Vaccination in the United States has been and continues to be a great public health success. Many common infectious diseases that were seen during the first half of the 20th century now rarely occur. When isolated outbreaks of mumps or measles occur, these exceptions prompt headlines in national media. Managed-care organizations have long focused on preventive services, and it was through their innovation and expansion after passage of the Health Maintenance Organization Act of 1973 that coverage for many preventive services became a more-integrated part of individuals’ health insurance.

Additional focus on health plan programs to enhance immunization rates occurred in November 1993, with the inclusion of pediatric immunization rates in the National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set measures, which now are used to evaluate the performance of health care organizations and health care providers with respect to important dimensions of care and service. Although these metrics have evolved over time, health benefit organizations such as WellPoint and other members of America’s Health Insurance Plans continue to develop innovative programs to increase immunization rates for members.

It was with enthusiasm that I accepted the opportunity to participate in the National Vaccine Advisory Committee working group that led to collaboration on the production of the report included in this supplement. Initially, there was much discordance among group members regarding the financing, costs, and reimbursements related to vaccination services. Very little factual information was available regarding vaccine financing, with anecdotes seemingly substituting for facts, an approach used by politicians but not scientists. A significant result of the working group process was that it created a catalyst for researchers to initiate important data collection and analysis, for understanding of several vaccine financing–related issues. One issue identified was tremendous variation in cost and revenue related to vaccination.

Specifically, working group members noted variation in the efficiency of various clinical practices in delivering vaccines and differences in reimbursement to physician practices for vaccine delivery, both for the vaccine itself and for the administrative costs, as reported by Freed et al. It is not unreasonable to anticipate some variation in a free market; however, it remains essential that the United States maintains its great public health success in childhood immunization through a delivery network that is financially stable and efficient.

Cost-shifting from the public sector to the private sector for vaccine services continues to cause concern, because government programs generally pay less, both for the vaccine itself and for administrative costs. As an example, the study by Coleman et al included in this supplement identified the reimbursement issues for surveyed prac-
tices in Georgia, noting, “On average, there is a positive net return from vaccinating private-pay patients, but the financial losses from vaccinating VFC [Vaccines for Children]-eligible patients tend to negate any net gain from private-pay patients”; this effect was greater for practices with large proportions of Medicaid-enrolled patients. In these difficult economic times, state government budgets are likely to face even greater strains. At the same time, the private sector is less able to afford the cost-shifting that occurs when reimbursement from the public sector is less than the true cost of the service.

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Vaccination in the United States: Payer Perspective on the Working Group and Its Recommendations

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