In a country growing increasingly diverse, goals such as the 90% coverage levels for pneumococcal and seasonal influenza vaccinations in Healthy People 2020 can only be reached by identifying, addressing and eliminating health disparities and inequities among various racial, ethnic, and socioeconomic subgroups.\(^1\) Gaps are evident in shingles, pneumococcal, and influenza vaccine coverage among older patients, according to a report last year from the Centers for Disease Control and Prevention (CDC)–gaps that are not only persisting but may be widening.\(^2\)

A recent article, published in the journal Vaccine, proposes a taxonomy for vaccine uptake consisting of the five A’s: access, affordability, acceptance, awareness, and activation.\(^3\) These provide a useful framework for health professionals, family members, and caregivers to identify ways we all can address disparities in immunizations among our aging patients, colleagues, friends, and family members.

In addition to knowing which influenza viral strains to grow, pharmaceutical companies need to know how much product to manufacture. Each manufacturer must balance their manufacturing plan with their capacity and their expected sales. Vaccines remain available in physician offices, health departments, and other traditional settings. In addition, they are now widely available in pharmacies, retail clinics, residential and nonresidential care facilities for seniors, schools, workplaces, and other emerging settings. Thus, while access may be perceived as a problem, people today can get vaccines in a lot of the places they visit frequently—even the supermarket.

For some seniors, though, lack of transportation and lack of providers in accessible areas create disparities. Minority and impoverished community-dwelling elders often find fewer primary care providers in their neighborhoods. Health care providers located there are less likely to provide preventive services such as vaccines.\(^4\) Health systems and providers, along with community organizations, can address this access disparity as one means of improving vaccination rates among older Americans.

With implementation of the Affordable Care Act, vaccines became a fully covered benefit for qualifying insurance policies. Thus, for seniors with ACA-qualified policies or Medicare, all vaccines recommended by the CDC’s Advisory Committee on Immunization Practices are covered with no copayment or deductible.

Disparities based on insurance status persist nevertheless. Minorities and low-income workers are least likely to have insurance.\(^5\) Public health insurance plans can fill this gap, but eligible patients may not sign up because of language or literacy barriers, inconvenient registration sites, immigration status, or simple unawareness of service existence. This inability to obtain health insurance disproportionately affects individuals of ethnic minority or lower socioeconomic status, and further complicates existing barriers to immunization for older patients.
Addressing potential insurance misunderstandings should be a routine and important component of clinic visits for individuals with insurance coverage. Vaccines should be promoted and not just recommended (“Which arm should we use for your flu shot?”). Patients whose vaccinations would be covered by insurance may not realize that their benefits extend to immunizations, particularly if they have irregular or limited access to health care services (“Do you know that the vaccines are free?”).6

Acceptance is another key factor in vaccine uptake, and it can be affected by cultural beliefs, social norms, and other patient factors with the potential to create disparities in coverage. The seasonal influenza vaccination is a prime example of a vaccine disparity created by efficacy perceptions. Without testing, people can’t tell the difference between mild cases of influenza and one of several other upper respiratory infections with similar symptoms. Additionally, the level of protection that the influenza vaccine confers was thought to be 70% to 90% for many years. This efficacy rate was contradicted by results of a 2012 meta-analysis suggesting the true vaccine effectiveness rate in older adults is closer to 50% or 60%.7

People, not understanding the biology or epidemiology of influenza, hear numbers like those and begin wondering if getting the vaccine is worthwhile. Seniors hear about the high-dose influenza vaccine (Fluzone High-Dose, Sanofi Pasteur), which has 22% to 24% increased effectiveness in older patients compared with standard Fluzone, but they may not appreciate why a higher dose is needed and how their aging body responds to vaccines differently than when they were younger.8

Innovations begin in the laboratory and have the potential to improve acceptance rates among patients. In coming years, research may lead to universal influenza vaccines that don’t need to be administered annually and better vaccines against shingles.10 The result should be greater realization and acceptance among patients that vaccination can help protect themselves and their families against potentially devastating diseases.

Awareness affects vaccine uptake. Patients must know vaccines are available, understand the recommended administration schedule as it applies to them and those in their care, and know where and how to get immunized.3 Education and marketing are the mechanisms generally used to increase consumer awareness of vaccines and their benefits. Language differences can prevent subgroups of patients from receiving messages, and cultural differences can affect one’s interpretation of the messages and therefore minimize their uptake. Awareness is a contributing factor even among the well-educated health professional group. Studies have shown that nurses with high vaccine knowledge are more likely to be vaccinated than those with low knowledge.11
The authors of the vaccine uptake study\(^3\) began with the hypothesis that four A's would be enough to describe findings from the literature. However, they ended up with several motivating factors—such as reminder systems and employment or residency policies—that did not fit into the access, affordability, acceptance, and awareness scheme.\(^3\)

Activation factors, as defined in the study,\(^3\) include systems for reminding staff in elder care facilities to get vaccinated, reducing the time between educational and marketing efforts and the availability of a vaccine, and implementing workplace policies and practices that require or strongly encourage vaccination. Such factors can “nudge” people toward getting vaccinated.

By thinking about vaccine promotions in terms of the 5 A's, GSA members can be energetic immunization advocates when interacting with patients, including those with known disparities in vaccine coverage. Much progress is being made, but the need for advocacy persists.

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**SOURCES AND RESOURCES**


