

Council of Ontario Medical Officers of Health

Position Paper on Public Funding of Immunisation in Ontario

July, 2003 / Revised Sept, 2003

Introduction

For over 200 years, vaccines have significantly diminished the morbidity and mortality associated with many infectious diseases (see [Resource 1](#)). Vaccination remains the most effective medical intervention administered to date, responsible for preventing illness and saving lives in countless populations.

Examples of the effectiveness of vaccines abound. To illustrate, prior to the availability of measles vaccine, over 300,000 cases of this highly infectious disease occurred in Canada annually. Of these cases, between 0.1% and 0.3% of cases died; that is, there were between 300 and 900 deaths each year from measles. By 2001, an effective vaccination strategy reduced the annual occurrence of measles in Canada to 33 cases, a greater than 99% reduction. Today, almost all of the few cases of measles that occur in Canada are related to importation from other parts of the world, occasionally spreading to inadequately vaccinated Canadians.

A second example of the effectiveness of vaccines has been well documented following the introduction of polio vaccine in the 1960's. Before polio vaccine was available, 20,000 cases of this debilitating disease occurred annually, often leaving the person with permanent neurological sequelae, or even death. In 2001, there were no cases of polio in Canada. In fact, polio has been eliminated from North and South America and is approaching worldwide eradication because of vaccination.

The use of safe and effective vaccines in Canada has improved the health of Canadian children, has reduced health care costs, and has made savings available for the care and treatment of people with other, more chronic illnesses. Until recently, the low cost of vaccines has actually resulted in cost-savings to the health care system. Due to increases in the cost of development, research and the use of more sophisticated technologies, newer vaccines tend to be more costly initially to manufacture. As such, incorporation of new, safe and effective vaccines into publicly funded vaccine programs has been slow and selective. As a result, many people, children in particular, suffer and die from vaccine preventable diseases each year.

In Ontario, the Ministry of Health and Long-Term Care (MOHLTC) purchases and supplies vaccines free of charge to children to protect against diphtheria, tetanus, whooping cough, polio, measles, mumps, rubella, haemophilus b invasive disease, and hepatitis B. In the past, the province consistently led the way in Canada by providing free vaccines to protect children.

Since 1999, however, Ontario's children have fallen behind with respect to immunisation. Between then and now, the National Advisory Committee on Immunisation has recommended vaccines for all children against chickenpox (varicella vaccine, the first of which was licensed in 1998), invasive pneumococcal disease (the conjugated pneumonia vaccine, licensed in 2001), and group C invasive meningococcal disease (the conjugated meningitis vaccine, the first of

which was licensed in 2001). It has also recommended vaccinating adolescents and adults against whooping cough (with Adacel ®, a combined booster vaccine for pertussis, diphtheria and tetanus, licensed in 1999) (see [Resource 2](#)).

Recently, the MOHLTC announced additional vaccine funding for conjugated pneumococcal vaccine, conjugated meningococcal Group C vaccine, and varicella vaccine for a few hundred HIV positive children in the province. It has also announced funding for conjugated pneumococcal vaccine for high-risk children and Adacel ® for adolescents only. While any new funding for vaccines is welcomed, these announcements fall far short of the current need in Ontario that is outlined below. Other provinces now provide some or all of these recommended vaccines to all children (see [Resource 3](#)). Ontario, unfortunately, is not among them.

Ontario is one of only four jurisdictions in Canada that does not provide a comprehensive, publicly funded programme for all children for at least one of these vaccines. As a result, most parents must arrange for payment of these vaccines either personally, sometimes at prohibitive cost to families, or through their own private insurance. The complete primary series of immunisations for pneumococcal, meningococcal, and chickenpox vaccines for an infant born in 2003 to age 18 months would cost his or her family \$700-\$800.

For some young families, this additional cost weighs impossibly against food, clothing and shelter. Ontario's children thus face inequities compared to children in other parts of Canada, as well as within Ontario, where the ability to pay determines the level of protection. Yet, the diseases that these vaccines prevent fail to recognize any administrative or socioeconomic borders.

The Vaccines and the Diseases They Prevent

1. Chickenpox

Chickenpox is a highly infectious and very common disease in children that is caused by varicella zoster virus. Most children will have experienced chickenpox by the age of 10 years. The lifetime risk of developing chickenpox is 95%.

It is a falsehood that all cases of chickenpox are mild and harmless. While most children experience minimal or no scarring, chickenpox can have serious consequences. Research from studies in the United States and Britain indicate that between 1 and 6 cases out of 1000 require admission to hospital. Severity is highest during the first year of life and after age 15 years.

Complications of chickenpox include ear infections, pneumonia, sepsis, bone and joint infections as well as heart problems. Neurological complications such as encephalitis (inflammation of the brain) can also occur at a rate of one per 5,000 cases. A history of chicken pox poses one of the greatest risks for the development of invasive group A streptococcus (GAS), leading to necrotizing fasciitis (flesh-eating disease). It is estimated that 15% of severe GAS may be prevented through universal use of chickenpox vaccine.

Deaths from chickenpox, while infrequent, do occur. The overall fatality rate due to chickenpox is 1 to 3 per 100,000 cases many have no identifiable risk factors prior to their deadly infection. Immune-compromised children are at risk for serious disseminated infections with death occurring in 7%.

Although the rate of severe complications is fortunately low, the fact that almost every child will develop chickenpox means that these complications and their costs are trivial neither on a population basis nor to the affected families.

Because of its near universality of infection, chickenpox has a tremendous economic impact on the health system and society. One Canadian economic analysis of the cost of chickenpox estimated a yearly total cost of \$122.4 million or \$350 per individual case. Most of these costs are attributable to personal expenses and lost productivity; 19%, however, were attributable to the use of the health care system.

2. Invasive Pneumococcal Disease

Streptococcus pneumoniae (pneumococcus) is the leading cause of invasive bacterial infection, bacterial pneumonia and acute otitis media (ear infections) in young children. In Canada there are an estimated 65 cases of meningitis, 700 cases of bacteremia (i.e., blood infection), 3,200 hospitalized cases of pneumonia, 9000 cases of pneumonia that are not hospitalized and an average of 15 deaths per year due to *S. pneumoniae* in children less than five. The annual incidence of pneumococcus for all age groups in Canada is estimated to be 11.6 to 17.3 per 100,000 population. Children less than five years have the highest incidence of disease, with those less than one year at greatest risk.

Because of the immaturity of the immune system, the conjugated pneumococcal vaccine is necessary to maximize protection in children less than two years. A polysaccharide vaccine is currently funded for older children and adults with specific risk factors. This however leaves the most vulnerable population unprotected.

3. Invasive Group C Meningococcal Disease

Over the last 15 years, invasive meningococcal disease caused by group C organisms has been the source of numerous outbreaks in all parts of Canada. These outbreaks and individual sporadic cases have a significant mortality rate, often causing long-term sequelae for those that survive. Although the annual number of cases ranges from 16 to 247 in any given year (Ontario 51-106), it is the severity of these cases that causes the most concern. The high mortality rate, up to 20% to 40%, makes this infection one of the most feared when it enters a community. The public health response to identify, locate and treat close contacts of the case also stresses health resources and the family of the case at their time of crisis. Media attention is often high, and hysteria rampant as the community becomes aware of the sudden death of a previously healthy child or youth.

In Ontario, the highest risk for group C invasive meningococcal disease is among youth aged 15 to 19 years, followed by young adults aged 20-24, and children under the age of 10 years. Outbreaks in those aged 15-24 years occur regularly. To stop the outbreak, mass immunisation campaigns are often required. The response is known to cause great disruption in communities and require tremendous public health resources in a necessary, but reactive manner (e.g., Haliburton-Kawartha-Pine Ridge, Ottawa, London, and Kitchener-Waterloo outbreaks).

In Quebec and Alberta, every child and adolescent over the age of two months has received conjugated meningococcal vaccine to arrest the outbreaks that have occurred

recently in those provinces. Both provinces have now implemented routine programmes of immunisation to prevent the recurrence of these outbreaks. Invasive group C meningococcal disease has caused such significant morbidity and mortality in Quebec that every child and adolescent is now offered immunisation with the new conjugated group C meningococcal vaccine. Alberta has also incorporated the vaccine into its immunisation program after repeated outbreaks. In February 2003, British Columbia announced that it would begin funding conjugated meningococcal and conjugated pneumococcal vaccination.

The conjugated meningococcal vaccine has also been used effectively to arrest high levels of Group C meningococcal disease among children and adolescents in the United Kingdom. It may only be a matter of time before Ontario is affected more widely by this serious infection. It seems sensible, therefore, to initiate a routine programme against this unpredictable disease before outbreaks and deaths recur.

The National Immunisation Strategy

The National Immunisation Strategy (NIS) has been the focus of the work of the Bureau of Immunisation, Health Canada, for the last two years. This strategy addresses the fact that Canada is one of the only industrialized countries in the world that does not have a national strategy for immunisation of its children. The adoption of this strategy will provide Canada with the blueprint that it needs, through co-operation of national, provincial and territorial governments, to ensure that all of the children of Canada are immunised according to the best available recommendations, with safe and effective vaccines, and with enviable immunisation records that can be transferred, no matter where a child may live or move.

The NIS comprises five components:

- **Equitable Access:** Collaborative Immunisation Program Planning: children living in different provinces are provided different vaccines through provincial programmers; the NIS will ensure that all Canadian children receive the benefit of all vaccines recommended by the National Advisory Committee on Immunisation as necessary for children's health
- **Immunisation Safety:** while vaccines are among the safest of medical interventions, the NIS will ensure that a system of monitoring of vaccine safety is comprehensive and timely
- **Vaccine Procurement:** the NIS will strive for sustained availability, and for the best possible price for vaccines, purchased in a co-ordinated way for all of the vaccines recommended for children
- **National Goals and Objectives:** the NIS will ensure that a process is in place nationally to set and work toward the fulfillment of national goals for immunisation in Canada
- **Immunisation Registries:** the NIS will work toward an automated system of vaccine administration and adverse vaccine events recording that will enable all families to move immunisation records with ease, whenever and wherever they move in Canada; the system will also allow for real time assessment of levels of

protection for Canadian children and early identification of any unusual vaccine side effect

All of these components are necessary for a comprehensive approach to protecting Canadian children from vaccine preventable diseases. For the strategy to be realized, however, it must be supported by professionals, administrators, funders and most importantly, by the various levels of government across Canada. Without this collaboration, the benefits to the children of Canada through the NIS will not come to fruition. The importance of a National Immunisation Strategy has been recognized by Commissioner Romanow in his recent report on the status of the health system in Canada, in which the adoption of the NIS is one of the important recommendations on disease prevention.

The federal budget of February 2003 contains a good start on funding for a national immunisation strategy, promising \$9,000,000 per year for five years. In addition, \$7,000,000 has been allocated for this programme for children under the jurisdiction of the Indian Act. This funding will allow for beginning this program, but will not be sufficient for any vaccine purchase beyond that for children on reserves. More investment for the NIS will be needed over time to ensure a sustained, viable and comprehensive approach to immunisation in Canada.

The Council of Ontario Medical Officers of Health (COMOH) urges the government of Ontario, and every government in Canada, provincial and national, to support politically, financially and operationally the components of the NIS. The development and implementation of the NIS, however, should not be used as an excuse to withhold funding of the new recommended vaccines.

Discussion

COMOH supports the universal provision of publicly funded, safe and effective vaccines for all children in Ontario. COMOH strongly supports and urges the inclusion in Ontario's publicly funded immunisation schedule the following vaccines for all children in the province:

- chickenpox (varicella) vaccine,
- conjugated pneumococcal vaccine, and
- conjugated meningococcal group C vaccine

The National Advisory Committee on Immunisation has recommended all three vaccines for routine administration to Canadian children after extensive review. The safety and efficacy of these vaccines are well documented. The provision of these vaccines in Ontario will prevent illness, hospitalization, family disruption due to illness, and most importantly, preventable deaths each year.

Within provincial and federal governments, no argument has been raised that these vaccines are unnecessary or ineffective. The obstacle in Ontario is the ongoing debate between the federal and provincial governments about which one has the responsibility for providing the necessary resources to make the vaccines available. There is no question that immunisation programmes are the exclusive jurisdiction of the province, but its government continues to argue that transfer payments from the federal coffers to cover health expenses generally are

inadequate. This is a convenient political argument that we believe is untenable where the proven cost-effectiveness of vaccines as a health intervention is accounted for.

Given that Group C meningococcal disease, pneumococcal infections and chickenpox are preventable causes of illness and death in children, COMOH considers it unethical not to make the vaccines to prevent them available on a universal basis. They should be considered medically necessary and made immediately and universally available by the government of Ontario. Any further delay in the name of unfulfilled federal responsibilities (e.g. developing the National Immunisation Strategy and increasing health-related transfer payments) is unconscionable and unacceptable.

The Ontario government has already shown leadership in the development of programmes for children, such as the Healthy Babies, Healthy Children Programme and the Early Years Challenge Fund. These programs are meant to be comprehensive strategies to provide Ontario's children the healthiest start possible, and we believe that maximum protection from vaccine preventable diseases must be a key component. Recently, it has been announced that the few hundred HIV infected children in Ontario will be eligible for these vaccines free of charge. This announcement is an excellent precedent for extending the programme to cover all Ontario children, since the serious side effects and deaths that occur from these diseases affect all children, not only those with HIV infection. In addition, given the potential for a reduced immune response for children with HIV, protecting those around them through herd immunity is likely more effective. Also, since HIV in children is rare, the burden of disease from these vaccine preventable illnesses lies with children who are not infected with HIV. Vulnerability, therefore, is relative when one considers the real impact of these diseases.

Equal access for all Canadian children to these safe and effective vaccines is necessary to protect their health and minimize preventable illness and death. Currently in Canada, a patchwork of programmes for these three vaccines exists, where children in one part of the country are not provided with the same access to effective preventive measures that other children enjoy. In Ontario specifically, children whose parents have access to reimbursement for these vaccines through employers, or whose parents can afford to purchase the vaccines, are in a much better position to be protected than children who are less privileged. Thus, some children in Ontario will have the benefit of the protection these vaccines afford against illness and death, whereas others will continue to be at risk, because of ability to pay. While this situation needs to be addressed nationally, it is nevertheless unacceptable that children in Ontario are treated differently based on ability to pay, breaching one of the fundamental principles of our publicly funded health care system, namely that of universality.

Because of the emphasis on universal access to basic medical services in Canada, a user-pay approach leads to the counterproductive perception that services not covered by governments must medically unnecessary. According to a public opinion poll (Wyeth-Ayerst Gallup poll, October 2001), over 90% of Canadians believe that only the vaccines that are paid for by governments are important for their children to receive. This perception stands in the way of truly educating parents on the importance of vaccinating their children with all recommended safe and effective vaccines. A family physician may itemize the benefits to a parent of immunising a child against meningitis, but that parent may continue to believe that if it were so important, he or she would not have to write a cheque to cover it.

This perception is unfortunately not limited to the parents. The exclusion of new and effective childhood vaccines from the routine schedules results in a lack of consistent information on and systematic promotion of their use. Family doctors may thus not have the necessary knowledge

or incentive to recommend them. Even if armed with an adequate risk-benefit argument, they may be hesitant to recommend necessary but unfunded vaccines to families that clearly cannot afford them. Because families rely primarily on these health care providers for such recommendations, it is essential that physicians give consistent accurate advice about the benefits of the vaccines that are not yet part of the funded schedule. The best way to accomplish this is to make the vaccines part of that schedule, provide public funding to cover the cost, and produce government-sponsored fact sheets and promotional campaigns to ensure that every child receives them.

Such coverage, it is worth adding, would also serve to eliminate some inefficiencies inherent in the current approach. The decision to purchase the new vaccines typically requires two visits - the first to receive the prescription and the second to have the vaccine administered. This process creates a preventable cost to the health system, as well as unnecessary inconvenience for families and missed health care opportunities for physicians. Matters of convenience, travel and access to physicians thus further diminish voluntary uptake of these vaccines, even if the financial resources are not a factor.

While there are few who would disagree with the benefits of these new vaccines, or who would not like to see the inclusion of these vaccines in the publicly-funded routine schedule, opposition based on cost remains. The costs of vaccine research, development and production have increased with today's higher standards for medical interventions and with higher public expectations of safety. As a result, the vaccines themselves are more costly than the bargain vaccines of the past. Conjugated pneumococcal, conjugated meningococcal and varicella vaccines currently retail for between \$80 and \$115 per dose, which translates into a rough cost to a family of \$700 to \$800 per child to add the complete schedule of newly recommended vaccines. If these numbers form the basis of estimates of how many taxpayers' dollars would be required to make them universally available, the cost argument would indeed appear to be a significant one.

We believe, however, that there are additional factors that would require that such estimates be based on more than a simple multiplication exercise. One of these is the significant cost saving in bulk purchasing. It is already known that when hepatitis B vaccine was made universally available, its per-dose cost decreased from over \$30 to under \$10. It would therefore be reasonable to expect similar reductions when these three vaccines are added to the routine schedule.

An analysis of the costs to implement fully the recommendations for all three vaccines for children and youth, including a catch-up program is estimated to cost \$456 million dollars at 100% prices. Annualised, this cost would be \$64 million. The current OHIP fee for immunisation of \$3.75 (as part of a visit) has not been included. Several options are available to decrease this cost including:

- implementation of bulk purchasing of these vaccines: a bulk discount of 25% would result in an annual cost of approximately \$48 million; a bulk discount of 50% would result in an annual cost of approximately \$32 million
- adoption of a phased-in approach: start with highest risk as defined by NACI and build to universality as has been done in Québec and British Columbia
- choosing schedules to maximise cost-benefit: e.g., begin meningococcal vaccine at age 1 year, realising that children less than one will be at risk, albeit herd immunity should offer some protection (Québec model)

- use of catch up campaigns: administration of vaccines to older children through catch up clinics, similar to the measles and hepatitis B campaigns, as opposed to OHIP billings

These amounts seem more than reasonable when additional factors, such as the reduction of the impacts on publicly funded health care resources where treatment is required, the economic impacts of lost workdays and the developmental impacts of lost school days, are considered. These factors are typically cited alongside the obvious reduction in morbidity and mortality whenever the benefits of vaccination need to be illustrated. The National Immunisation Program of the Centers for Disease Control, for example, reports that in 1994, every dollar spent to purchase measles vaccine saved \$10.30 in direct medical costs and \$3.20 in indirect societal costs.

While we acknowledge that the positive impacts of the new vaccines are unlikely to be as dramatic (i.e. costs per case prevented will increase relative to those of other diseases), vaccines are still among the most cost-effective health interventions available. For all of these reasons, COMOAH urges the Government of Ontario to make the investment in its children and youth, and redirect the savings realized by current vaccine programmes back into other vaccines.

All three of these vaccines have already been recommended the National Advisory Committee on Immunisation and the Canadian Paediatric Society. In December 2002, the Canadian Medical Protective Association stated that “it seems likely that a court would hold that recommending pneumococcal and varicella vaccines has become part of the standard of care for physicians”. They go on to say that parent’s inability to pay for these vaccines once discussed with them “raises a troubling issue for physicians and is not one that lends itself to an easy solution”. By building the vaccines into the current well-established immunisation system within Ontario, patients and their physicians can be assured that the optimum care has been provided in preventing unnecessary illnesses and death.

Even more new, safe and effective vaccines will soon become available. For the time being, we are urging the Government to consider immediate public funding for universal provision of these three vaccines as part of Ontario’s routine immunisation schedule. We are asking, however, that this programme be done as part a longer-term strategy to ensure the efficient implementation of future recommendations for the provision of licensed and effective vaccines. We believe that the best way to accomplish this goal is for Ontario to take a leadership role in supporting the components of the National Immunisation Strategy. This initiative will be the key to ensuring maximum protection from vaccine preventable diseases in Ontario and across Canada.

Recommendations

1. The Council of Ontario Medical Officers of Health strongly recommends that the Ontario Ministry of Health and Long-Term Care immediately make available through new funding all of the currently recommended vaccines for children as recommended by the National Advisory Committee on Immunisation:
 - chickenpox (varicella) vaccine
 - conjugated meningococcal group C vaccine,
 - conjugated pneumococcal vaccine

2. The Council of Ontario Medical Officers of Health recommends that the Public Health Branch establish a procedure so that all vaccines recommended by the National Advisory Committee on Immunisation be reviewed, set in priority, and made available through new funding through the Public Health Branch's vaccine purchase programme.
3. The Council of Ontario Medical Officers of Health recommends the Ontario Ministry of Health and Long-Term Care, in collaboration with local Boards of Health, fully participate and cooperate in the development and implementation of the National Immunisation Strategy.

Resources

1. Effectiveness of Immunisation
2. National Advisory Committee on Immunisation Statements
 - Varicella Vaccine
 - Meningococcal Vaccine
 - Pneumococcal Vaccine
 - Adolescent and Adult Pertussis Vaccine
3. Comparison of the funding coverage of vaccines in provinces and territories across Canada.
4. Estimated Costs to Cover Ontario's Children
5. Stories/Supporting Advocacy
6. Advocacy ideas/messages.
7. Supporting References

Resource 1. Effectiveness of Immunisation

Immunisation:		
The Best Defence		
Vaccine Preventable Disease	Cases in Canada Before Vaccine	Cases in 2001*
Polio	20,000	0
Diphtheria	9,000	0
Rubella	69,000	23
Mumps	52,000	73
Haemophilus influenzae b (Hib)	2,000	41
Pertussis (Whooping Cough)	25,000	2,477
Measles	300,000	33
Total	475,050	2,647

* Provisional data from the Division of Immunisation & Respiratory Diseases, Health Canada

Resource 2. National Advisory Committee on Immunisation Statements

Varicella vaccine:

<http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/ccdr-rmtc/99vol25/25sup/acs1.html>

<http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/ccdr-rmtc/02vol28/28sup/acs3.html>

Adolescent/Adult Pertussis vaccine:

<http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/ccdr-rmtc/00vol26/26sup/acs1.html>

Meningococcal vaccines:

<http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/ccdr-rmtc/01vol27/27sup/acs6.html>

Pneumococcal vaccines:

<http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/ccdr-rmtc/02vol28/28sup/acs2.html>

Resource 3. Comparison of the funding coverage of vaccines in provinces and territories across Canada.

Abstracted from Dr. Monika Naus, BC CDC, Presentation to the National Immunisation Conference, Victoria, December 2002.

“I will now show you the information that Dr. Hammond presented yesterday in a table on a series of maps. The choice of “gold” stars for jurisdictions which have implemented new programs is wholly intentional. Red stars designate implementation of programs for select populations, which in some instances are very small indeed, and green stars designate “approval” to proceed with some kind of program.

Varicella is implemented in PEI, Alberta and the NWT and Nunavut; in Nunavut as a routine program for 1 year olds, and in the other three as a routine program with a catch-up component. A pilot program for susceptible health care workers and 10 year old children is underway in Quebec, with prospects for expansion to routine programs thereafter. Nova Scotia now has approval to proceed with a program for 1 year olds and high risk groups.

The next vaccine to be licensed and available in Canada was meningococcal C conjugate, a far harder sell. Thankfully, this disease is more than a 1000 times less frequent than varicella. Nevertheless, and partly because of the panic generated by outbreaks, Alberta and Quebec now have routine programs for infants or one year olds, respectively. BC and New Brunswick” [note: Ontario as well, although no written policies have been circulated] “have programs for contacts of cases, and PEI for splenectomized patients.

Conjugate pneumococcal, despite its high cost, has been implemented in Alberta for routine use in infancy, and in high risk children under 5. Nunavut similarly has an infant program, and a catch-up for children under 2. Quebec has a program for Cree and Inuit children in two northern regions, and will be starting a high risk program for children under 2 as will Saskatchewan. PEI’s program is limited to splenectomized patients.

Finally, adolescent programs of Td incorporating acellular pertussis have been implemented in NWT, Nunavut and Newfoundland.

What is not shown on these four slides is that with the exception of aP for adolescents, almost all of the remaining jurisdictions have submitted requests for funding of one or all of the other 3 new vaccine programs through their usual funding allocation process.”

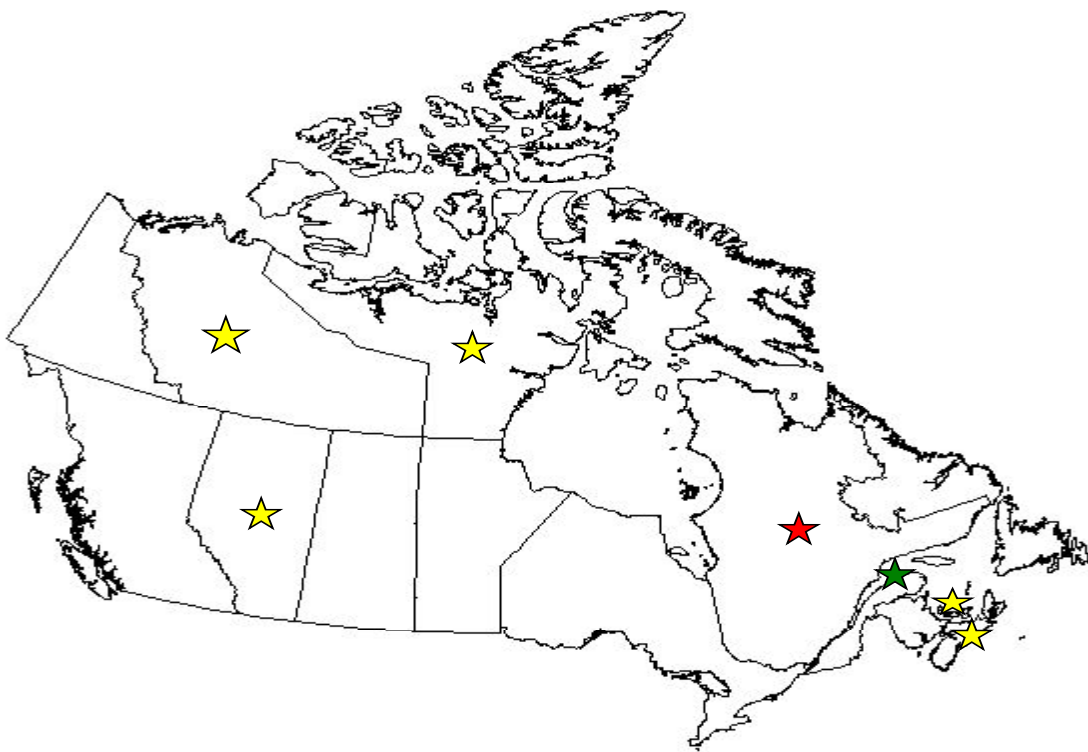
[NB: British Columbia announced on Feb 27th, that they would begin funding pneumococcal and meningococcal vaccines using a staged approach.]

Map 1 – VARICELLA – As of May, 2003

★ Implemented

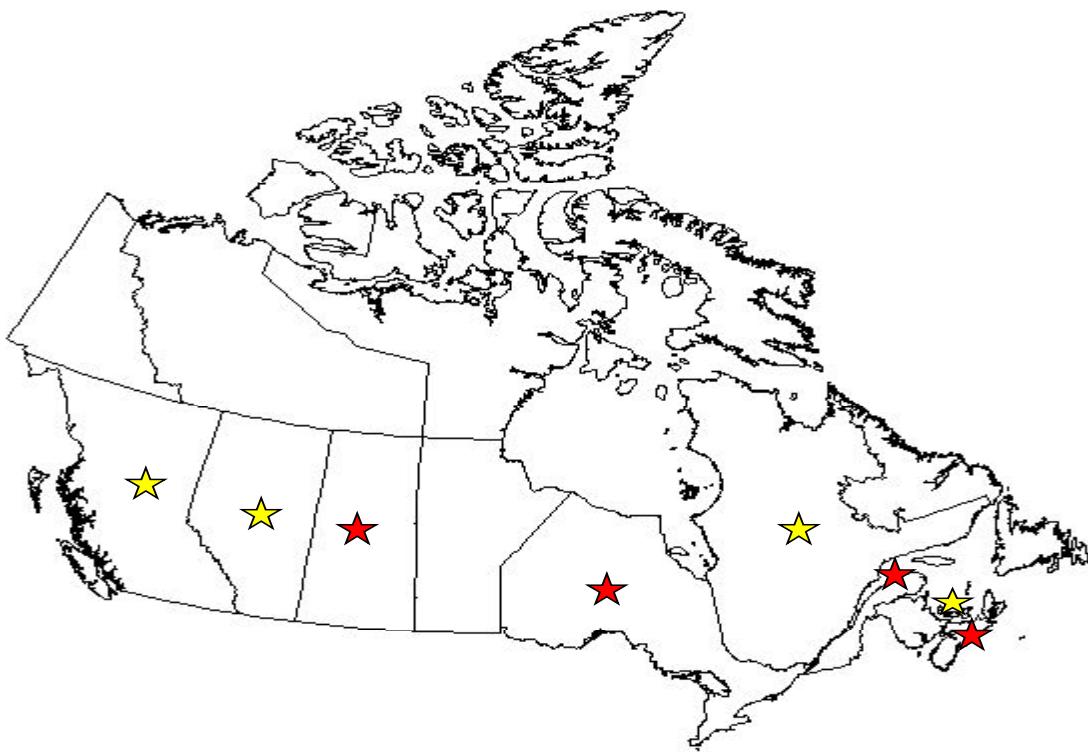
★ Implemented for categories of individuals

★ Approved but not yet implemented



Map 2 Conjugate Meningococcal C – As of May, 2003

- ★ Implemented
- ★ Implemented for categories of individuals
- ★ Approved but not yet implemented

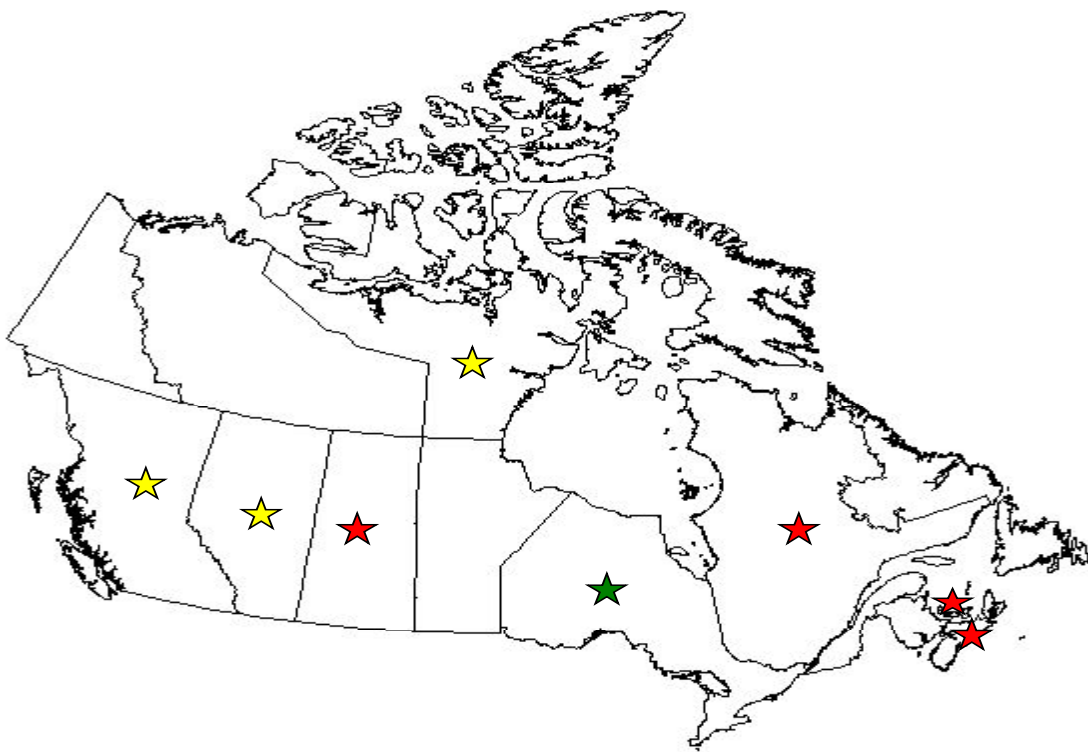


Map 3 - Conjugate Pneumococcal - As of May, 2003

★ Implemented

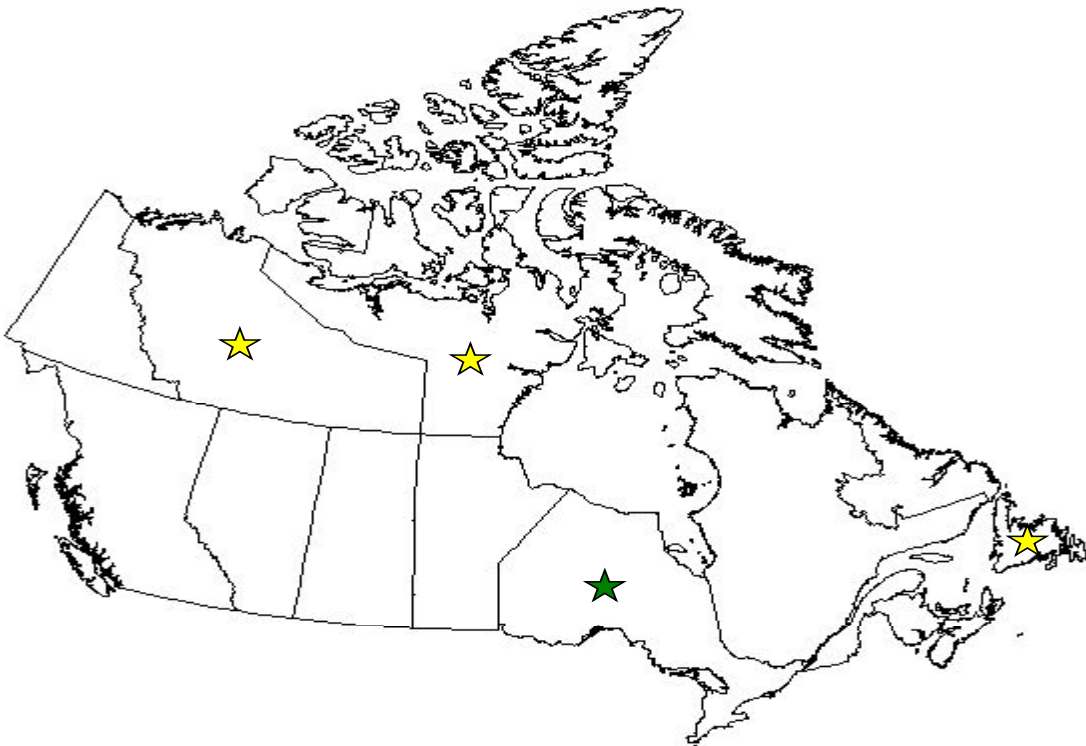
★ Implemented for categories of individuals

★ Approved but not yet implemented
(Please note that the approval in Ontario is for immunization of high-risk individuals)



Map 4. Adult/Adolescent Pertussis - As of May, 2003

- ★ Implemented
- ★ Implemented for categories of individuals
- ★ Approved but not yet implemented



**STATUS OF VACCINE PROGRAMS ACROSS CANADA
FOR FOUR NEW VACCINES AS OF MAY 2003**

P/T	Conjugate Pneumococcal	Conjugate Meningococcal	Varicella	Adolescent Pertussis
BC	I	I		
AB	I	I	I	
SK	I *	I*		
MB				
ON	A*	I*		A
QC	I *	I	I*	
NB		I*	A	
NS	I*	I*	I	
PEI	I*	I	I	
NF				I
YK				
NWT			I	I
NU	I		I	I

Legend: I = implemented

A= approved but not yet implemented

* = program targets a subset of those for whom vaccine has been recommended
eg high risk children or contacts

Source: Health Canada & Canadian Paediatric Society. IMPACT News. September 2003

Resource 4. Estimated Costs to Cover Ontario's Children

Click below to view the chart

http://www.alphaweb.org/docs/VaccineEstCostNoAdmin-25_06_2003-12_52_49.pdf

Resource 5. Stories/Supporting Advocacy

This section summarizes a small selection of personal stories, advocacy efforts, and communications.

Editorial:

A patchwork policy: vaccination in Canada
CMAJ 2003;168 533

<http://www.cmaj.ca/cgi/content/full/168/5/533>

“A young girl in Ottawa died recently from meningococcal meningitis; it is sad to consider how things might have been had she lived a mile away, in Gatineau, where meningococcal vaccination is routine. Those of us who live near the US border might also ponder why 75% of American children are now vaccinated against chickenpox, while few Canadian children are. Even more alarmingly, there is such a lack of national leadership that Canada does not even track varicella vaccine use or rates of varicella disease. Regional deficiencies will only become more complex as new vaccines come on the market. When a vaccine for human papillomavirus becomes available,⁵ will girls in Newfoundland and Ontario be denied this protection?”

Commentary:

Canada needs a national immunisation program: an open letter to the
Honourable Anne McLellan, federal minister of health
Monika Naus and David W. Scheifele
CMAJ 2003;168 567-568

<http://www.cmaj.ca/cgi/content/full/168/5/567>

” We must end the current provincial vaccination hodge-podge that results in treating some children (and adolescents and adults) as more precious than others. We urge you to act quickly to put into place a national coordinated system of planning, procurement, implementation, monitoring and evaluation. The status quo is a sure recipe for chaos.”

News:

One country, 13 immunisation programs
Barbara Sibbald
CMAJ 2003;168 598

<http://www.cmaj.ca/cgi/content/full/168/5/598-a>

“NACI is responding to the patchwork coverage by working with Health Canada to develop a national immunisation strategy. However, this is proving difficult because immunisation is a provincial/territorial responsibility. “Our hands are tied because of the way medicine is structured in Canada,” says pediatrician Victor Marchessault, NACI’s chair. NACI would like Ottawa to cover the cost of immunisation, perhaps through a targeted portion of its transfers to the provinces.

Support for a national program is growing. The CMA is calling for a Childhood National Immunisation Strategy to ensure that new vaccines against varicella, meningitis and

pneumococcal infection are introduced nationally. President Dana Hanson says the variation in immunisation rates across Canada is "unacceptable."

Marchessault wants physicians to write their MPs to demand national coverage. Public pressure worked in Nova Scotia, where the varicella vaccine is now provided. And since Alberta has added all 3 new childhood vaccines to its list, Marchessault hopes other provinces will be "shamed into doing the same."

Varicella vaccination needed to avoid severe complications: surgeons

Brian Whitwham

CMAJ 2003;168 599

<http://www.cmaj.ca/cgi/content/full/168/5/599-a>

"The researchers concluded that doctors should suspect necrotizing fasciitis in any child with a history of chickenpox who has symptoms such as increasing pain, fever associated with swelling in a particular area, and reddening or blistering of the skin. "Vaccination against varicella infection should become the standard of care in order to prevent these serious complications," the authors conclude."

"B.C. Government Announces Immunisation Program to Fight Meningitis and Pneumonia"

Canadian Press

www.canpress.ca/english/hp.htm (02/27/03)

"The recent death of a three-year-old boy from meningitis C and the occurrence on the same day of a second case in Abbotsford of the disease have prompted the government of British Columbia, Canada, to launch an immunisation program against meningitis and pneumonia. In years past, immunisation programs similar to this have been rejected by the government because of the expense; the program is expected to cost about C\$15 million this year, rising to C\$18.3 million in fiscal year 2004-2005. The two-phase program of free immunisations for those considered at high risk for meningitis C will commence in April. It will also target high-risk children under the age of five and aboriginal infants with immunisation against a streptococcus [*Streptococcus pneumoniae*], which can cause pneumonia and lead to other forms of meningitis. Phase two, which will target all one-year-olds and children in grade six, will begin in July, later followed by vaccinations of children ages two, four, six and 18 months old."

Perth District Health Unit

Date issued: March 4, 2003

Contact: Lee Griffi, Communications Manager

"ONTARIO FAR BEHIND IN INTRODUCING NEW CHILDHOOD VACCINES"

"STRATFORD – Ontario parents face stiff costs for four childhood vaccines that should be provincially funded, charges Dr. Susan Tamblyn, Medical Officer of Health for Perth County.

"Every day our public health nurses hear from parents who can't afford the new vaccines for their children" she adds.

Parents face a price tag of over \$700 to fully protect each young child. Drug plans cover the costs for some, but families with few resources do without.

The new vaccines, which are recommended for every child born in Canada, are varicella (chickenpox) vaccine, pneumococcal vaccine and meningococcal vaccine. A pertussis booster is also recommended for adolescents at age 15, using the new acellular pertussis vaccine.

“I know that family doctors are troubled by this situation,” says Dr. Tamblyn. “It’s discouraging to recommend an important preventive treatment when you know that most parents can’t afford it. As a Medical Officer of Health, I’m saddened whenever I get a report of a vaccine-preventable disease.” She adds, “It’s hard to explain to a parent that there is a vaccine that could have protected their child, but it’s not yet a priority for our province. We particularly dread the winter season when we see more meningococcal meningitis.””

“More cash urged for vaccine plan”
Toronto Star, Feb 20, 2003
Tanya Talaga

“The federal government has set aside \$45 million for the creation of a national immunisation strategy – money Ontario’s chief medical officer says is not enough to make the access of vaccines equitable for children across the country...
...Dr. Colin D’Cunha, the province’s chief medical officer of health, said yesterday he’s “grateful” to the federal government for recognizing the need to implement a national strategy, but “it’s not enough money.””

Canada NewsWire Jan 31, 2003
“Eves government to provide vaccines to HIV positive babies”

TORONTO, Jan. 31 /CNW/ - All HIV positive babies born in Ontario on or after January 1, 2002, will be vaccinated against varicella (chicken pox), meningitis and pneumococcal disease, Health and Long-Term Care Minister Tony Clement today announced.

"The Ernie Eves government realizes the importance of protecting the most vulnerable members of our society -- our children," said Clement. "In taking this initiative, I call on the federal government to follow our lead to formulate a national immunisation program to protect all children."

The cost to start up the program is estimated at \$200,000, with an annual investment of \$100,000.

"These vaccines will significantly reduce what could be life-threatening infections for children born with HIV. I am pleased the Ernie Eves government is making these vaccines available, and providing added protection for these children," added Dr. Stan Read, Head of Infectious Diseases, Hospital for Sick Children, Toronto and member, Ontario Advisory Committee on HIV/ AIDS.

WINNIPEG FREE PRESS SAT JAN.25,2003 PAGE A6

“Vaccine policy ‘two-tiered’: MLA Pediatric society recommends them, but parents must pay for 3 new shots”

Mia Rabson

“Tory MLA Heather Stefanson yesterday accused the NDP of adopting a two-tier health system because it won’t pay for three new vaccines many families can’t afford to give their kids. Stefanson said vaccines for chicken pox, pneumococcus and meningitis are recommended by the Canadian Pediatric Society and most pediatricians suggest parents give them to their children. But the bill to give all three is between \$265 and \$635.”

Infectious Disease News Brief, Dec 20, 2002

“Chickenpox Vaccine: Nova Scotia”

Source: Nova Scotia Department of Health Media Release, 11 December 2002

“Commencing January 2003, the Department of Health will provide free chickenpox vaccine for infants when they reach their first birthday. The vaccine will be offered at the same time as the measles, mumps and rubella (MMR) vaccine. The Department is planning to expand the vaccination program next year to include special-risk groups and, in the future, to include all children who have not had chickenpox.”

Cases/Comments

“...a woman who tried to get pregnant for 5 years and then contracted chicken pox in the first trimester – at which time it was recommended she have a therapeutic abortion because of the high rate of congenital anomalies. A tragedy for her personally and very hard as a health provider to sit across from this woman, suffering terribly with chicken pox but also grieving her loss of child”

“...one of our GPs told us that he won't be carrying varicella vaccine in his office any more because he couldn't bear to see the families that couldn't afford it, so ended up donating a lot of vaccine.”

“...Upon my return home I endured an experience that no person should ever experience...there, in his office with the phone in his hand, lay my husband dead. When we left that morning, my son and I thought we left my husband sick with the flu. I didn't know what had killed him...John died of meningococcal septicemia.”

“...the toddler was just recovering from chicken pox when he became ill. At first, doctors thought it was encephalitis due to chicken pox. Less than two days after becoming ill, the 3 year old was dead from meningococcal meningitis. We'll never know if the chicken pox was responsible for increasing this child's susceptibility to meningococcus. Had the child been vaccinated by even one of these vaccines, this tragedy might have been avoided.”

“Recently my wife and I were notified of the presence of Chicken pox in our child's classroom. At that time it was suggested that we consider a chicken pox vaccination for both our children 6 and 4. We discussed this with our family doctor who also confirmed the idea as a sensible one. The problem stems from the fact that according to our family doctor the vaccination would cost approx. \$100.00 per child. I am the sole income provider on a family of four and I can tell you that \$200.00 out of my monthly budget is an expense that would be felt hard.”

“A great deal of money and effort is being put into early childhood initiatives such as Early Years, Best Start etc. All of these are excellent programs, but I think we are presuming that everyone has access to "the basic underpinnings" for a healthy start, one of the most important of which is adequate immunisation and disease prevention. To invest in social programs without maintaining immunisation programs puts our children at a significant disadvantage and in some cases may even diminish the effect of the social programs. It seems as though the commitment to immunisation has been "stalled" in the 90's in Ontario. We need to keep moving forward. Catch up costs a great deal more than maintenance in the end.”

In answer to the request for an update on the status of the funding for the four vaccines recommended for children by NACI that are not in the Ontario program, the MOHLTC provided the following reply (Dec 13, 2002):

“Status of funding for the vaccines: We continue to advocate for funding for the priority vaccines from all sources, including the Federal Government, particularly with the increased emphasis placed on immunisations by the Romanov Report. We shall, as always, promptly advise you of any positive developments. We continue to welcome your input.”

Federal Health Minister Anne McLellan’s reply to a letter advocating for funding for meningococcal vaccination (Jan 9, 2003):

“Because the provinces and territories are responsible for immunisation programs, they decide whether to make a particular immunisation compulsory, unless there is a medical or philosophical/religious exemption.”

Tony Clement, Minister of Health and Long-Term Care “Vaccination put an end to smallpox and polio” – from a speech given at the OPHA conference on Nov 19th, 2002.

Examples of Association of Public Health Agencies (aPHa) & Local Boards of Health Resolutions & Position Statements

aPHa Position Statement: Vaccine Availability and Subsequent Provincial Funding for Public Health Programs and Services (03/03)

aPHa Resolution – A02-8: Urge Government of Ontario to include meningococcal & pneumococcal conjugate and varicella vaccines in the schedule of publicly funded routine childhood immunisations.

aPHa Resolution– A01-3: Petition Provincial Government to:

1) fund all vaccines licensed in Canada within 12 months of such licensure and make all vaccines licensed in Canada available through Boards of Health...as recommended by NACI

Kingston, Frontenac, Lennox and Addington (KFLA)

Feb 27 2002-Unanimous support for / endorsement of the National Immunisation Strategy – that all Canadians have access to currently licensed vaccines for childhood illnesses.

Renfrew County & District Board of Health

Endorsement of Middlesex-London BOH Resolution to advocate for public funding of varicella, group C meningococcal, pneumococcal and Hep A vaccines

Durham Region Health and Social Services Committee of Regional Council

Endorsement of KFLA Resolution (see above)

Haliburton, Kawartha, Pine Ridge Health Unit

Sept 18, 2002-letter addressed to Ms. Martel, Dr. Hukowich indicated support for the intentions behind Bill 107, but urged the NDP to press the Government for a comprehensive approach to public funding of any licensed an effective vaccine. [Bill 107 – Michael Maxwell amendment to the Health Insurance Act – to add meningitis C vaccine to list of insured services- First Reading, June 13, 2002. August 1 – aPHa received a letter from Shelley Martell (NDP health critic and originator of Bill 107) asking for support for the Maxwell Amendment.]

North Bay & District Health Unit

June 27, 2002 – resolved to request that the MOHLTC provide funding for varicella, Hep A, conjugate group C meningococcal and conjugate pneumococcal vaccines.

Resource 6. Supporting References

Canadian Medical Protective Association Information Letter December 2002; 14 (4), 3.

Dolman S. and Kawa B. Invasive meningococcal disease in Ontario, January 1, 1998-December 31, 2002.

Fenner et. al., cited in Achievements in Public Health, 1900-1999 Impact of Vaccines Universally Recommended for Children – United States, 1990-1998, *MMWR Weekly*, April 02, 1999/48(12); 243-248 February 12, 2003
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Health Canada. Canada Immunisation Guide, Sixth Edition – 2002. Health Canada, 2002, Ottawa, Ontario, Canada.

National Advisory Committee on Immunisation (NACI). Statement on recommended use of varicella virus vaccine. *CCDR* 1999; Vol. 25 (ACS-1), 1 May 1999

National Advisory Committee on Immunisation (NACI). NACI update to statement on varicella vaccine. *CCDR* 2002; Vol. 28 (ACS-3), 15 Feb 2002

National Advisory Committee on Immunisation (NACI). Statement on adult/adolescent formulation of combined acellular pertussis, tetanus, and diphtheria vaccine. *CCDR* 2002; Vol. 26 (ACS-1), 1 May 2000

National Advisory Committee on Immunisation (NACI). Statement on recommended use of meningococcal vaccines. *CCDR* 2001; Vol. 27 (ACS-6), 1 May 2001

National Advisory Committee on Immunisation (NACI). Statement on recommended use of pneumococcal conjugate vaccine. *CCDR* 2002; Vol. 28 (ACS-2), 1 May 2002