

VITAL IMPROVEMENTS NEEDED TO AUSTRALIAN IMMUNISATION REGISTER

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SEVERAL targeted vaccine programs introduced to the Australian National Immunisation Program (NIP) in 2020 exposed the limitations of the Australian Immunisation Register (AIR), according to the authors of a Perspective published by the *Medical Journal of Australia*.

Dr Jane Tuckerman, from the Murdoch Children's Research Institute, and colleagues wrote that particularly, the AIR's inability to collect information on medical risk factors to monitor vaccine uptake in at-risk groups was highlighted.

"As of 1 July 2020, Bexsero (GSK), the meningococcal B vaccine, was funded by the NIP for all Aboriginal and Torres Strait Islander children aged under 2 years and for other populations with specific medical risk factors, including asplenia, hyposplenia, complement deficiency, and use of eculizumab therapy," Tuckerman and colleagues wrote.

"Additional doses of the pneumococcal 13-valent conjugate vaccine (Prevenar 13, Pfizer) and the 23-valent pneumococcal polysaccharide vaccine (Pneumovax 23, MSD) are now funded for Aboriginal and Torres Strait Islander people and for individuals with certain medical risk factors (eg, asplenia, immunosuppressive conditions, specific respiratory disorders).

"While these NIP changes are welcomed, clinicians need access to data that include information on medical risk to optimise benefits to patients.

"Both patients and medical practitioners need capacity to track receipt, ensuring that the most vulnerable people receive the recommended vaccines, and avoid unnecessary repeat vaccinations.

"Assessing compliance with these policy changes will be difficult because medically at-risk individuals are currently unable to be identified on the AIR. The functionality of the AIR needs to change to enable the collection of medical risk factors, including pregnancy, and strive for more complete reporting of vaccinations that will deliver benefits at both a population and individual level."

The inability of the AIR to record a person's at-risk status means that it cannot accurately track vaccine receipt nationally to identify strategies to improve coverage in at-risk groups.

"The lack of pregnancy status capture in the AIR necessitates the use of other data sources, such as perinatal datasets in jurisdictions where maternal immunisation is collected, or population surveys to obtain coverage estimates, but these are of no use to clinicians at the individual level," wrote Tuckerman and colleagues.



"This is also the case for children who are medically at-risk, with no capacity to link medical risk factors with vaccine receipt for identification and tracking of these children."

Potential solutions

The authors wrote that one potential solution was to "consider the linkage of AIR data to other national datasets (eg, Medicare, the Pharmaceutical Benefits Scheme, hospitalisations, the Therapeutic Goods Administration adverse event database)".

"Another solution would be to include pregnancy and medical risk factor data fields in the AIR. This information could be entered directly by providers if reporting on the AIR secure website or reported in a semi-automated manner via practice management software."

Tuckerman and colleagues concluded that "there is opportunity for improvement if the AIR is to fulfil its potential as a lifelong register".

"We are seeking support from the broader medical community to raise awareness and advocate that these changes should be prioritised, not only to improve accuracy in recording of vaccinations and at-risk status but also to facilitate providers' ability to access AIR data for better patient care," they wrote.

"We must ensure that we have the mechanisms to accurately assess coverage in these vulnerable groups, not just the routine childhood NIP-funded groups, to drive optimal uptake and best practice."

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