IMMUNIZATIONS NEWSLETTER

PROVIDING GSA MEMBERS WITH UPDATES ON ADULT IMMUNIZATIONS

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Developed by The Gerontological Society of America

FEATURES

News

• High-dose influenza vaccine was significantly more effective than standard-dose products in older adults during the A/H3N2-predominant 2012–13 season, according to an article recently published in the *Journal of Infectious Diseases*. A 24% advantage for high-dose vaccine was evident among 1.04 million Medicare beneficiaries aged 65 years or older. The effectiveness of these vaccines was statistically similar during the 2013–14 season when the A/H1N1 virus prevailed; these findings are similar to those of Gravenstein et al., as reported at the February meeting of the Advisory Committee on Immunization Practices and recounted in the March issue of this newsletter.

• Use of nonsteroidal anti-inflammatory drugs (NSAIDs) during an acute respiratory infection was associated with a 3.4-fold increase in acute myocardial infarction among adults aged 20 years or older in an analysis of data from Taiwan’s mandatory health system, according to a second *Journal of Infectious Diseases* study. Parenteral NSAIDs were especially problematic, with an adjusted odds ratio of 7.22 in the case–crossover design study. “Where NSAID use is deemed necessary, those judged safer from a [cardiovascular] perspective, notably ibuprofen or naproxen, should be used,” editorialists wrote in an accompanying commentary.

Resources

• Centers for Disease Control and Prevention (CDC) guidance on use of cholera vaccine in American travelers to areas of active cholera transmission.

• Best practice guidelines for immunization from the Advisory Committee on Immunization Practices.
In April, the March for Science featured signs such as “What do we want? Science! When do we want it? After peer review!” and “Alternative hypotheses, not alternative facts!” Signs such as these get at the heart of scientists’ frustration at denialists—those who reject scientific facts, despite overwhelming evidence, in favor of conspiracy theories. Denialists might say something like, “I don’t care what the science shows. I don’t believe that vaccines are safe.”

Providers trying to debunk myths, however, can lead to the backfire effect, in which individuals harden their beliefs when presented with contradictory information. In one study, investigators presented CDC materials to adults to counteract the myth that influenza vaccine can cause an influenza infection. Adults with high concerns about vaccines decreased in their intention to vaccinate from 46% to 28% after being presented with the materials, the opposite of expectations.

Communication experts suggest asking such denialists to explain how and why they think what they do, then gently expose any complexities or gaps in their arguments. Be sure to offer simple and credible facts to fill the gap. Presenting multiple facts that counteract the misconception is less effective than focusing on one or two concrete points.

And hang in there! Changing the minds of vaccine denialists will not happen in one discussion. Solicit questions, avoid a “hard sell,” and provide consistent messages over time delivered by trustworthy sources.


VACCINE POLICIES: SETTING THE BASELINE

As the U.S. Congress considers major changes to the laws undergirding financing of health care — representing one-sixth of the American economy — it’s difficult to determine the impact of changes on vaccine coverage and policies. A number of factors can affect how many people ultimately are immunized for recommended vaccine-preventable diseases (VPDs), and many are the result of laws, regulations, and policies. These include whether immunizations are mandatory, whether they are covered by public and private insurance, what out-of-pocket costs the patient or caregiver will incur, and whether vaccinations are offered by sufficient numbers of providers in convenient locations.

To participate in the debate over financing of health care in the United States, vaccine advocates need to know about current financing and other relevant policies. In this issue the NAVP Immunizations Newsletter, that baseline information is presented.
The Affordable Care Act (ACA) is complicated. Opposition to the law has focused on aspects that conservatives and libertarians find offensive, such as the requirement that every American obtain health insurance and governmental oversight inherent in the law’s approach to reform. However, the law has a great many other components, ranging from how biosimilar products are reviewed for marketing to research grants that encourage innovation in health systems. Among these other ACA components is reform of the funding of immunization programs. As shown in Figure 1, through fiscal year 2014, a major portion of the CDC budget for immunizations was supported through Section 317 of the Public Health Service Act. Section 317 funds have been replaced with monies from the ACA’s Prevention and Public Health Fund (PPHF); the current funding level is $600 million, according to the Shot of Prevention website. If the ACA is repealed without accounting for PPHF, funding for some vaccination programs would be reduced or eliminated, as would the budget that supports CDC’s emergency responses to foodborne outbreaks and emerging infectious threats such as Ebola and Zika viruses.

Several barriers to increasing vaccination rates center around money. Patients are less likely to be immunized when they have to pay for vaccines, and providers are less likely to offer vaccines when reimbursement rates fail to cover their costs. Under ACA, vaccines recommended in CDC schedules are provided with no co-pay as preventive care, which is one of the essential benefits required in insurance policies offered under this law. If a bill passes both houses of the current Congress and goes to the president for signature, the responsibility of defining essential benefits will likely be transferred to the states. Vaccines could remain with no co-pay in some states but not in others, creating confusion and uncertainty among patients.

Inadequate reimbursement for health professionals creates an access barrier that limits the number of adults getting immunized against VPDs such as influenza, tetanus, diphtheria, pertussis, pneumonia, and shingles. Studies show that large proportions of health providers already do not offer vaccines because payment is insufficient to cover the costs of vaccine purchasing, storing, administering, and filing for reimbursement.

Clinicians and other vaccine advocates can emphasize the value of these vaccines along with the need to avoid debilitating VPDs that can lead directly to increased morbidity and mortality and indirectly to declining activities of daily living, frailty, and loss of independence. Efforts must also continue to improve vaccine payment rates and convince health professionals that offering immunizations makes business sense in their practices.
Two important sources of federal vaccine funding are the Medicare and Medicaid programs. Medicare covers older adults and those with disabilities; Medicaid dollars go for indigent care. The confusion and resulting problems associated with Part B versus Part D coverage under Medicare were detailed in the January/February issue of this newsletter.

As a state-administered program, Medicaid is more complex and variable. One outcome is clear, however, should Congress repeal ACA: the Congressional Budget Office estimates that the current bill (the one that passed the House of Representatives) will reduce Medicaid funding, and many of the 23 million Americans who stand to lose health coverage without ACA will do so because their Medicaid benefits have been eliminated. Given that the people affected by the proposed change in legislation have low incomes, coming up with the money to pay for vaccines—or even see a provider—will not happen.

For vaccine researchers, sources of funding for basic vaccine research are important. Federal budget cuts could reduce monies for basic research. Lower demand for marketed vaccines could reduce research-and-development dollars that vaccine companies are willing to invest in their own basic research and in clinical trials.

Both of those outcomes are possible in the current environment. The administration’s budget for fiscal year 2018 calls for a number of cuts that could affect research funds provided by the National Institutes of Health and other federal agencies. Decreased industry funding would be a simple economic inevitability, should vaccine demand drop as a result of some or all factors discussed earlier. The pressure to reduce prices of pharmaceutical products could also play into companies’ considerations, all with the end result that fewer innovative products would be marketed in the United States.

Fortunately, these reductions are encountering much criticism and outright opposition on Capitol Hill. Combined with increased research funding in the current fiscal year budget and monies approved in the 21st Century Cures Act in December 2016, federal support of research could be maintained.

Vaccine advocates will need to continue their 360-degree support of vaccines, including their funding. GSA and its members need to work to keep immunizations free or low cost for patients, maintain health promotion activities regarding vaccines, and keep research funding at current levels. It’s a challenging time for supporters of immunizations, but not one when giving up is an option. For ideas on what you can do, access the NAVP section of the GSA website and online homes of organizations such as the Adult Vaccine Access Coalition, the National Foundation for Infectious Diseases, and the Immunization Action Coalition.
FIGURE 1. Changes in CDC immunization funding as a result of implementation of the Affordable Care Act, fiscal years 2008 through 2016
Abbreviations used: ARRA, American Recovery and Reinvestment Act; FY, fiscal year; Pgm Imp & Acct, program implementation and accountability; PPHF, Prevention and Public Health Fund; Section 317, Section 317 Immunization Program of the Public Health Service Act.