**Auckland Regional Public Health Service**
Rātonga Hauora ā Iwi o Tamaki Makaurau

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**Submission on Newborn Enrolment with General Practice Bill**

Thank you for the opportunity for Auckland Regional Public Health Service (ARPHS) to provide a submission to the Newborn Enrolment with General Practice Bill.

The following submission represents the views of ARPHS and does not necessarily reflect the views of the three District Health Boards it serves. Please refer to Appendix 1 for more information on ARPHS.

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**Summary**

1. The Auckland Regional Public Health Service (ARPHS) supports in principle the Newborn Enrolment with General Practice Bill (the Bill) as it formalises existing policy and best practice by setting explicit legislative timeframes for actioning newborns' pre-enrolment and 6-week immunisation pre-calls. Making this process a legislative requirement should further improve New Zealand's infant immunisation coverage and timeliness.

2. ARPHS considers there are opportunities to strengthen the Bill, and recommends that the Health Committee widen the Bill's scope to encourage greater communication between lead maternity carers (LMCs) and primary care, with the principal aim of improving maternal immunisation rates.

3. ARPHS considers the maternal pertussis booster is the most significant new pertussis (whooping cough) preventative intervention to emerge in the last two decades. Yet unlike the UK, uptake of maternal vaccination in New Zealand has remained low, and improvements in the system of delivering maternal vaccination are needed.[1]

4. This Bill provides an opportunity to support efforts to increase coverage by including provisions that require general practices and LMCs to work together to offer pregnant women maternal vaccinations.

**General support for the Bill**

5. ARPHS strongly supports the general principle behind this Bill as it seeks to further improve infant immunisation coverage and timeliness.

6. Latest statistics of Auckland's child immunisation rates illustrate that there is still room for improvement. According to the most recent data from the immunisation and catch-up schedules[2] (1 July 2016 to 30 June 2017), 94.1%, 93.4% and 91.8% of children were fully immunised at age eight months in the Auckland, Counties Manukau and Waitemata DHB areas respectively.

7. Vaccine preventable diseases are still important causes of childhood illness in New Zealand. The risk of vaccine-preventable diseases is greater if childhood immunisations are delayed or missed.[3] Delays are more likely to result in lower overall coverage, and receiving the first dose on the vaccination schedule on time is a strong predictor for subsequent complete immunisation.[4] We are also in the midst of large outbreaks of mumps and pertussis.

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[1] Reynolds, Gary & Grant, Nicola & Thornley, Simon & Hale, Michael. (2017). Low uptake of maternal vaccination in notified pertussis cases aged less than 20 weeks. *The New Zealand Medical Journal*. 130. 69-71.

[2] Accessed via http://archive.stats.govt.nz/browse_for_stats/snapshots-of-nz/nz-social-indicators/Home/Health/childhood-immunisation.aspx

[3] Goodyear-Smith, F., Grant, C., Poole, T., Petousis-Harris, H., Turner, N., Perera, R., & Harnden, A. (2012). Early connections: effectiveness of a pre-call intervention to improve immunisation coverage and timeliness, *Journal of Primary Health Care,* 4(3), p. 189-198.

[4] *Ibid*

8. Existing evidence supports the provisions in the Bill promoting early pre-enrolment with a primary care provider and 6-week immunisation pre-calls. Research conducted by Goodyear-Smith et al[5] examined the effectiveness of a general practice-based pre-call intervention to improve immunisation timeliness in the Auckland DHB area. This study found that non-enrolment of infants at birth with a general practice is a significant factor in delayed or missed immunisations. Notably, infants with no nominated general practice significantly reduced the overall coverage rate for the region, making the general practices look as though they were performing less well than they were.

9. We further note that a recent systematic literature review[6] shows that reminders and recall systems (which are made possible by having patients on a practice register) are effective interventions for improving immunisation rates among adults and children across various settings.

10. Early enrolment also provides other benefits, as it provides an opportunity for the general practice to inform the family what other support it might be eligible for to protect the child's health and wellbeing.

11. The 2013 report from the Inquiry into improving child health outcomes recommended to the Health Select Committee that the Government require the enrolment of children in general practitioner health services before discharge from the postnatal ward or from the LMCs care, to ensure continuing engagement with primary care and Well Child services, and timely newborn enrolment. This recommendation reflected the findings in the previous 2011 Inquiry into improving rates of childhood immunisation.

12. In practice, newborn notifications are already sent to general practices through the National Immunisation Register (NIR). These notifications are the main trigger for pre-approving enrolment of newborns and activating pre-calls for immunisations and other health care services. In 2012 the Ministry implemented the preliminary newborn enrolment policy to improve the timeliness of enrolment.[7] It enabled general practices to pre-enrol newborns following an NIR notification.

13. Thus the Bill formalises existing practice by setting explicit legislative timeframes for actioning newborns' pre-enrolment and 6-week immunisation pre-calls.

14. With the inclusion of appropriate compliance and maternal vaccination provisions, and with adequate funding and resourcing behind it, this Bill could form legislation that moves beyond supporting the status quo.

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[5] *Ibid*

[6] Jacobson Vann JC, Jacobson RM, Coyne-Beasley T, Asafu-Adjei JK, Szilagyi PG. Patient reminder and recall interventions to improve immunization rates. Cochrane Database of Systematic Reviews 2018, Issue 1. Art. No.: CD003941. DOI: 10.1002/14651858.CD003941.pub3.

[7] Ministry of Health. 2014. Enrolling babies at birth: a resource for general practice. Wellington: Ministry of Health.

**Extending Bill's scope for maternal vaccination**

15. Immunisation during pregnancy has the potential to protect the mother and the infant against vaccine-preventable diseases. Currently in New Zealand pregnant women can access fully funded influenza and whooping cough vaccines during pregnancy, and this is encouraged by the Ministry of Health (MoH).

16. The opportunity to extend the scope of this Bill to include maternal vaccination is pertinent given New Zealand is currently experiencing a national outbreak of pertussis. On 1 December 2017, a MoH press release declared a national outbreak of pertussis with 1,315 reported cases nationwide since the beginning of 2017.

17. ESR reporting[8] shows that there continues to be a high rate of pertussis cases in the <1 age group, and in 2017, 52% of the cases within this age group were hospitalised. Our own data for Auckland shows that 70% of cases in the <1 age group have been hospitalised for the same period.

18. Due to their immune system not being fully developed, the highest risk period for pertussis for infants is in the first four months of life before the primary series of immunisations is completed.

19. Maternal immunisation was used as an epidemic control strategy during the last pertussis outbreak in 2013 because the most vulnerable infants are those too young to be immunised, and transmission from household members is a significant risk factor. Maternal pertussis vaccination increases protective antibody levels in newborns due to transplacental transfer.[9] There is a growing body of evidence that demonstrates that maternal pertussis vaccination with Tdap (Boostrix) provides some passive immunity to the infant during their first six months of life.[10]

20. Despite the internationally recognised benefits of this intervention (vaccine efficacy 91%), and maternal boosting being funded and recommended, maternal pertussis vaccination uptake across New Zealand is low, especially when compared to overseas programmes that have been running for a similar length of time. ARPHS was recently informed that all three Auckland DHBs had maternal immunisation coverage rates below 45%. The coverage rate in the UK is 75%, and has approached 80% in recent times.[11]

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[8] Accessed via https://surv.esr.cri.nz/surveillance/PertussisRpt.php

[9] Warfel JM, Beren J, Merkel TJ. Airborne transmission of Bordetella pertussis. *The Journal of infectious diseases.* 2012;206(6):902-906.

[10] Centers for Disease Control and Prevention. Updated recommendations for use of tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine (Tdap) in pregnant women and persons who have or anticipate having close contact with an infant aged <12 months --- Advisory Committee on Immunization Practices (ACIP),. *MMWR Morb Mortal Wkly Rep.* 2011;60(41):1424-1426.

[11] Amirthalingam G, Andrews N, Campbell H, et al. Effectiveness of maternal pertussis vaccination in England: an observational study. *Lancet (London, England).* 2014;384(9953):1521-1528.

21. In 2014 the Health Quality and Safety Commission[12] made a number of national policy recommendations, local recommendations and community messages for pertussis prevention, including:

    - *..."A national system should be developed that helps facilitate pertussis booster vaccination referrals and improves two-way communication between GPs and LMCs. This system should:*

        *a. facilitate the safe and appropriate recall of pregnant women for their third trimester immunisation*

        *b. allow GPs and other immunisation providers to notify LMCs when the immunisation has been provided."...*

    - *"All health providers in a general practice setting (ie, practice nurses and GPs) who confirm a pregnancy should initiate a plan to safely recall the pregnant woman for a pertussis booster vaccination in the third trimester.*

    - *LMCs in contact with pregnant women in the third trimester should ensure those women:*

        *a. are aware that a pertussis booster vaccination in the third trimester can protect young infants from pertussis*

        *b. understand where they can go to receive a pertussis booster vaccination in their region, and are offered the vaccination, or referred to an appropriate immunisation provider..."*

22. LMCs are not currently obliged to communicate with a woman's general practice during her pregnancy. For pregnancies confirmed at a general practice, we understand some general practices have a policy where they choose to enter the woman's details into the Practice Pregnancy Register, which allows them to offer Boostrix immunisations to the woman at the appropriate time during pregnancy.

23. We note from its 1 December 2017 press release that the MoH has asked midwives and general practices to work together to ensure that pregnant women are referred to general practices for maternal immunisation.

24. This Bill provides an opportune time to encourage greater maternal vaccination uptake, and improve communication and coordination between general practices and LMCs.

25. We recommend that the scope of this Bill be widened to include provisions requiring the LMC to notify the nominated general practice that a woman has booked with them to receive pregnancy care. This would enable general practices to recall their patients for maternal immunisation in the third trimester. The general practice should also be required to notify LMCs if maternal vaccinations are administered.

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[12] Child and Youth Mortality Review Committee, Te Ropu Arotake Auau Mate o te Hunga Tamariki, Taiohi. 2015. Mortality and morbidity of pertussis in children and young people in New Zealand: Special report 2002–14. Wellington: Child and Youth Mortality Review Committee.

26. There is evidence for pertussis maternal vaccination to be effective across the second and third trimester. The Auckland SHIVERS study showed the susceptibility of pregnant women to severe influenza so vaccine delivery is required across the whole pregnancy.

27. Having these requirements in the Bill will help to enhance communication between primary and maternity care providers. Earlier presentation to a general practice could also provide non-vaccination benefits, such as identifying smoking or diabetes during pregnancy.

28. In the future there are likely to be more vaccines for use in pregnancy to protect young infants from disease. New vaccines already in development include respiratory syncytial virus, Group B streptococcus and cytomegalovirus.

**Other matters**

*Adequate funding and supportive measures*

29. Barriers to immunisation coverage and timeliness can be due to structural and organisation aspects of general practices.[13] Due to differences in staffing, infrastructure capabilities, and existing practice systems and processes, there is likely to be a varying ability amongst general practices to deliver on the requirements set out in the Bill. Therefore, adequate support and funding will need to accompany this Bill to ensure general practices can fulfil the requirements set out in it without being financially burdened.

30. In addition, adequate funding and support for initiatives that seek to address immunisation inequities is still necessary. Families in environments of poverty face a range of immediate challenges that are likely to take precedent over accessing primary health care immunisation services. Families that are highly mobile pose a considerable barrier to holding accurate parent contact information. Continued support and funding for outreach immunisation services (OIS) will be necessary to follow-up on those children and their families who fail to present for vaccination in a timely fashion.

31. The 2014 Health Quality and Safety Commission report noted that some pregnant women decided not to get their free Tdap booster vaccination for pertussis because they were told by their general practice they needed to have a consultation in order to receive the vaccination, and therefore would be charged a consultation fee. It was suggested in the report that having a fully funded GP visit for all pregnant women in their third trimester would remove this cost barrier and help establish relationships for post-natal care. ARPHS would support such a measure.

*Compliance*

32. We note the Bill contains no measures to encourage the responsible practitioner or general practice to comply with the provisions in clauses 4-6.

[13] Turner, N., Charania, N., Chong, A., Stewart, J. & Taylor, L. (2017). The challenges and opportunities of translating best practice immunisation strategies among low performing general practices to reduce equity gaps in childhood immunisation coverage in New Zealand, *BMC Nursing,* 16:31.

33. While not wanting to add an unnecessary burden on existing resources, consideration should be given to requiring some form of auditing or reporting mechanism to monitor compliance.

*Clause 6 responsibilities*

34. Following the receipt of a pre-enrolment request, clause 6(1) allows a nominated general practice to decline enrolment of a newborn if it has a "good reason". The wording in this clause is ambiguous and subjective in nature, and has the potential to undermine the intent of the Bill.

35. According to the MoH,[14] the main reason a practice declines a NIR request is that it does not know the family concerned. More concerning would be if a practice chose to refuse enrolment due to a caregiver's outstanding debts or had made a previous complaint against the practice. Furthermore, if a lack of time or inadequate administrative support is a good enough reason, then GPs who are currently underperforming in this area will continue to do so.

36. We understand there is currently no contact details included in newborn NIR nominations sent to GPs, and only the mother's name is included. General practices need to utilise other systems and processes to get the contact details. This lack of information may be used by some general practices to enact clause 6(3), and it also complicates the process set out in clause 6(2).

37. A more descriptive drafting of this provision is warranted to provide more clarity for all parties concerned. Before referring a newborn back to the PHO under clause 6(3), ARPHS recommends a general practice should have to first outline its rationale for declining the newborn's pre-enrolment request.

[14] Citation: Ministry of Health. 2014. Enrolling babies at birth: a resource for general practice. Wellington: Ministry of Health.

**Appendix 1 - Auckland Regional Public Health Service**

Auckland Regional Public Health Service (ARPHS) provides public health services for the three district health boards (DHBs) in the Auckland region (Counties Manukau Health and Auckland and Waitemata District Health Boards).

ARPHS has a statutory obligation under the New Zealand Public Health and Disability Act 2000 to improve, promote and protect the health of people and communities in the Auckland region. The Medical Officer of Health has an enforcement and regulatory role under the Health Act 1956 and other legislative designations to protect the health of the community.

ARPHS' primary role is to improve population health. It actively seeks to influence any initiatives or proposals that may affect population health in the Auckland region to maximise their positive impact and minimise possible negative effects on population health.

The Auckland region faces a number of public health challenges through changing demographics, increasingly diverse communities, increasing incidence of lifestyle-related health conditions such as obesity and type 2 diabetes, infrastructure requirements, the balancing of transport needs, and the reconciliation of urban design and urban intensification issues.