

certified U.S. geriatricians — one for every 7242 older Americans. The situation is not much better when it comes to geriatric nurses and social workers, it's worse for geropsychiatrists, and just a handful of public health practitioners focus on healthy aging. Strategies are needed for building the geriatric health workforce and age-friendly medical and public health systems.

One of the most pressing challenges faced by older adults and the health workforce is Alzheimer's disease. Despite decades of investment and a trove of relevant new knowledge, little progress has been made against this devastating disease. It is difficult to imagine a more powerful game changer for aging than effective prevention and treatment of Alzheimer's disease. We do, however, have in hand underused approaches, including stroke prevention, that would lower clinical Alzheimer's rates, as well as educational, occupational, and public health interventions that strengthen cognitive reserve and may slow cognitive decline.

From a broader perspective, climate change is posing new threats to health in old age, from heat stress, drought, and food insecurity to smoke inhalation

from wildfires, to a growing necessity for migration. Environmental exposures, including exposure to air pollution, which is worsened by global warming, impair cognition and increase susceptibility to infections, such as Covid-19. The sciences of aging are just beginning to consider these threats.

Nevertheless, the evidence indicates that it's possible — with public health interventions, medical care, education, economic security, and supportive environments — to compress the average period of disease and disability so that our health span approximates our longer life expectancy. Unfortunately, these goods have not benefited all older people equally, and disparities threaten the health span for future generations. We need to understand how to resolve persistent disparities to create a healthy, long-lived population.

With longer health spans, we need to reconsider our traditional life-course plans, which have been divided into successive stages of education, work, and retirement. Redesigning the life course<sup>4</sup> and enabling society to benefit from older people's capabilities and goals could transform our future. Such transformation will require investing in healthy longevity, creating opportunities for older

people to participate meaningfully in the labor force and roles contributing to the public good, reconceiving education as a life-long experience, and adopting environmental and lifestyle changes that support healthy longevity and societal well-being. With healthy older people bringing unprecedented social capital, societies would receive a demographic dividend from longer lives, as the assets contributed by older adults support better lives for younger people now and in the future.<sup>5</sup>

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 An audio interview with Dr. Fried is available at NEJM.org

## Ensuring Uptake of Vaccines against SARS-CoV-2

Michelle M. Mello, J.D., Ph.D., Ross D. Silverman, J.D., M.P.H., and Saad B. Omer, M.B., B.S., M.P.H., Ph.D.

As Covid-19 continues to exact a heavy toll, development of a vaccine appears the most promising means of restoring normalcy to civil life. Perhaps no scientific

breakthrough is more eagerly anticipated. But bringing a vaccine to market is only half the challenge; also critical is ensuring a high enough vaccination rate to achieve

herd immunity. Concerningly, a recent poll found that only 49% of Americans planned to get vaccinated against SARS-CoV-2.<sup>1</sup>

One option for increasing vac-

### Six Trigger Criteria for State Covid-19 Vaccination Mandates.

Covid-19 is not adequately contained in the state. The Advisory Committee on Immunization Practices has recommended vaccination for the groups for which a mandate is being considered.

The supply of vaccine is sufficient to cover the population groups for which a mandate is being considered.

Available evidence about the safety and efficacy of the vaccine has been transparently communicated.

The state has created infrastructure to provide access to vaccination without financial or logistic barriers, compensation to workers who have adverse effects from a required vaccine, and real-time surveillance of vaccine side effects.

In a time-limited evaluation, voluntary uptake of the vaccine among high-priority groups has fallen short of the level required to prevent epidemic spread.

cine uptake is to require it. Mandatory vaccination has proven effective in ensuring high childhood immunization rates in many high-income countries. However, except for influenza vaccination of health care workers, mandates have not been widely used for adults.

Although a vaccine remains months to years away, developing a policy strategy to ensure uptake takes time. We offer a framework that states can apply now to help ensure uptake of the vaccine when it becomes available — including consideration of when a mandate might become appropriate. Our approach is guided by lessons from U.S. experiences with vaccines for the 1976 “swine flu,” H1N1 influenza, smallpox, and human papillomavirus (HPV).

We believe that six substantive criteria should be met before a state imposes a SARS-CoV-2 vaccine mandate (see box). The first is the existence of evidence that Covid-19 is inadequately con-

trolled in the state by other measures, such as testing, contact tracing, and isolation and quarantine — as indicated by sustained, troubling trends in new cases, hospitalizations, or deaths. Principles of public health law and ethics require that interventions that impinge on autonomy be reasonable and necessary; therefore, Covid-19 must present an ongoing threat. By the time a vaccine is available, more will be known about natural immunity in the population, the consequences of relaxing community mitigation measures, and the feasibility of scaling up test-and-trace strategies. There should be a reasonable indication as to whether further measures are needed.

The second criterion is that the Advisory Committee on Immunization Practices (ACIP), after reviewing the safety and efficacy evidence, has recommended vaccination for the persons who would be covered by a mandate. Currently available evidence suggests that the elderly, health professionals working in high-risk situations or working with high-risk patients (e.g., nursing home residents and patients with severe respiratory symptoms), and persons with certain underlying medical conditions may be high-priority groups for the ACIP’s consideration, along with other workers with frequent, close, on-the-job contacts and persons living in high-density settings such as prisons and dormitories. When a vaccine nears approval, the ACIP should review the updated evidence and develop recommendations. Only recommended groups should be considered for a vaccination mandate, though health officials can encourage voluntary uptake for others, using means

such as public education campaigns and free vaccination.

The fact that a vaccine has received Food and Drug Administration (FDA) approval — whether under an Emergency Use Authorization (EUA) or ordinary review processes — is an insufficient basis on which to conclude that it should be required. FDA approval reflects a determination that clinical trial evidence shows that the benefits of a vaccine outweigh its risks. ACIP recommendations reflect broader considerations, including values and preferences of affected groups, implementation issues, and health economic analyses. Overweighting FDA decisions would be particularly problematic for SARS-CoV-2 vaccines because EUAs may be based on very limited evidence and consciously or unconsciously influenced by the intense pressure to speed countermeasures to market.<sup>2</sup>

The third criterion is that there is an adequate supply of vaccine to cover the groups for which a mandate is being considered. Initially, global demand for SARS-CoV-2 vaccines will outstrip supply, making the salient question not who must get them but who will be granted access to them. New York State’s unsuccessful attempt to mandate H1N1 influenza vaccination for health care workers demonstrates that imposing requirements before adequate supply has been secured needlessly provokes controversy and alienates people who have already made sacrifices to fight an epidemic.<sup>3</sup>

The fourth criterion is that there has been transparent communication of the best available evidence about the vaccine’s safety and efficacy.<sup>4</sup> Particularly given

the possibility that the evidence underlying FDA approval of SARS-CoV-2 vaccines may be more modest than usual, policymakers and the public will need to understand the limits of what is known. Public trust has already been compromised by federal officials' endorsement of hydroxychloroquine as a Covid-19 treatment without evidentiary support; the same must not occur for vaccines.

The fifth criterion is that the government has put in place certain support mechanisms for persons required to receive the vaccine. Lessons from past vaccination campaigns suggest that a generous compensation pro-

posed legislation should be supported by attestations from the state health officer, the ACIP, or another expert committee that all trigger criteria have been met. Targeted SARS-CoV-2 vaccination mandate policies may also be appropriate in certain federal contexts, including high-risk groups in active-duty military environments, Veterans Affairs facilities, federal prisons, and immigration detention centers.

gram for people who have serious vaccine side effects should be a centerpiece of these efforts. A federal compensation fund like the Smallpox Vaccine Injury Compensation Program is one attractive model, although identifying compensable injuries may be challenging with a novel vaccine. States will also have to create distribution systems to provide SARS-CoV-2 vaccine to high-priority groups with near-zero financial and logistic barriers — for example, bringing free vaccine to points of care, pharmacies, and work sites. It is equally critical to have a safety-assessment plan in place before

vaccines are widely distributed to enable health officials to evaluate safety evidence in real time. States should work with health systems to ensure that reporting systems for vaccine-related adverse events are consistently used and specify a process for reconsidering mandate decisions as evidence evolves.

The last criterion is that vaccination mandates are imposed only after a time-limited trial of voluntary vaccine provision has proved unsuccessful. Principles of public health ethics support trying less burdensome policies before moving to more burdensome ones whenever possible. In

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Although state vaccination mandates are usually tied to school and day care entry, that approach is not appropriate for SARS-CoV-2 because children won't be a high-priority group. In addition, state mandates should not be structured as compulsory vaccination (absolute requirements); instead, noncompliance should incur a penalty. Nevertheless, because of the infectiousness and dangerousness of the virus, relatively substantive penalties could be justified, including employment suspension or stay-at-home orders for persons in designated high-priority groups who refuse vaccination. Neither fines nor criminal penalties should be used, however; fines disadvantage the poor, and criminal penalties invite legal challenges on procedural due-process grounds. Both are bad public health policy for a Covid-19 vaccine because they may stoke distrust without improving uptake.

The need to build public trust requires that state officials implement vaccination policy through a transparent and inclusive process, working closely with stakeholder groups such as local health officers, health professional and hospital associations, representatives of high-risk population groups, and groups con-

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this case, the costs of a failed voluntary scheme are sufficiently high that the attempt should be limited to a matter of weeks. States should implement a system for measuring vaccine uptake within each high-priority group against a set of coverage targets. Ensuring that the economic and logistic supports described above are in place will maximize the chances for success.

If the proposed trigger criteria were met, what might a vaccination mandate look like? Because the constitutional power to protect public health rests primarily with states, each state will need to adopt its own legislation. Pro-

cerned about vaccine safety. States' experience with HPV vaccination mandates offers another process tip: vaccine manufacturers should stay on the sidelines. The HPV vaccine manufacturer's direct involvement in crafting and lobbying for mandate legislation raised suspicion that profit rather than public health motives lay behind such proposals, undercutting support for vaccination even without a mandatory regime.<sup>5</sup>

As with social distancing orders, we can expect that the advent of SARS-CoV-2 vaccines will spark intense clashes of feeling about what people owe to one another in the fight against the

pandemic. In contrast to earlier phases of the pandemic, though, we currently have some time on our side. Careful deliberation now about state vaccination policy can help ensure that we have a strategy when the breakthrough comes.

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## Voluntary Do-Not-Sell Lists — An Innovative Approach to Reducing Gun Suicides

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**S**uicide is a public health crisis. Self-harm was the 10th leading cause of death in the United States in 2018, claiming tens of thousands of lives.<sup>1</sup> No single policy can be expected to eliminate a problem of this magnitude. In April 2020, however, Virginia joined Washington State in adopting an innovative tool — allowing people to place themselves on a “do not sell firearms” list — that could prevent a substantial number of suicides. Clinicians can counsel patients at risk for suicide about this option where it is available.

Roughly half of all suicides involve a firearm, according to the Centers for Disease Control and Prevention, and firearms are by far the deadliest common means of suicide. The laws establishing the new programs, known

in Washington as the Voluntary Waiver of Firearm Rights program and in Virginia as the Voluntary Do Not Sell Firearms List, allow people to confidentially put their own names into the federal firearm background-check system to prevent their own future gun purchases. Participants can change their minds and request to have their names removed from the system, but there is a delay in implementing such requests. Delaying firearm purchases has been found to reduce gun suicides without increasing the number of suicides carried out by other means,<sup>1</sup> so substitution of other methods is unlikely to undermine the life-saving potential of these laws.

Laws establishing voluntary do-not-sell programs can be, and have been, tailored to align with policy preferences and existing

gun laws in individual states. The three most important implementation choices are related to registration, removal of names from do-not-sell lists, and the scope of restrictions. Bills in California, Louisiana, and Tennessee sought to maximize participation in these programs by providing for easy, Internet-based registration, but the estimated cost of creating and maintaining a secure website proved to be a substantial barrier to passage. Requiring in-person registration (as Washington has done) is less expensive for the state, but more burdensome for participants. Providing a registration-by-mail option (as Virginia has done) may achieve higher participation at relatively low cost.

Provisions related to the removal of names from do-not-sell