495,000 + system payment set-up costs for claiming

3. General Practices are committed to the national immunisation target of 95%. There is recognition that the current Immunisation Benefit Subsidy is adequate (along with other practice subsidies that support this) for the children who attend regularly but extra time and resources are needed for the children who are harder to locate and do not reliably attend. Extra practice funding will be given to support the time commitment to accessing the families who do not bring the children after a simple precall/recall phone call, letter or text. On average around 80 – 85% of children are immunised with current effective GP systems, 10% require more active, more frequent contacting, 2- 5% are even harder and may need to be referred to Outreach services and 5% are decliners. Children from backgrounds of greater socio economic deprivation or Maori and Pacific ethnicity are harder to access. Increased funding for accessing these children will be based on recognising that the average general practice requires extra funding for around 10 – 15% of children, but practices

with higher deprivation populations, higher percentages of Maori and Pacific will require extra funding.

A tiered approach will offer funding to practices who achieve high immunisation coverage, in recognition of the extra time and resources required to audit and recall these children. The funding will be given to the practices pro rata, based on their coverage rates at the ages of 2 years and 5 years.

Estimated Costs: suggest we check what the UK, both England and Scotland put in their funding formulas here to come up with some costings. At a rough guesstimate maybe an extra \$20 for 10% of the childhood enrolled population in a practice under 2, up to 15% for practices with higher needs populations. Add in a similar incentive system at 5 for fully immunised at the 4 year old visit..

Kids under 2 years in NZ = 110,000: $10\% \times \$20 = \$220,000$, and maybe another \$110,000 for 4-5 year olds. Need a bit of analytic work on it but maybe 20% of practices with higher needs (22,000 kids) adding another \$20 for 5% = \$22,000. Please no one hold me to cornflakes packet maths!

Total: $\$220,000 + \$110,000 + \$22,000$ roughly \$360,000 and set up costs



Component Four: Responsibilities/support for parents

Strengthen legislation that requires parents to present immunisation certificates when their child starts early child care services and schools, particularly for the early childcare services to support delivery of on time immunisation.

1. When a parent enrolls a child, they either present a certificate demonstrating a fully completed immunisation series appropriate to the age, or a completed 'declination' form. Either needs to be delivered and recorded by the Early Child Care centre. If a child is enrolled when they are under 2 years of age, on their second birthday the ECC will be obliged to contact the parents and sight/record the completed certificate or 'declination' form.

Estimated Costs: \$5 to each ECC for every child enrolment and a further \$5 for each child turning 2 needing to recheck if there is not a certificate completed to the 15 month event. Assume birth cohort of 55,000 and 80% enrolled in ECC - \$275,000 and a bit more for those needed to be contacted who started prior to 18 months i.e. prior to completion of the 15 month event. Also need set up costs for allocating funding to ECC centres.

Could also do this for enrolment at primary schools and secondary schools (covers the 11 year old event and the HPV programme) but adds significant costs.

2. The current 20 hours free entitlement to early childcare education will continue to be offered to all parents/caregivers; however eligibility will include the obligation to show a certificate of completion of immunisation events or a 'declination' form.

Estimated costs: some compliance costs of setting up the system for checking (but it should already be on ECC registers and on the NIR).

3. Government child benefits – when a child turns 2 years of age a parent receiving any child benefit will be obliged to show a completed immunisation certificate or 'declination' form. In recognition of the extra effort required to obtain the certificate and attend a WINS office to show the certificate parents/caregivers will be entitled to a \$20 one off payment.

Estimated costs: compliance costs for WINS and \$20 a child for all 2 year old children of beneficiary parents. I haven't checked the numbers here but made a very rough assumption 10,000 children = \$400,000.



Component Five: Communications

Communicating the need for immunisation is paramount to the success of an immunisation programme. In a country where parents make an informed decision to immunise, the responsibility to provide them with the means to make that decision lie with the governing bodies of the health system.

Communication strategies should move beyond reactive plans for outbreaks and epidemics. The way forward is to normalise immunisation as the 'default' position for a healthy lifestyle, rather than a stressful decision that exposes your family to risk from vaccines side effects.

Building understanding and trust in the media is an important step. Communities are affected by national and international stories of actual or perceived vaccine risk. Media organisations need to have easy access (at any time) to articulate and knowledgeable spokespeople who can communicate effectively to lay people.

Providing an understanding of disease risk in the New Zealand context requires New Zealand images and stories. Developing local resources available for media and health promoters will help guide the way immunisation is represented in the media, and in education materials.

The way that New Zealanders access information is changing, immunisation information needs to be available in whatever format works best for a particular audience.

Coordination between PHO, DHB and national immunisation communication strategies would both maximise expenditure and manage oversaturation or conflicting messages. When communication moves towards a more proactive approach, such coordination should become more achievable. This does require a stable and connected communication workforce at varying national and local levels.

Potential communication components:

1. Guidelines for immunisation communication

Develop and disseminate evidence-based guidelines for Primary Care and PHOs, defining how to differentiate immunisation audiences within their catchment, and what messages and delivery mechanisms are most effective.

2. Experience of disease resources

Record personal, New Zealand-based stories of current/recent experiences with vaccine-preventable diseases. Make these available in a variety of materials. Ensure a broad range of subjects from varying cultural and social backgrounds.

3. Consistency of messages and information collateral

Provide editorial consistency across resources developed to provide immunisation information.

4. Effective print, internet and social media monitoring with rebuttal of misinformation

Building on existing monitoring, develop a protocol that organisations can use to effectively identify and refute inaccurate or misleading immunisation information. This is as much about understanding when not to respond as it is how to respond.

5. Improve communication and relationships with key groups

There are key groups who can be central to parents' immunisation decision-making. Lead Maternity Caregivers, antenatal education groups, parent advocacy groups are all strongly linked to families at the time when most immunisation decisions are being made. Specific communication plans are needed to engage effectively with each type of organisation. Careful relationship management would ensure that such groups may come to better understand evidence-based immunisation information and feel confident in communicating that to their audiences.

Estimated Costs – can be as much as you can allocate after costing the other components out,



Component Six: Safety Surveillance

NZ has an excellent passive safety surveillance system via the Centre for Adverse Reaction Monitoring at the University of Otago, with event reporting rates being one of the highest in the world. However NZ parents remain concerned that a passive system does not guarantee that all safety signals are appropriately noticed and responded to. There are also common misconceptions regarding the significance of event reporting, especially a misunderstanding about causality between vaccines and adverse events. The development of the National Immunisation Register enabled the meningococcal B immunisation programme to develop a high quality vaccine safety monitoring system that was recognised as world quality. NZ will take many aspects of this programme to enhance the vaccine safety monitoring for the national immunisation programme.

In recognition of community concerns and the need to maintain a high quality programme NZ will offer a range of enhancements to its vaccine safety monitoring programme. By utilising the National Immunisation Register and disease coding systems within general practice coding systems and the hospital ICD10 coding systems NZ has now has the capability to offer a broader, more active vaccine safety surveillance system.

NZ will develop an Independent Vaccine Monitoring Programme (IVMP). Recommended approach includes:

- The current health professional and public safety reporting on any incidents of concern following receiving an immunisation event.
 - Enhancing the opportunities and ease for public reporting via all modalities including online and hardcopy.
- Enhanced adverse event reporting – as per the intensive medicine monitoring programme, focusing on specific issues or vaccines in a more proactive encouragement for health providers to report any concerns. E.g. with the introduction of a new vaccine
- Active monitoring for potential events of concern via database matching Examples include:
 - General Practice based: assessment of suspected adverse events following immunisation via use of electronic detailing of events coded on the practice management systems from sentinel general practices and using the NIR to compare rates in immunised with unimmunised children.

- Hospital and Emergency Department based: assessment of suspected adverse events following immunisation via use of electronic detailing from hospital and ED based coding (ICD disease coding) and use of the NIR to compare rates in immunised with unimmunised children.
- The development of an Independent Safety Monitoring Board to review the IVMP results, regularly assess and report on the safety aspects of the vaccination programme.

Estimated costs: not sure. Maybe the ISMB about 30,000. Enhancing adverse event monitoring 200 – 300, and another 200,000 for lots of active monitoring. Perhaps 450,000 in total