COMMENTARY

ON VACCINE INJURY COMPENSATION

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An Idea Whose Time Has Come

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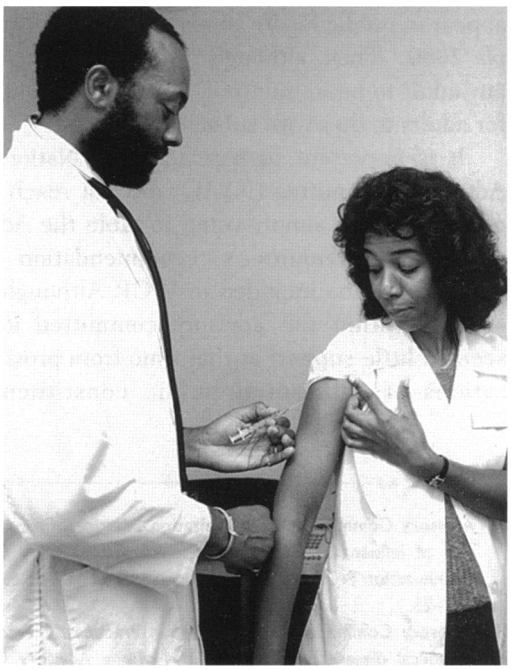
I BELIEVE THAT INCLUSION of the influenza and pneumococcal vaccines in the Vaccine Injury Compensation Program (VICP)—as presented by Lloyd-Puryear et al. on pages 236–242 in this issue—is appropriate, timely, and in the public interest for two reasons.

First, doing so is likely to enhance levels of adult immunization. There is substantial evidence that fear of adverse events is a significant factor both in physician failure to recommend vaccines and in patient failure to accept them. There is not, unfortunately, direct evidence that the presence of an injury compensation program would enhance either physician recommendation or patient acceptance. Further studies to address these questions would be difficult to design in such a way as to permit valid conclusions to be drawn, but perhaps could be done in the context of one or more demonstration projects.



The second, and in my view, dominant reason for endorsing inclusion of these vaccines in VICP is ethical—equality in the treatment of our citizens and the vaccines recommended for them. This issue was not addressed by Lloyd-Puryear et al., but I believe it to be of criti-

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cal importance. We have an ethical responsibility to provide coverage in VICP for all vaccines actively promoted for use by the Federal government.

One of the arguments made in favor of excluding vaccines primarily for use in adults from VICP is that the covered vaccines are *mandated* for children and used not only to protect the recipients themselves but also to protect the broader population, to establish "herd immunity." These arguments are unconvincing and do not withstand critical examination.

Federal recommendations for use of influenza and pneumococcal vaccines in adults have grown stronger year by year; phraseology such as "strongly recommended" and "all persons...should receive..." appear in current recommendations of the Advisory Committee on Immunization Practices (ACIP) for both vaccines.[1,2] Target goals for immunization levels for both vaccines appear in public health projections such as *Healthy People 2000*.[3] Thus, although there are no "mandates" for any adult to be immunized, the governmental pressures for adults to do so are substantial indeed.

It is important to note that the National Vaccine Advisory Committee (NVAC) did not reach a decision on the issue; it simply voted to table the Adult Immunization Subcommittee's recommendation that these two vaccines be included in VICP. Although there was support within the advisory committee itself, there seemed little support at that time from provider organizations or substantial public constituencies. The National Coalition for Adult Immunization was a singular exception, supporting the proposal in the belief that it would enhance levels of adult immunization. The recommendation could be brought forward again at an appropriate time.

The four points addressed in the report by Lloyd-Puryear and colleagues are certainly relevant, but they may be only incompletely addressed. For example, although there is no direct evidence that inclusion of these two vaccines in VICP will increase levels of adult immunization, the available evidence does permit the inference that it would very likely have such an effect.

The liability burden for these two vaccines is low, as is the frequency of adverse events following vaccination. Both are substantially lower than the frequencies of such events following DTP and oral polio vaccines during the mid-1980s. Not addressed, however, is the question of just how much risk is necessary to warrant inclusion of a vaccine in VICP.

Finally, the initial lack of support from provider organizations or public constituencies probably reflects unfamiliarity with the issues rather than a considered judgment. Such support is likely to evolve as these issues are recognized and considered further.

Meanwhile, I believe that the ethical considerations alone justify proceeding with the necessary steps to bring about inclusion of these two vaccines in VICP.

References

1. Advisory Committee on Immunization Practices. Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices. MMWR Morb Mortal Wkly Rep 1997; 46(RR-9):1–25.
2. Advisory Committee on Immunization Practices. Prevention of pneumococcal disease: recommendations of the Advisory Committee on Immunization Practices. MMWR Morb Mortal Wkly Rep 1997; 46(RR-8):1–24.
3. Public Health Service (US). Healthy People 2000: national health promotion and disease prevention objectives: full report, with commentary. Washington: Department of Health and Human Services; 1991; DHHS Pub. No.: (PHS) 91-50212. ■