EDITORIAL

Mandatory Immunization of Health Care Providers
The Time Has Come

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In this issue of the CJPH, two articles advise on how to improve professional and public confidence in and compliance with vaccine programs. In the first, Gallant et al. advocate that a multiple intervention approach be used to increase the uptake of influenza vaccine among health care providers (HCPs). In the second, Wilson et al. make recommendations on increasing public confidence in the safety, and consequently the public acceptance, of paediatric immunization programs. Both of these articles have implications for an issue that needs debate and resolution in Canada: mandatory immunization of HCPs against influenza to protect from serious illness patients of treatment facilities and residents of long-term care facilities, many of whom are highly vulnerable and who trust that the health system will improve, not jeopardize, their health.

Past generations of HCPs have cared for people suffering not from chronic, communicable diseases, but rather from infectious diseases that put these HCPs and their families at risk. Health professionals who practised in the era before immunization controlled many infectious diseases saw it as their professional duty to provide care, notwithstanding the risk. Today, by contrast, not only do 40-75% of HCPs in acute care settings eschew the operation patients who go home in less than a week. Those left in the hospitals now are the sickest. Second, influenza vaccine is safe and effective and provides up to 90% protection against circulating strains4,5 for the HCP. It prevents a highly unpleasant illness that sends its victims to bed for a week, keeps them from work and other activities, and depletes physical energy even after recuperation. It also reduces the likelihood that the HCP will take influenza home to their families, including some who may be medically compromised. Third, the health system benefits when all HCPs are immunized by reducing preventable absenteeism and the risk that the system will not be able to function if too many HCPs are ill with influenza. There is very little downside to a fully immunized health workforce.

The reasons that some health care providers resist taking influenza vaccine need consideration. Although every vaccine at one time or another has had aspirations cast on its safety and effectiveness, influenza vaccines seem to be favourite targets. The reasons are a matter of speculation. Because influenza is such a confounding and unpredictable virus, there are years in which a mismatch occurs between the vaccine and the circulating strains. The illness that occurs, albeit usually mitigated by the vaccine, prompts critics to say that the vaccine has no value. It may be that, because the vaccine needs to be administered every year, there are more adverse events following immunization (AEFIs) than reported with other vaccines. These events are temporally but infrequently causally related. The reaction to some HCPs (paramedics in Ontario) being singled out for mandatory administration with this vaccine may have escalated the case against it. Perhaps the legacy of the swine influenza vaccine of 1976 – in which a poor vaccine was coupled with dire predictions of a pandemic that never materialized – is still part of the mythology that surrounds this vaccine. For whatever reason, influenza vaccine has more than its share of misbeliefs and mistrust about it.

Gallant quotes abysmal levels of uptake of influenza vaccine by the very people who have promised, through their professional vows, to do no harm (non nocere), and makes suggestions on how these levels of immunization can be improved through a multi-pronged approach. This modus operandi has proven its effectiveness in the reduction of illness and deaths from tobacco and thus, it clearly has application to...
increase the confidence of HCPs in influenza immunization. Another lesson learned from public health’s experience in reducing the detrimental effect of tobacco on health, however, is that part of that multiple approach has to be regulation. It was through policies and by-laws restricting smoking in workplaces and public venues that many of the health gains on this issue were realized. The same will no doubt be true for immunization of HCPs.

The paper by Wilson provides insight into how the concerns of HCPs about influenza vaccine may be addressed.² Although the paper discusses ways that public confidence in paediatric vaccine programs can be enhanced, the four-point strategy outlined is highly applicable if mandatory immunization of HCPs is implemented. It comprises:

• better AEFI reporting: this measure will demonstrate to HCPs that those promoting the mandatory use of influenza vaccine are also serious about ensuring that safety is comprehensively monitored;

• no-fault compensation for AEFI: persons who have an AEFI, whether it is owing to the vaccine or not, now must appeal to courts and prove fault for compensation. No one, including an HCP immunized in a mandatory program, should have to resort to this cumbersome system. A no-fault system recognizes that vaccine programs benefit all of society and that therefore all of society should share the costs when a possible AEFI occurs;

• pre-emptive strategies to identify and manage possible emerging AEFIs: the comprehensive public health response to oculo-respiratory syndrome is a model that can be expanded to help vaccine recipients – in this case, HCPs – to feel more confident in the vaccine’s safety if influenza immunization is mandatory;

• improving communication about vaccine safety and its monitoring: this may be the most important recommendation of all, as it appears that myths about influenza vaccine may be the biggest barrier to its acceptance. If the vaccine is mandatory, copious reliable and accurate information before and during the program is essential to its acceptance.

Gallant is right that “a multiple intervention approach provides a practical, innovative way to guide a comprehensive program to address HCP vaccination uptake needs”, but it does not go far enough. Despite efforts for years by dedicated prevention advocates to encourage all HCPs to be immunized, levels remain unconscionably low.³ It is worthwhile to pursue Gallant’s strategy in the short term to ascertain whether gains can be made through that approach. At the same time, however, because many HCPs have not fulfilled their professional obligation by taking this vaccine voluntarily, the process to make it mandatory should be initiated as well. The National Advisory Committee on Immunization (NACI) has made strong statements about professional duty,⁴ and other professional organizations (the Association of Local Public Health Agencies in Ontario) fully support this recommendation.

The educative and regulatory approaches are not incompatible; in fact, education can assist the regulatory approach significantly. Furthermore, the suggestions made by Wilson provide additional ancillary measures that are needed for better professional confidence and that demonstrate a true commitment to monitoring safety and dealing with any real or temporally associated adverse events following immunization. All of these recommendations should be undertaken immediately so that the ultimate goal of reducing preventable exposure of the most vulnerable to a serious infectious disease can be achieved before another preventable outbreak leads to unnecessary deaths, unnecessary outbreak control measures and costs, unnecessary investigations into the professional conduct of HCPs, and unnecessary worry and anxiety on the part of all concerned.

Clearly, a safe vaccine that is effective against all influenza viruses, rather than subspecies, and that has a longer duration of protection is the ultimate goal for influenza control programs. When such a vaccine is available, the efforts to immunize millions of Canadians annually will be unnecessary and higher sustained levels of HCP immunization may be achievable through a voluntary program. In the meantime, public health professionals should advocate mandatory use of this vaccine for HCPs, the multi-faceted approach to promote and increase the use of this vaccine among HCPs described by Gallant, and the mechanisms to increase the acceptance of this vaccine among HCPs outlined by Wilson. They should also be the first to reach 100% compliance with influenza immunization, to demonstrate their commitment to preventing the unnecessary harm caused by this disease.

The sooner that routine use of influenza vaccine is comprehensively implemented, the better. A voluntary program with full compliance would be highly desirable, but in its absence, public health must lend strong support to the mandatory approach for the protection of those who expect their health care providers and the health system to heal them, and not to make them ill.

REFERENCES/RÉFÉRENCES