

A Health Policy Lesson Learned, or Not

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Here's an easy lesson for health reformers and policymakers: you get what you pay for.

O'Leary and colleagues demonstrate how costs are the rate limiting step to enhancing US immunization rates, noting that "private practices are the backbone of the childhood immunization program."¹ Yet from their study we might glean how to change this step from rate limiting to rate accelerating.

Immunization delivery policy in the United States has historically had 2 arms: (1) immunizations provided by the private sector to individuals who would accept or who requested this protection for themselves or their families; and (2) immunizations provided in public health clinics to the indigent or the general public in times of public health emergency. The public health sector, which includes the US Centers for Disease Control and Prevention and state health departments, researches and gives guidance on proper vaccine administration to all children, but the delivery of essential immunizations largely relies on the private health care sector.

I believe I was fully immunized as a child certainly thanks to my caring and wise parents, but also owing to Dr Charles Millwater of Washington, DC, my warm, careful, and thorough primary care pediatrician. In my childhood polio was common and feared. My brother and I were vaccinated with the inactivated polio vaccine when it was released in the mid 1950's. Then in 1960 OPV became available and was shown to be more effective. Suddenly, throughout the country, families came to public health clinics on Polio Sundays to get the 3 necessary doses. The personal decision of our pediatrician to provide us with necessary immunizations, arguably 1 of the key acts that defines pediatrics as a preventive specialty, was augmented by the public health sector, recognizing the severity and high prevalence of this disease and the opportunity to rapidly protect an entire population.

Ours is a curious system, between the public health and private sectors, perhaps cooperative but sometimes not as collaborative as we might like. The 2 sectors seemed to work well until the 1980s. Back then, vaccines were inexpensive and the real costs and the perceived financial risks to practices of doing the majority of immunizing were small enough to either go unnoticed or be judged inconsequential. Since then, the arrival of many new vaccines, overblown concern about vaccine safety and liability, and the astounding cost of many newer vaccines have changed this assessment. Now immunizing our patients is a notable cost to our practices, making vaccine administration a business concern as well as a health concern, because the cost of providing immunizations has become a part of a practice's bottom line.

Today we have public health policy relying on the kindness of others (the nongovernmental primary care clinician) to continue to "provide" patients with access to immunizations. There is an abundance of

kindness in the pediatricians and family medicine physicians that I know, but there are also limits.

The frustration O'Leary and colleagues document highlights the practitioner's tension created when a clinician's strong belief in the importance of immunizations, to insure a commitment to a patient's health and wellness, clashes with personal financial risk for that same clinician. One's passion for giving immunizations becomes dampened in any pediatric or family medicine practice if they must shoulder the fiscal burden of subsidizing the vaccines' costs. Most clinicians might tolerate under-reimbursement for the less expensive vaccine administration costs,

but would they likely not tolerate being under-reimbursed for part or all of the more expensive real vaccine costs? The "fear" of financial peril begins with awareness of financial loss in delivering immunizations, then moves to the uneasy feeling of "Why am I paying for this?" followed by "How will I send my kids to college?" But if the question becomes "How will I meet payroll?" then the practice fails and the decision by private practice clinicians to administer human papillomavirus, meningococcal conjugate, and other vaccines is not as automatic as the public health sector would hope. Does anyone's business model allow their practice to buy vaccines and then give them away?

We rely on studies such as this one by O'Leary et al to guide us in making essential decisions regarding how to deliver preventive care to all of our infants, children, adolescents, and young adults. Advocates and decision-makers who oversee vaccine administration policy, please take heed. What O'Leary et al show us has impact not only for immunization rates, but also for the complex choices we face in the current US health reform process. A public health system based on good will is a system at risk. We may just wind up getting what we pay for, and if we don't pay adequately, US youth will likely get less and less of the preventive health benefits we strive to achieve through vaccination administration.

REFERENCE

1. O'Leary ST, Allison MA, Lindley MC, et al. Vaccine financing from the perspective of

primary care physicians. *Pediatrics*. 2014; 133(3):367–374

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