The National Immunization Strategy

A Model for Resolving Jurisdictional Disputes in Public Health

Jennifer Keelan, PhD¹Harvey Lazar, PhD^{2,3}Kumanan Wilson, MD, MSc, FRCPC^{3,4}

ABSTRACT

Immunization is a public health area in which the intergovernmental challenges of formulating a national policy are evident. It is also an area in which harmonization of policy across Canada is particularly critical. The National Immunization Strategy was a F/P/T initiative designed to achieve this policy goal. The combination of national guidelines and flexible federal funding via a trust has, to date, been effective in improving equality of access to vaccines in provincial/territorial programmes with limited intergovernmental discord. The long-term success of the initiative will, however, largely depend on ongoing federal financial support and provincial/territorial views on national guidelines. This approach to immunization is a model that would lend itself well to other public health areas in which there is large variability in provincial/territorial programmes, where uniformity of programmes is particularly important and where there is a reluctance or inability of the federal government to legislatively mandate the harmonization of programmes.

Key words: National Immunization Strategy; immunization; inter-governmental relations; Canada

RÉSUMÉ

L'immunisation est un secteur où la formulation d'une politique de santé publique nationale pose clairement des difficultés de coordination intergouvernementale. C'est aussi un secteur où il est particulièrement critique d'harmoniser les politiques à l'échelle du Canada. La Stratégie nationale d'immunisation, une initiative fédérale-provinciale-territoriale, visait une telle harmonisation des politiques. La combinaison de lignes directrices nationales et d'un financement fédéral souple (par l'entremise d'une fondation) a, jusqu'à maintenant, réussi à améliorer l'égalité d'accès aux vaccins dans les programmes provinciaux et territoriaux en limitant les désaccords intergouvernementaux. À long terme, l'efficacité de la stratégie dépendra cependant en grande partie d'une aide financière soutenue de la part du gouvernement fédéral et de l'opinion des provinces et des territoires à l'égard des lignes directrices nationales. La Stratégie nationale d'immunisation est un modèle qui pourrait être efficace dans d'autres secteurs de la santé publique, là où il existe une grande variabilité dans les programmes provinciaux et territoriaux, où l'uniformité des programmes est particulièrement importante et où il y a une réticence ou une incapacité, de la part du gouvernement fédéral, à harmoniser les programmes en légiférant.

Mots clés : Stratégie nationale d'immunisation; immunisation; relations intergouvernementales; Canada

1. Dalla Lana School of Public Health, Faculty of Medicine, University of Toronto, Toronto, ON

2. Centre for Global Studies, University of Victoria, Victoria, BC

3. Institute of Intergovernmental Relations, Queen's University, Kingston, ON

4. Department of Medicine and Ottawa Health Research Institute, University of Ottawa, Ottawa, ON

Acknowledgements: This study was supported by a grant from the Canadian Institutes of Health Research and the Public Health Agency of Canada. Dr. Wilson is supported by the Canada Research Chair in Public Health Policy.

Correspondence and reprint requests: Dr. Kumanan Wilson, The Ottawa Hospital, Civic Campus, 1053 Carling Avenue, Admin. Services Bldg., Rm 1009, Ottawa, ON K1Y 4E9, Tel: 613-798-5555, ext. 17910, E-mail: kwilson@ohri.ca

The formulation of national public health policy is uniquely challenged by intergovernmental obstacles.^{1,2} Strategies confined to regions defined by political borders are unsatisfactory because of the ease by which these borders are crossed by many public health threats. The lack of description of roles and responsibilities related to public health in the Constitution further complicates the policy-making process.³ Furthermore, public health has also been consistently under-resourced, creating tensions over funding between orders of government.⁴

Immunization is a policy area in which these problems are manifest and developing a national approach is particularly critical.⁴ The National Immunization Strategy (NIS) was a federal/provincial/territorial (F/P/T) initiative designed to overcome some of the obstacles to harmonization of provincial/territorial programmes. We conducted an analysis of the effectiveness of the NIS from a governance perspective. The study was informed by a documentary analysis, semi-structured interviews and the use of an analytic framework.² The NIS, whose objectives have been partly financed through the use of a federal Trust, is an example of a successful intergovernmental strategy in public health and one from which other sectors in public health could potentially learn. However, the NIS does face ongoing challenges that need to be addressed to ensure its long-term success.

THE NATIONAL IMMUNIZATION STRATEGY

Since 1964, national recommendations for routine immunizations have been determined by the National Advisory Committee on Immunization (NACI).⁵ However, what vaccines were ultimately adopted depended on local provincial/territorial policy processes and their varying capacity to fund these programmes. Regional disparities in immunization policy that developed in the late 1990s opened a policy window for public health activists who had been lobbying for over 10 years to remedy the "patchwork" of provincial/territorial immunization policies across Canada.^{6,7} Between 1999 and 2002, the situation became acute when four new vaccines were added to the *Canadian Immunization Guide*, however

Figure 1. NIS goals and the policy process

TABLE I

Vaccine Coverage Before and After the Implementation of the NIS

Vaccine	First Licensed	NACI Recommends Routine Immunization	P/T Uptake Pre-NIS; c. 2003	P/T Uptake Post NIS 2007
Varicella	1998	1999	5	13
Pneumococcal	2001	2002	3	13
Meningococcal-C conjugate	2001	2001	3	13
Acellular Pertussis (14-16 yo)	1997	2003	7	13
HPV (12-24 yo)	2006	2007	—	0

Provincial and Territorial health insurance coverage for four new vaccines recommended by NACI between 1999 and 2006 (Health Canada, January 2003) and post implementation of the NIS (April 2005) (PHAC 2005). Data compiled by author, May 2007. Nunavut added meningococcal in December 2006.

by 2003 only Alberta and Nunavut publicly funded at least three of the new vaccines for routine use.⁶ This heterogeneity in practice had an impact at the clinical level where physicians reported that the costs to purchase these new vaccines privately were prohibitively expensive for many of their patients and they felt uncomfortable recommending them.⁸

In 1999, motivated by growing concern about the variability in immunization programmes across the country, the F/P/T Deputy Ministers of Health endorsed developing a national immunization strategy. Core components of the strategy included setting national goals and objectives, ensuring collaboration on immunization programme planning, research, and

evaluation, securing the vaccine supply and setting up a national vaccine registry. In 2003, the NIS was approved and the Canadian Immunization Committee (CIC) was established in 2004 to implement the NIS.⁹ The CIC, unlike NACI, is comprised of decision-makers from each province and territory and its recommendations represent joint decisions taken by all jurisdictions, encouraging national consensus and harmonization from the first. The NIS, therefore, provides a framework to bridge recommendations made by NACI with provincial/territorial priority setting and programme planning (Figure 1). It also provides a national forum to coordinate basic research, vaccine-preventable disease surveillance, and public

and professional education, and to identify and target special-needs populations across the country.

Funding the National Immunization Strategy

In 2003, the federal government provided \$45 million to develop the NIS infrastructure. In the 2004 federal budget, a per capita allocation of \$400 million was made available to provinces and territories in the form of an ad hoc third party trust, the "Public Health and Immunization Trust" (Appendix 1). \$300 million of this was earmarked for the four newly recommended vaccines. Within three years, all 13 jurisdictions had added all four new vaccines to their routine schedule, ending a period of significant inequity (Table I).¹⁰ In 2006, the federal government allocated an additional \$300 million into the trust for 2007-10. This funding was explicitly earmarked for a new Papillomavirus (HPV) Vaccine recommended for routine use by NACI in February 2007, although provinces/territories were not restricted from using the Trust to support other immunization priorities.

A trust fund is a financial vehicle used by the Government of Canada as an alternative way to provide funding to provinces and territories. Provinces/territories are permitted to withdraw their share of funds at any point in the three-year fiscal cycle according to their respective spending priorities and accounting practices. Funds provided to a trustee are irrevocable and once transferred, the provinces and territories are the beneficial owners of the funds. There is therefore no accountability mechanism to ensure that these federal funds are used to meet the aims of the NIS. The creation of the immunization Trust in 2004, however, exerted a strong political pressure to expand programmes to add the full complement of NACI-recommended vaccines to the provincial/territorial programmes. Bypassing potential constitutional obstacles that would limit the federal government's role in regulating insured access to immunization, the Trust has directly financed the goals of the NIS.

Evaluating the immunization governance strategy

The strategy utilized by the federal government to ensure equity in access to vaccines

Appendix 1**Public Health and Immunization Trust Provincial/Territorial Allocations**

Fiscal Year	NL	PE	NS	NB	QC	ON	MB
2004-05	2,118,393	564,354	3,822,803	3,063,544	30,688,650	50,463,283	4,765,324
2005-06	2,180,728	583,863	3,942,337	3,156,570	31,773,858	52,588,858	4,933,935
2006-07	2,161,717	581,664	3,914,965	3,131,909	31,678,484	52,773,301	4,919,225
2007-08*	1,500,000	400,000	2,800,000	2,300,000	23,400,000	39,000,000	3,600,000
2008-09*	1,500,000	400,000	2,800,000	2,300,000	23,400,000	39,000,000	3,600,000
2009-10*	1,500,000	400,000	2,800,000	2,300,000	23,400,000	39,000,000	3,600,000
Beneficiary's Total Allocation	10,960,838	2,929,881	20,080,106	16,252,023	164,340,992	272,825,442	25,418,483
Proportionate Share	1.5%	0.4%	2.8%	2.2%	22.5%	37.4%	3.5%

Fiscal Year	SK	AB	BC	NU	NT	YT	Total
2004-05	4,052,721	13,011,125	17,024,921	122,522	172,643	129,717	130,000,000
2005-06	4,167,379	13,566,793	17,659,304	129,188	179,931	137,255	135,000,000
2006-07	4,126,497	13,622,031	17,638,609	131,170	180,578	139,851	135,000,000
2007-08	3,000,000	20,400,000	13,200,000	100,000	100,000	100,000	109,900,000
2008-09	3,000,000	20,400,000	13,200,000	100,000	100,000	100,000	109,900,000
2009-10	3,000,000	20,400,000	13,200,000	100,000	100,000	100,000	109,900,000
Total Allocation	21,346,597	101,399,949	91,922,834	682,880	833,152	706,823	729,700,000
Proportionate Share	2.9%	13.9%	12.6%	0.1%	0.1%	0.1%	100.0%

Shares of this \$400 million expenditure were provided to provinces/territories on May 18, 2004 by way of trust funds following passage of Bill C-30. In 2006, the federal government put an additional \$300 million into the trust for 2007-10. This money was explicitly earmarked for the HPV vaccination. Table compiled by author, May 2007.

across Canada offers some valuable lessons. The implementation of the NIS ties the continuation of national standards to essentially unconditional federal funding. In doing so, it strikes a balance between intergovernmental collaboration and federal leadership. Relying solely on national guidelines leaves provincial/territorial programmes without federal funding yet publicly accountable, and exposes those that do not conform to national standards to legal liability.¹¹ Utilization of a Trust mitigates this to an extent by providing funds to provinces, with some flexibility as to how they can utilize these funds. While there is no mechanism for Ottawa to govern how the funds will be spent, the provinces/territories are aware that the public can hold them accountable if national standards are not met. While this approach imposes a certain degree of national direction or coercion (using federal spending power to bring provinces and territories in line with national standards), the major policy alternative – a legislative strategy – is unlikely to be politically wise or successful due to constitutional ambiguities over jurisdiction.

While the Trust has had an important contribution to unifying access to NACI-recommended immunizations, it is unclear whether or not the NIS will prevent heterogeneity in uptake as new vaccines are introduced. Because the Trust fund is time limited, provinces/territories are vulnerable to unilateral federal discontinuation of the programme. In particular, it would be politically difficult for a province to

remove a programme targeted at protecting the health of children after it has been initiated, even if continued federal funds needed to sustain the programme are removed. A salient example of this is the recent Trust allocation that is tied to an additional expansion of the programmes to include routine HPV immunization. It is unclear how directives like this will continue to accelerate the uptake of new vaccines. In the case of HPV vaccine, it appears to have been successful as many provinces have introduced HPV vaccine programmes, however the federal government's budget recommendations were made before the CIC made their final recommendations for national guidelines.¹² In future, provinces and territories will have to anticipate taking over the costs of immunization programme expansions in a relatively short period of time, creating a scenario analogous to the problems with reduced federal transfers for hospital and medical care.¹³ Another potential drawback of this approach is that the lure of federal spending may distort long-term provincial/territorial priority setting. By committing future dollars into meeting national guidelines, provinces/territories may not be able to focus on what they perceive are, while perhaps lower profile, equally if not more important priorities for immunization.

While the NIS has been successful in reducing disparity in access to vaccines, less progress has been made in the other elements of the strategy. In particular, frustration has been expressed about the delays in

the development of an immunization registry.¹⁴ Multiple explanations exist for the disparity in success of the various elements of the programme, however, it is important to recognize that recommendations for the uptake of vaccines are currently the only component of the NIS accompanied by national guidelines.

CONCLUSION

Despite not having met all of its objectives, the NIS has to be viewed at this point as a successful federally-funded initiative. It rapidly resolved the issue of equal access to new vaccines across the country with minimal intergovernmental discord. The strategy of combining national guidelines with flexible start-up funding could be a model for intergovernmental cooperation in other public health areas. The trust fund mechanism would be particularly effective in areas in which the start-up costs of developing a programme are a major obstacle, for example health surveillance.

The long-term success of the NIS will ultimately depend on multiple factors including provincial/territorial perspectives on NACI recommendations and its alignment with CIC recommendations, and the effectiveness of the CIC itself. Most importantly, the NIS is dependent on the availability of ongoing federal funds, and the provinces/territories' ability to maintain programmes in the absence of ongoing federal funding. Given both the importance of immunization as a public health intervention and the particular need to

develop coordination of policies in this area, it is in the best interests of all orders of government to ensure the long-term viability of the NIS.

REFERENCES

1. Wilson K. The complexities of multi-level governance in public health. *Can J Public Health* 2004;95(6):409-12.
2. Wilson K, McCrea-Logie J, Lazar H. Understanding the impact of intergovernmental relations on public health: Lessons from reform initiatives in the blood system and health surveillance. *Can Public Policy* 2004;30(2):177-94.
3. Jackman M. The constitutional basis for federal regulation of health. *Health Law Review* 1996;5(2):3-10.
4. Deber R, McDougall C, Wilson K. Public health through a different lens. *Healthcare Papers* 2007;7(3):66-71.
5. Public Health Agency of Canada. National Advisory Committee on Immunization Terms of Reference, 2005. Available online at: http://www.phac-aspc.gc.ca/naci-ccni/tor_e.html (Accessed May 22, 2007).
6. Sibbald B. One country, 13 immunization programs. *CMAJ* 2003;168(5):598.
7. Naus M, Scheifele DW. Canada needs a national immunization program: An open letter to the Honourable Anne McLellan, federal minister of health. *CMAJ* 2003;168(5):567-68.
8. Paterson M, Neimanis IM, Goebel CR, Kraftcheck D. Informed consent for uninsured services: A primary care perspective on the new childhood vaccines. *CMAJ* 2004;171(8):877.
9. Public Health Agency of Canada. Canadian National Report on Immunization. *Can Commun Dis Rep* 2006;3253(Supplement).
10. Butler-Jones D. Opening Session of the 7th Canadian Immunization Conference. Winnipeg, MB: Public Agency of Canada, 2006. Available online at: <http://www.phac-aspc.gc.ca/cpho-acsp/speeches-discours/cic061203-eng.php> (Accessed May 2007).
11. Sirnick A, Ross M. New childhood vaccines. *Information Letter (The Canadian Medical Protection Association)* 2002;17(4):3-4.
12. Comeau P. Debate begins over public funding for HPV vaccine. *CMAJ* 2007;176(7):913-14.
13. Wilson K. Health care, federalism and the new Social Union. *CMAJ* 2000;162(8):1171-74.
14. Kondro W. Progress report on the National Immunization Strategy. *CMAJ* 2007;176(13):1811-13.

Received: July 4, 2007

Accepted: March 14, 2008

CPHA Update, from page 364

public health infrastructure and called for the establishment of a funding mechanism dedicated to supporting the implementation of a social determinants of health approach to reducing health inequity in Canada.

And finally, at the Closing Session of CPHA's Annual Conference, CPHA issued a Call to Action, informed by the public health community and proceedings of the Conference, emphasizing the need to move forward on specific actions to address health inequity in Canada. The Call, posted on our website, outlines some of our specific commitments as an organization. One of CPHA's first commitments is to promote the much-anticipated report of the WHO Commission on the Social Determinants of Health. By the time this Journal goes to press, I am hopeful that the Report and CPHA's response will have already been widely publicized. The ongoing challenge will be to sustain the momentum for a 'social movement' to eliminate health inequity in Canada.

CPHA will continue its history of excellence in public health advocacy. Stay tuned to the Association's website for new postings on policy and advocacy development.

Debra Lynkowski
Chief Executive Officer

Mise à jour de l'ACSP, de la page 364

Enfin, à la séance de clôture de sa conférence annuelle, l'ACSP a lancé un appel à l'action, étayé par les opinions des intervenants en santé publique et les délibérations de la conférence, afin de souligner qu'il faut prendre des mesures concrètes pour redresser les inégalités en santé au Canada. Cet appel, publié sur le site Web de l'Association, présente certains des engagements de l'ACSP en tant qu'organisme. L'un des principaux est de promouvoir le rapport très attendu de la Commission des déterminants sociaux de la santé de l'OMS. Lorsque la Revue ira sous presse, j'espère que le rapport et la réponse de l'ACSP auront déjà été publicisés à grande échelle. Le défi sera de soutenir l'élan en faveur d'un « mouvement social » pour éliminer les inégalités en santé au Canada.

L'ACSP entend conserver sa réputation d'excellence en matière de politiques, de programmes et de défense des droits en santé publique. Par divers moyens, notamment dans la *Revue canadienne de santé publique*, elle rendra compte auprès des intervenants de la santé publique du pays des résultats de ses efforts de revendication.

La chef de direction,
Debra Lynkowski