Letter to the Editor

Immunisation coverage estimates

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To the Editor: Dr Selvey's concerns[1] regarding our article demonstrating that earlier Australian Childhood Immunisation Register (ACIR) coverage estimates should be adjusted upwards based on ACIR data alone[2] highlight the importance of local knowledge in interpreting ACIR data. This has been recognised in the recent ACIR evaluation, resulting in the new recommendation that reports from each jurisdiction be made to each meeting of the ACIR management committee. Although our paper did not discuss in detail the differences among jurisdictions, it did reference an earlier paper which covered this more extensively.[3] The recent report on vaccine preventable diseases and vaccination coverage[4] discusses interpretation of ACIR estimates, with particular attention to those for the Northern Territory, in some detail.

Dr Selvey's letter mentions three apparent anomalies. The first was the finding that jurisdictions with the longest lag times from encounter date to receipt at the Health Insurance Commission (HIC) (Queensland and the Northern Territory) had the lowest increase in coverage due to late notifications, which was felt to be counter-intuitive. This observation is a tribute to Dr Selvey's careful reading of the Tables, and would have escaped many readers as it did the authors. As stated in the paper, long lag times occur in Queensland and the Northern Territory because data are entered locally before transmission to the HIC, rather than sent directly to the HIC by providers. We suspect that this means data are checked more rigorously before transmission (reducing errors) and that there is a longer period for receipt of notifications, both of which would tend to reduce late notifications.

The second and third anomalies pointed out by Dr Selvey (a small decrease in MMR coverage and differences between immunisation history forms and late notifications) relate only to the Northern Territory. We agree that the explanation for this is likely to be the high interstate migration of Northern Territory families. This effect is much more evident in the Northern Territory because of its relatively small population, making this a much higher proportion compared with other jurisdictions.

Finally, Dr Selvey's letter has provided a helpful and comprehensive update on progress in adapting and improving the ACIR to provide maximum utility in the Northern Territory. Although it is important for readers of *Commun Dis Intell* to be aware of these issues, which probably apply to comparable populations in rural and remote areas of Australia, we do not believe that they invalidate the core message of our paper. This was to emphasise again that immunisation coverage estimates from the ACIR are minimum estimates and that even based on the ACIR itself, as opposed to other data sources, should be revised upwards. In the case of the Northern Territory, this effect is dwarfed by the other initiatives and issues referred to by Dr Selvey. Our updated coverage figures were also able to demonstrate the impact of catch-up immunisation which is not captured by the regular cohort-based ACIR quarterly reports. We believe that these conclusions apply generally across Australia, and that periodic re-examination of ACIR coverage estimates in addition to routine reporting is informative, although the impact of immunisation history forms should lessen over time.

References

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3. Hull BP, McIntyre PB, Heath TC, Sayer GP. Measuring immunisation coverage in Australia. A review of the Australian Childhood Immunisation Register. *Aust Fam Physician* 1999; 28: 55-60.
4. McIntyre PB, Amin J, Gidding H et al. Vaccine preventable diseases and vaccination coverage in Australia, 1993-98 *Commun Dis Intell* 2000;24 Suppl (June):54-57.