The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

21 May 2021 Our ref: KM21-169

PHARMAC
PO Box 10254
The Terrace
WELLINGTON

via email: vaccines@pharmac.govt.nz

Tēnā koutou katoa,

Proposal to fund meningococcal B vaccine for certain groups of people

Thank you for giving The Royal New Zealand College of General Practitioners the opportunity to comment on the proposal to fund meningococcal B vaccine for certain groups of people.

The Royal New Zealand College of General Practitioners is the largest medical college in New Zealand. Our membership of 5,500 general practitioners comprises almost 40 percent of New Zealand's specialist medical workforce. Our kaupapa is to set and maintain education and quality standards for general practice, and to support our members to provide competent and equitable patient care.

We note that the proposal would see vaccination against meningococcal B disease using Bexsero funded for people who are close contacts of meningococcal cases of any meningococcal group (e.g., A, C, W, Y or B), or are at higher risk of meningococcal B disease because they are pre- or post-splenectomy, have functional or anatomic asplenia, HIV, complement deficiency, are pre- or post-solid organ transplant, following bone marrow transplant or following immunosuppression.

Submission

The College welcomes this proposal but considers that it does not go far enough. The College considers that the groups with the highest burden of disease, namely Māori and Pacific infants and young children, should be eligible to receive funded vaccine as this would be a significant step in increasing equity.

Meningococcal disease is a significant cause of mortality and morbidity in New Zealand

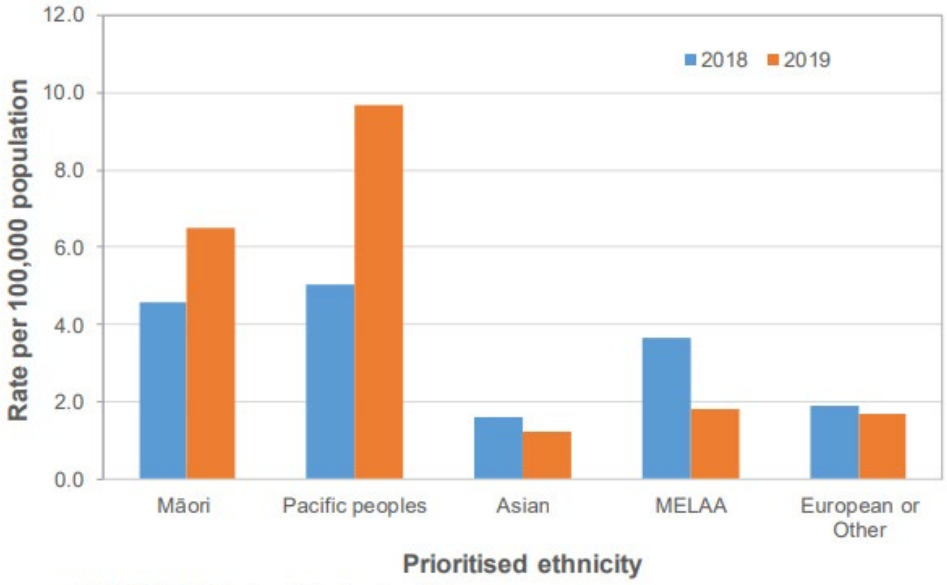
In 2019, the most recent year for which data is available, 139 cases of meningococcal disease were notified in New Zealand, with 10 deaths.[1] Among those who survive meningococcal disease, 10-20 percent have long term complications.[2]

Māori and Pacific Island people are disproportionately affected by meningococcal disease

Meningococcal disease incidence is about three-fold higher in Pacific people (9.2 per 100,000, 29 cases in 2019) and two-fold higher in Māori (6.1 per 100,000, 47 cases) compared with the total population. Household crowding is an important risk factor for meningococcal disease, independent of ethnicity.[1] Figure 4 from the ESR Invasive Meningococcal Disease Report January–December 2019[3] gives a good indication of the magnitude of the differences in incidence by ethnicity.

[1] https://www.health.govt.nz/our-work/immunisation-handbook-2020/13-meningococcal-disease Accessed 19/5/21
[2] https://www.immune.org.nz/sites/default/files/resources/Written%20Resources/DiseaseMeningococcalImac20200630V01Final.pdf
[3] https://surv.esr.cri.nz/PDF_surveillance/MeningococcalDisease/2019/MeningococcalDisease_Q4_2019.pdf

Figure 4. Meningococcal disease notification rates by ethnicity, 2018 and 2019



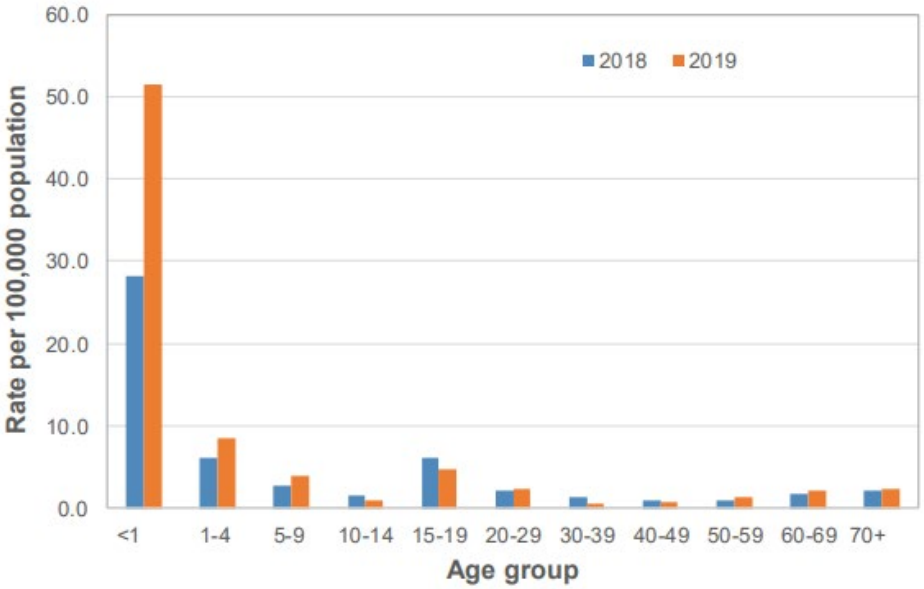
MELAA - Middle Eastern/Latin American/African.

Meningococcal disease is most common in infants and young children

The College considers that vaccination against meningococcal disease should be funded for infants and young children, particularly Māori and Pacific infants and young children.

In 2019, the highest age-specific disease rates were among those aged under 1 year.[1] This is well illustrated by figure 3 from the ESR Invasive Meningococcal Disease Report January–December 2019[3] below.

Figure 3. Meningococcal disease notification rates by age group, 2018 and 2019



Meningococcal group B is the most frequent cause of meningococcal disease in New Zealand

The College considers that vaccination against the B strain should be funded. We note that the consultation information states that on average in New Zealand, meningococcal group B causes around two-thirds of meningococcal disease each year.[4] This is consistent with the information in Table 3 from the ESR[3] below.

We are aware that although vaccination against the A, C, W and Y strains causing meningococcal disease is available to certain groups of people, this is not the case for vaccination against the B strain.

Table 3. Meningococcal disease notifications by group by ethnicity, 2018 and 2019

Prioritised Ethnicity	2018 Group					2018* Total	2019 Group					2019* Total
	B	W	Y	C	X		B	W	Y	C	E	
Māori	19	7	1	2	0	**33**	24	10	2	4	0	**47**
Pacific peoples	3	6	2	2	0	**15**	12	7	2	1	0	**29**
Asian	5	3	0	0	1	**9**	5	0	1	0	0	**7**
MELAA	1	0	0	1	0	**2**	1	0	0	0	0	**1**
European or Other	23	17	13	5	0	**61**	20	19	11	2	1	**55**
Unknown	0	0	0	0	0	**0**	0	0	0	0	0	**0**
Total	**51**	**33**	**16**	**10**	**1**	**120**	**62**	**36**	**16**	**7**	**1**	**139**

Note: Non-groupable not shown in table.
*2018 and 2019 totals include cases where the group was not identified.
MELAA - Middle Eastern/Latin American/African.

Funded vaccination against ACWY strains of meningococcal disease

The groups for which ACWY vaccine (currently Menactra) is funded are broader than the groups for which PHARMAC is proposing to fund Bexserco. Specifically, Menactra is funded for people aged 13-25 living in boarding schools, halls of residence, military barracks, or prisons[1], whereas it is not proposed that Bexserco be funded for these groups.

Another difference is that whereas Menactra is funded for patients prior to planned or following immunosuppression,[1] PHARMAC is proposing that Bexserco is funded only *after* immunosuppression has occurred, leaving patients starting therapy causing immunosuppression susceptible in the interim. The College recommends that Bexserco also be funded when immunosuppression is planned, as is the case for Menactra.

New Zealand now has an additional vaccination event at 12 months.

A 12-month immunisation event was added to the immunisation schedule in 2020. This creates space in the schedule which would allow the addition of Bexserco without increasing the number of injections at each event above the current maximum of three.

[4] https://pharmac.govt.nz/news-and-resources/consultations-and-decisions/consultation-2021-05-03-menb-vaccine/

The need to add another scheduled visit to the Childhood Immunisation Schedule was one of the four concerns expressed by the Immunisation Subcommittee of PTAC when they considered this issue at their meeting of 8 March 2019.[5] The College suggests that PHARMAC investigate the latest evidence regarding the subcommittee's other concerns namely:

- The reactogenicity of the vaccine
- The need for prophylactic paracetamol administration
- Expense.

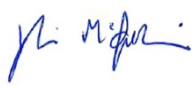
Conclusion

Although PHARMAC states that "this proposal would improve access to meningococcal vaccination for Māori and Pacific peoples in the groups proposed for funding" the College considers that the numbers reached by targeting contacts and those with reduced immune function will fall well short of the numbers required to improve equity of access and because of this, broadened access to funded vaccination is required.

The College recommends that PHARMAC pursues the 'other options for widening funded access to the meningococcal B and meningococcal ACWY vaccines (that) remain under consideration" as noted in the consultation document.[4] We note the recent work by PHARMAC to address inequity of access to medications and encourage PHARMAC to also consider access to meningococcal vaccines.

We hope you find our submission helpful. If you have any questions, or would like more information, please email us at policy@rnzcgp.org.nz

Nāku noa, nā



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[5] https://pharmac.govt.nz/assets/ptac-immunisation-subcommittee-minutes-2019-03.pdf