Ministry of Health response to Dr Nikki Turner's submissions
1 December 2010

The Health Select Committee asked Dr Nikki Turner from the Immunisation Advisory Centre to review the Ministry's report and to provide her recommendations for improving immunisation coverage.

Dr Turner submitted 2 documents to the Committee as private evidence:

- Comments on the Ministry's final report and recommendations
- Draft 6-star plan:
  1. Enhance business as usual
  2. Contractual/legislative
  3. Responsibilities/support for primary care
  4. Responsibilities/support for parents
  5. Communication
  6. Safety surveillance

The Ministry has been asked to comment on these documents at the Committee's 24 November meeting.

The Committee also asked for qualitative data on completed immunisation certificates at early childcare services as required by legislation. The committee would like to know if the legislation is enforced in any way.

Summary

In summary, the Ministry and Dr Turner share the common goal to protect New Zealanders from vaccine preventable diseases. The Ministry and Dr Turner regularly work together and share ideas – and therefore we agree with most of what Dr Turner has provided in her 2 documents – just as she has endorsed most of our approach to achieving the immunisation coverage target.

However, there are some components of Dr Turner's plan that the Ministry does not agree with, these are outlined below and can be discussed on 24 November.

The Ministry's view is that building and maintaining trust among the public as well as providers is critical. Although an approach based on stronger advocacy and regulation is a genuine option, our view is that it also creates significant risks and could erode rather than build trust. The Ministry also considers Dr Turner's costings to be underestimates – especially for IT systems and communications campaigns.

In terms of immunisation registers at schools and child-care centres, parents are not legally required to provide immunisation certificates but the institution is obliged to ask for them and record either the diseases covered, any lab-proven immunity, or that no certificate was provided. The Ministry does not undertake any active enforcement but the Education Review Office mentions it in their Handbook of Contractual Obligations and Undertakings and does audit this requirement. Medical Officers of Health would ask for the registers if there was an outbreak of a vaccine-preventable disease at a school or centre.

1. Enhance business as usual

Ministry comment
The Ministry agrees with Dr Turner's proposals and comments with the very minor addition that general practices may not suit all families, so some other service delivery models will also be needed.

2. Contractual/legislative proposals:

- Contracts for immunisation services to 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 must be committed to keeping to the recommended immunisation schedule time frames

Ministry comment
The Ministry disagrees with using regulation and contract obligations to deal with 'provider ambivalence'. Although there is evidence that some providers are ambivalent, the numbers are small and there is also evidence that access to healthcare is a bigger problem. This approach does not address the biggest problems, risks undermining rather than building trust, and puts the Ministry in between a physician's care of their patient. The Ministry is not comfortable with prescribing the informed consent conversation between the provider and the patient – our role is to help rather than restrict what can be said in these conversations. We are making differences to contracting, funding and delivery systems that, while not radical, are significant enough that we should be able to achieve the immunisation coverage target without regulation.

3. Responsibilities/support for primary care

- All children enrolled with a PHO at birth or prior to birth
- Enrolled children contacted by primary care provider before the 6 week check; additional $10 paid per child for the 6 week check to be delivered by 10 weeks of age or parent completes a decline form.
- To reflect the extra effort required for primary care to reach some of their enrolled children, an additional payment is made to primary care providers when the enrolled child turns 2 and is fully immunised; high needs practices would receive more funding

Ministry comment
The Ministry agrees that the first primary care visit at 6 weeks of age is important. We support the recommendation that all children should be enrolled on the NIR and with a primary care provider at birth and that the transfer of care between providers is seamless and suitable for the patient.

The Ministry considers that asking parents to sign a form declining immunisations might work, but also creates some risks and would need to be discussed with the Health and Disability Commissioner. Feedback from providers about this proposal is mixed, with quite strong views both for and against. Such an approach may not work for parents who want to delay rather than avoid all immunisations. Our audience research suggests that some parents who have chosen not to immunise reconsider when they feel their risks change (when children turn 2, if they move, or before they

start school), so we would not want to lock them into a decision made soon after birth. The Ministry has been working with the office of the Health and Disability Commissioner to improve our consent forms and the way informed consent is described in the Immunisation Handbook, so they would expect to be involved in proposals for a formal document to decline immunisations.

As per previous advice to the Committee, the Ministry does want to explore incentives, but any incentive scheme needs to be carefully thought through to ensure there are no perverse unintended consequences.

Rather than having parents sign a declination form, providers could be incentivised to complete the already existing Immunisation Certificate by 15 months and 5 years of age. This would mean that parents are given a further opportunity to discuss immunisation with their primary care provider. This approach will not directly improve timely immunisation for babies and infants but may improve coverage in older age groups. Further work is needed to explore how this could be implemented and to determine costs (if any).

4. Responsibilities/support for parents

- Funding to early childhood centres (and potentially primary and secondary schools) for each child enrolled and who has presented a certificate demonstrating a fully completed immunisation series appropriate for the age, or a completed ‘declination’ form
- 20 hours free entitlement to early childhood education continues but only if parents show a certificate demonstrating a fully completed immunisation series appropriate for the age, or a completed ‘declination’ form
- Government child benefits - when a child turns 2 years of age a parent receiving any child benefit will be required to present to the WINS office a certificate demonstrating a fully completed immunisation series appropriate for the age, or a completed ‘declination’ form, and would receive a one-off $20 payment.

Ministry comment

As per previous advice to the Committee, the Ministry does want to explore incentives, but any incentive scheme needs to be carefully thought through to ensure there are no perverse unintended consequences. Our audience research suggests that children who are not fully immunised are less likely to attend early childcare education.

5. Communication

- Campaigns to ‘normalise’ immunisation and build trust and understanding about vaccines and risk and benefit.

Ministry comment

Data from the National Immunisation Register and the Ministry’s audience research indicates that the main barrier to immunisation is access to services rather than parent ambivalence. But the Ministry agrees that communication is important and there is room for a more proactive and more targeted approach, especially to explain the relevance of these diseases to modern New Zealand families.

Communication campaigns can be very expensive, and a general communication campaign may not target the right groups of people. The Ministry's view is that targeted media, including using new social media like Facebook and YouTube are likely to be the most effective ways to communicate with younger parents.

6. Safety surveillance

- Enhance public reporting of adverse events – online and in hardcopy
- Set up an intensive vaccine monitoring programme focusing on specific issues or vaccines and encourage providers to report any concerns – eg with the introduction with a new vaccine
- Active monitoring of potential events of concern via database matching
- Develop an intensive safety monitoring board to review the intensive vaccine monitoring programme results, and assess and report on the safety aspects of the vaccination programme.

Ministry comment

We agree that long term investment in safety systems would improve confidence and vaccine safety and the Ministry intends to pursue several options. One option is to implement an intensive vaccine monitoring programme, using sentinel practices as was used with the Meningococcal B Immunisation Programme. This would involve a step increase in investment – to increase the capacity at the Centre for Adverse Reactions Monitoring and to expand IT systems.

The return on investment may not justify the costs to set up new systems, especially as our small population mean that we may not be able to detect any problems quickly and would not be able to detect rare events at all. Most of the vaccines we use are widely used and monitored in other countries already. Database matching may have benefits for the health of individuals, and this option could be considered in planned review of exiting databases and development of new ones. The Ministry and the University of Otago are already working on proposals for matching databases to assess medicine safety, including managing the privacy implications.

Whatever the vaccine safety systems look like in the long term, they must be responsive to patients and clearly show that the health system is acting in their interests.

The Medicines Adverse Reaction Committee already review vaccine adverse reactions at each meeting and can publicly speak to issues if they arise. The Committee is currently considering whether to add vaccine expertise to its membership (to fill an existing vacancy).