Influenza Vaccine Availability for Seniors

On behalf of the AGS Clinical Practice Committee, the following author drafted this position statement:

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Background:

Influenza is a potentially lethal condition, especially in older patients. Influenza-related deaths can result from pneumonia as well as from exacerbations of cardiopulmonary conditions and other chronic diseases. Older adults account for ≥90% of deaths attributed to pneumonia and influenza (1, 2) Estimated rates of influenza-associated pulmonary and circulatory deaths/100,000 persons were 0.4-0.6 among persons aged 0-49 years, 7.5 among persons aged 50-64 years, and 98.3 among persons aged ≥65 years. In the United States, the number of influenza-associated hospitalizations and deaths may be increasing in part because the number of older persons is increasing. (3,4) There were three influenza pandemics during the twentieth century. Influenza vaccination can reduce both health-care costs and productivity losses associated with influenza illness (5). Apart from the potential human costs of a new global pandemic, the economic costs would be staggering. (6) Economic studies of influenza vaccination of persons aged ≥65 years conducted in the United States have reported overall societal cost savings and substantial reductions in hospitalization and death. (7-9) Vaccination of health-care workers has been associated with reduced work absenteeism (10) and fewer deaths among elderly patients.

Acute shortages of influenza vaccine in the United States have raised concerns about the appropriate distribution of available doses to those most in need. In response to this, in late 2004 the Centers for Disease Control and Prevention (CDC) convened the Advisory Committee on Immunization Practices to prioritize the recommendations based on the limited vaccine supply. Targeted risk groups initially included:

- Children, age 6 to 23 months.

- Adults age 65 years and older.
- Patients 2 years and older with underlying chronic diseases, including heart and lung, kidney, blood disorders or a weakened immune system (including those with HIV/AIDS).
- Women who would be pregnant during the influenza season.
- Patients in nursing homes or other chronic care facilities.
- Children age 2 years to 18 years taking chronic aspirin therapy.
- Health care workers providing direct patient care.
- People taking care of babies under 6 months old.

Continued availability of the vaccine in January 2005 lead to inclusion at that time of:

- Caregivers and household contacts of high-risk persons in the community.
- Adults age 50 to 64 years old.

Positions:

1. To ensure an adequate annual supply of influenza vaccine, including the availability of vaccine in the event of a pandemic, the federal government should: continue to fund the recent increases in Medicare reimbursements for influenza vaccine; partially indemnify the vaccine manufacturers against losses associated with unused vaccine; increase research funding aimed at producing an effective non-egg based vaccine; and continue to fund the Vaccine Injury Compensation Program (VICP).

Rationale: Higher rates of reimbursement for the vaccine will lead to an increase in the number of companies who produce and compete to sell the vaccine. Because the need from season to season is so unpredictable and because the vaccine must be produced annually, manufactures are concerned about producing too much vaccine. At the same time there needs to an adequate supply of vaccine in the event of a major outbreak or pandemic. One mechanism to help achieve this is for a government agency to contract to buy a certain percentage of unused vaccine. A balance struck would need to be struck between the manufacturers desire to avoid a loss and the government's desire to have sufficient vaccine available if needed. The current method of influenza vaccine production is antiquated and slow. Manufacturers must predict the number of vaccines that will be utilized at the beginning of a season and have little capacity to increase production at short notice. Current vaccine production also precludes patients with an egg allergy from being given the vaccine. Alternatives include cell-based technology for growing up influenza virus and methods to produce large quantities of individual viral proteins. Increasing research funding in this area will speed the development of vaccines that are safe, cost effective and available at short notice. Fear of litigation costs may be a contributing factor to the reduction in the number influenza vaccine manufacturers. The American Geriatrics Society (AGS) supports the recent inclusion of the trivalent influenza vaccine in the National Vaccine Injury Compensation Program (VICP).

2. There needs to be sufficient vaccine available to meet the needs of older patients.

Rationale: Older patients are at increased risk for developing complications and dying from influenza. They should never go unvaccinated in the event of a vaccine shortage when at the same time healthier lower risk patients are being vaccinated. Older patients who live in group settings such as nursing homes and assisted living facilities are a high priority to receive the vaccine.

3. The Center for Disease Control and Prevention (CDC), professional medical societies and others, should continue to publish an annual prioritization, listing those who should receive the vaccine. State and local health departments, manufacturers, distributors and other government agencies should then develop a plan which ensures that those deemed to be a priority have access to the vaccine.

Rationale: There needs to be a coordinated process in place to ensure that those patients most in need of being vaccinated are vaccinated. Government agencies are best positioned to fulfill this role. Without this type of coordinated effort, we will see a repeat of the confusion and disorganization of recent years, which led to many frail and older patients waiting in line for hours outside of stores to get vaccinated.

4. Government agencies should be authorized and funded to purchase vaccine at short notice and should stock pile adequate amounts of vaccine and influenza antivirals to limit the spread and effects of influenza, in the event of a pandemic.

Rationale: The impact and extent of influenza in any one year is unpredictable. An influenza pandemic would require the vaccination and treatment of millions at short notice. Government agencies are best positioned to prepare for and react to an influenza pandemic.

5. There should be a national campaign to educate seniors and their health care providers about influenza and the benefits of being vaccinated. This should include a special effort to encourage higher vaccination rates for minority seniors and for health care workers who work in long term care settings.

Rationale: The public and health care providers may underestimate the potentially serious consequences of influenza and an influenza pandemic. Vaccination rates still fall short of expectations for high-risk groups. In 1998, influenza immunization rates were 64 percent in adults aged 65 years and older—almost double the 1989 immunization rate of 33 percent. Though this was an impressive gain, almost everyone in the age group should be vaccinated annually. Minority patients are less likely to have had an influenza vaccination than the general population. (11,12) Influenza rates for health care workers are much lower. Many health care workers avoid the vaccination because they believe it will make them sick or they dislike the idea of getting a shot. If a nasally administered vaccine is shown to be safe for health care workers and their patients, vaccination rates would almost certainly increase. Vaccination of health care workers has been demonstrated to reduce influenza related mortality in older institutionalized patients. (13) Patients and health care providers need to be aware of the indications and benefits of using an antiviral medication.

Though vaccination is the preferred means of prevention, antiviral medications may be indicated for prophylaxis if the patient could not or did not want to be vaccinated, and may also be of benefit in treating patients with early clinical influenza.

Health care providers and the public should be further educated about the potentially serious consequences of influenza, especially for older patients, and of the effectiveness and safety of current prevention and treatment options.

6) State and local health departments should work with primary care providers to ensure that they have the influenza vaccine they need on an annual basis to meet the needs of their older patients. There needs to be adequate reimbursement for the administration of influenza vaccine to compensate for the time that health care providers and their staff spend educating and encouraging patients to have the vaccine and for administering the vaccine. Primary health care providers should adopt reminder mechanisms to increase immunization rates for their patients.

Rationale: Primary health care providers, especially those who care for large numbers of older patients, can help promote effective influenza prevention and ensure that the vaccine is administered to those most in need. Primary health care providers have stated that inadequate reimbursement for influenza vaccination administration is one factor contributing to reduced vaccination rates. (14) Primary health care providers require a reliable source of influenza vaccine to meet the needs of their patients. Instead of relying on vendors alone, State and local health departments need to assess

the number of vaccine doses primary care physicians anticipate needing and ensure that they receive it. They also need to be able to ensure the delivery of additional vaccine doses to primary care providers at short notice in the event that more extensive vaccination is recommended. Studies have shown that when physician practices adopt an automated influenza vaccination reminder system (postcards, letters, telephone or autodialed calls), immunization rates among their patients increase. (15)

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