Submission to ANAO Audit: Administration of the Australian Childhood Immunisation Register

Australian Primary Health Care Nurses Association (APNA)
29 September 2014

For further information and comment please contact Kathy Bell, Chief Executive Officer,
Australian Primary Health Care Nurses Association (APNA) on 1300 303 184 or kathy.bell@apna.asn.au.

Executive summary

The Australian Primary Health Care Nurses Association (APNA) is the peak professional body for nurses working in primary health care including general practice. APNA's vision is for a healthy Australia through best practice primary health care nursing.

APNA is pleased to make this response to the request from the Australian National Audit Office (ANAO) for feedback on the Human Services' Administration of the Australian Childhood Immunisation Register (ACIR). Primary health care nurses play a significant role in immunisation, both clinically in immunisation delivery, and administratively through data management and population health activities. APNA is proud to represent these nurses and to make recommendations to ANAO based on our members' feedback.

Nurses are a substantial component of the primary health care workforce. There are now at least 11,000 nurses working in the general practice sector alone, and the majority of general practices in Australia employ at least one nurse. These nurses play a major role in improving health outcomes through their role in delivering quality chronic disease management, immunisation services, and other preventative care, as well as curative care, care for the ageing, dealing with issues such as medicines safety, and implementing improvements in primary health care systems. Nurses are key players in the maintenance of safe, high quality primary health care.

APNA supports an effective immunisation register, such as the ACIR. APNA believes that further improvements in the effectiveness of the ACIR could be gained by expanding the parameters of the ACIR to include groups beyond children under seven years old. At a minimum, the ACIR should encompass all school-aged children; however, it is important to note that immunisations are recommended across the life-span and a record of these activities would be beneficial to population health monitoring and planning.

APNA recommends that general practices are supported to ensure practice software is correctly set up to communicate relevant information to the ACIR to eliminate duplication of tasks, and that practice staff are supported to provide meaningful data to the register. Incentives to practices should be considered.

This data provided to the ACIR should be compiled and distributed in a useful manner which enables practices to provide well informed care. This includes the provision of valuable ACIR reports on individual patients at practice level, rather than individual GP level; and the routine provision of quarterly ACIR reports to practices identifying immunisation rates and overdue patients.

Primary health care organisations should also be provided with relevant ACIR data to inform the development of locally appropriate population health plans.

Australian Childhood Immunisation Register

Effectiveness of the Register

The ACIR is a valuable national register which records the details of vaccinations given to children under the age of seven. APNA acknowledges the important and good work done by the ACIR collecting and collating immunisation data. This valuable service not only helps to identify and facilitate follow-up individuals who may be under immunised and at risk of vaccine preventable diseases but also contributes to the formulation of a national picture of childhood vaccination rates.

However, the National Immunisation Program (NIP) includes vaccines given to many age groups. Whilst APNA acknowledges that access to vaccine records has improved in some jurisdictions, it can still be difficult for GPs and nurses working in private practices to track vaccines given to individual teenagers given in school programs and this can contribute to under or over vaccination in some cases. APNA recommends that the ACIR parameters be increased – ideally to encompass immunisations received across the life-span, but at a minimum to encompass whole of school life to include the school program. This would enable population health monitoring for vulnerable populations, for example those at risk of influenza, and inform population health planning to target these groups.

With the move towards the Personally Controlled Electronic Health Record (PCEHR), APNA is pleased that the ACIR is able to be linked to the PCEHR. This is further reason to expand the parameters of the ACIR to ensure that the recommended population immunisations can be recorded in a central database.

Recommendations:

- *That the ACIR be expanded to encompass immunisations across the life-span.*

Support for using the ACIR

The withdrawal of some financial incentives for General Practitioners (GPs) has impacted the effective use of the ACIR. In 2008 the General Practice Immunisation Incentives (GPII) scheme was altered and the GPII Service Incentive Payment (SIP) was ceased. Prior to this a SIP payment of $18.50 was made to GPs for reporting vaccinations which completed schedule points on the NIP, at 6, 12, 18 and 60 months of age. Following this in 2013 the GPII Outcomes Payments, which were paid to practices achieving 90% or greater levels of full immunisation, were also ceased. The cessation of consistent national financial incentives reduces the support available for GPs to effectively utilise the ACIR. While most practice software can be set up to directly communicate with the ACIR, if this is not occurring there is little incentive to repeat data entry tasks, which can result in the loss of valuable national data. In addition some software packages have nuances that can delay or prevent data submission, eg additional steps may be required for data to be transmitted to ACIR, which can result in inadvertent non-transmission.

General practice nurses are well positioned to coordinate the cleansing, entry and analysis of this data, however, support to complete these tasks is crucial to ensure the importance of the ACIR is not overlooked.

Loss of ACIR field officers has resulted in no specifically targeted education or support for general practices on the ACIR. The ACIR field officers were previously well-regarded speakers who were recognised as highly valued members of the education team, providing updates at local, regional and state levels. In addition, not all Medicare Locals employ immunisation support staff, further compounding the problem.

Recommendations:

- *That support be provided to general practices to ensure existing practice software is correctly set up to communicate relevant information to the ACIR without duplication of tasks.*
- *That support is provided to general practice staff for correct and meaningful use of the ACIR.*
- *That education on the ACIR be provided consistently across Australia to ensure the ACIR is utilised effectively and provides meaningful data.*

ACIR reports

The ACIR relies on data entered by a number of different sources. As a national register, the ACIR can only be considered effective if the data entered is clean, and the entered data is then used for follow up. Anecdotally very few people have a clear understanding of how to clean the data, and thus how to report on the entered data. The ACIR has the potential to provide important data to inform intervention for a wide range of population groups. Ensuring data entry is accurate and follow-up reporting is relevant should be a priority for the organisation. As Medicare Locals transition into Primary Health Networks with larger geographical responsibilities, utility of the data and support for data usage must be considered.

Prior to June 2013 the GPII allowed general practices to access ACIR data relevant to their practice. Each quarter registered practices were sent a statement informing them of the percentage of patients aged less than seven years who were appropriately immunised. The practice was able to order a number of reports, with the ACIR020A report being highly valuable as it listed all children aged less than seven years overdue for immunisation. In addition to these practice level reports, primary health organisations (former Divisions of General Practice, and current Medicare Locals) were able to order geographically based reports about the GPII registered practices, practice immunisation rates, and a six month history of overdue immunisation notifications to local practices. This allowed these organisations to assist practices whose immunisation rates were below 90% and provide targeted support.

With the loss of support to correctly utilise the ACIR, many practices are either confused by the process or not aware that they must now go to the website to request reports for each individual GP in their practice. Currently general practices are only able to order reports identifying overdue childhood immunisations prior to seven years old (11B) by provider only. This is very difficult for practices with multiple GPs to manage as each overdue child may appear on each individual GPs report. The previous form (20A) listed overdue children only once as it was a practice-based report. The 11B report currently provides an excessive amount of data which is often unmanageable and not utilised, with many practices then choosing not to order the report again. Practices are no longer able to access their own immunisation rates, and Medicare Locals are unable to identify or support practices with immunisation rates less than 90%. This important information is needed to drive population health strategies in relation to immunisation.

Consideration should be given for automatic provision of reports to all registered practices of the due/overdue immunisation report. This removes the onus from individual GPs to request reports.

Alternatively the administrative process for accessing these reports should by simplified. The content of these reports must be clear to ensure reviewing of these reports leads to meaningful outcomes. A centralised whole of practice based access to overdue immunisation data is particularly important to our members, as it is often the nurse in the general practice that follows up overdue immunisation and arranges recall from vaccination and associated child health checks.

Recommendations:

- *That primary health organisations be provided with support to use ACIR data in a meaningful way to inform population health planning for primary health care, for example, practice immunisation rates.*
- *That ACIR reports be available at a practice level to report on individual patients by practice, rather than by GP.*
- *That quarterly ACIR reports be automatically provided to general practices identifying immunisation rates and overdue patients.*

ACIR Forms

A number of forms related to the ACIR should be considered for review:

Immunisation history form (IMMU13): Consideration should be given to removing or modifying the following sentence from this form: *Immunisation history is not available but I believe the child identified on this form is age appropriately immunised or is following an approved catch-up schedule.* Parental memory of vaccination is not reliable and should not be utilised for such a crucial aspect of health.

Immunisation exemption – conscientious objection form (IMMU12): To facilitate uptake of immunisations and increase community protection against vaccine preventable diseases in children, consideration should be given to review the payment system to families who do not have a medical exemption to vaccination, but a conscientious objection to vaccination. Payments to these families should be much less than if they comply with Australian vaccination requirements.

About APNA

The vision of the Australian Primary Health Care Nurses Association (APNA) is for a healthy Australia through best practice primary health care nursing.

APNA is the peak professional body for nurses working in primary health care including general practice. With 4000 members, APNA provides primary health care nurses with a voice, access to quality continuing professional development, educational resources, support and networking opportunities.

APNA continually strives to increase awareness of the role of the primary health care nurse, and to be a dynamic and vibrant organisation for its members.

Primary health care nursing is wide ranging and covers many specialist areas including general practice, Aboriginal health, aged care, occupational health and safety, telephone triage, palliative care, sexual health, drug and alcohol issues, women's health, men's health, infection control, chronic disease management, cardiovascular care, immunisation, cancer, asthma, COPD, mental health, maternal and child health, health promotion, care plans, population health, diabetes, wound management and much more.

APNA aims to:

1. Support the professional interests of primary health care nurses
2. Promote recognition of primary health care nursing as a specialised area
3. Provide professional development for primary health care nurses
4. Represent and advocate for the profession
5. Collaborate with other stakeholders to advance our mission
6. Ensure a sustainable and growing professional association, by and for primary health care nurses.