The Economic Impact of Pandemic Influenza in the United States: Priorities for Intervention

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We estimated the possible effects of the next influenza pandemic in the United States and analyzed the economic impact of vaccine-based interventions. Using death rates, hospitalization data, and outpatient visits, we estimated 89,000 to 207,000 deaths; 314,000 to 734,000 hospitalizations; 18 to 42 million outpatient visits; and 20 to 47 million additional illnesses. Patients at high risk (15% of the population) would account for approximately 84% of all deaths. The estimated economic impact would be US$71.3 to $166.5 billion, excluding disruptions to commerce and society. At $21 per vaccinee, we project a net savings to society if persons in all age groups are vaccinated. At $62 per vaccinee and at gross attack rates of 25%, we project net losses if persons not at high risk for complications are vaccinated. Vaccinating 60% of the population would generate the highest economic returns but may not be possible within the time required for vaccine effectiveness, especially if two doses of vaccine are required.

Influenza pandemics have occurred for centuries, three times (1918, 1957, and 1968) in the 20th century alone. Another pandemic is highly likely, if not inevitable (1). In the 1918 influenza pandemic, more than 20 million people died (2). Improvements in medical care and technology since the last pandemic may reduce the impact of the next. When planning for the next pandemic, however, decision makers need to examine the following questions: Would it make economic sense to vaccinate the entire U.S. population if 15% were to become clinically ill? What if 25% were to become ill? To answer such questions, we conducted economic analyses of potential intervention scenarios.

Although many studies have examined or reviewed the economics of influenza vaccination (3-10), only one study (11), published in 1976, examined the economics of a vaccine-based intervention aimed at reducing the impact of an influenza epidemic in the United States. Our study examines the possible economic effects of the next influenza pandemic in the United States, analyzes these effects, and uses the results to estimate the costs, benefits, and policy implications of several possible vaccine-based interventions. These estimates can be used in developing national and state plans to respond to an influenza pandemic. Unlike the 1976 study, ours examined the effect of varying the values of a number of key input variables. Specific objectives were to provide a range of estimates regarding the number of deaths, hospitalizations, outpatient visits, and those ill persons not seeking medical care in the next influenza pandemic; provide a cost estimate of health outcomes; estimate the potential net value of possible vaccination strategies; evaluate the effect of using different criteria (e.g., death rates, economic returns due to vaccination) to set vaccination priorities; assess the economic impact of administering various doses of vaccine.

We limited our examination of possible interventions to those involving influenza vaccines. We did not consider the use of antiviral drugs for influenza prophylaxis because there may not be adequate supplies; first priority for such drugs may be for treatment; and the side-effects from the drugs, particularly amantadine, make them unsuitable for long-term prophylaxis for many workers, such as drivers, or heavy construction operators.

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1A complete plan detailing a response to an influenza pandemic should include definition of a pandemic, points that will initiate various steps in the response plan, and details about deploying the intervention. While a U.S. federal influenza pandemic plan is being developed, a guide to aid state and territorial health officials in developing plans for their jurisdictions is available at http://www.cdc.gov/od/nvpo/pandemicflu.htm. Printed copies can be obtained from the author.

2We limited our examination of possible interventions to those involving influenza vaccines. We did not consider the use of antiviral drugs for influenza prophylaxis because there may not be adequate supplies; first priority for such drugs may be for treatment; and the side-effects from the drugs, particularly amantadine, make them unsuitable for long-term prophylaxis for many workers, such as drivers, or heavy construction operators.
and of administering vaccine to different age

groups and groups at risk; and calculate an

insurance premium that could reasonably be

spent each year for planning, preparedness, and

practice.

Methods

The Model

Building a mathematical model of the spread

of influenza is difficult largely because of

differences in virus transmission and virulence,

lack of understanding of the primary factors

affecting the spread of influenza, and shortage of

population-based data (12). Because of the
difficulties in calculating realistic estimates of

the numbers of cases in the next influenza

pandemic, we used a Monte Carlo mathematical

simulation model (13-15), which uses predefined

probability distributions of key input variables
to calculate the number of illnesses and deaths that
could result from an influenza pandemic. Some

of the most important probability distributions

we used describe the population-based rates of

illness and death. These rates are based on

illness and death rates reported in earlier

influenza pandemics and epidemics. The model

produces a range of estimated effects rather than

a single point estimate. The model is not

epidemiologic and thus does not describe the

spread of the disease through a population.

Many details of the model are presented

below and in Appendix I; a more detailed

explanation and a complete list of all the

variables used and the values assigned to the

variables are available at Appendix II.

For interventions to contain and reduce the

impact of an influenza pandemic, we used a

societal perspective, which takes into account all

benefits and all costs regardless of who receives

and who pays.

Age Distribution and Persons at High Risk

Since the age distribution of patients in the

next pandemic is unknown, we assumed a

distribution (Table 1) among the three age

groups (0 to 19 years, 20 to 64 years, and 65 years

and older).\textsuperscript{3} Further, each age group was divided

into those at high risk (persons with a

preexisting medical condition making them more

susceptible to complications from influenza) and

those not at high risk (Table 1).\textsuperscript{4} Age by itself was

not considered a risk factor; persons 65 years and

older were assumed to have higher rates of

illness and death than the rest of the population

(Table 2).

Table 1. Estimate of age distribution of cases and

percentage of population at high risk used to examine

the impact of pandemic influenza in the United States

<table>
<thead>
<tr>
<th>Age group (yrs)</th>
<th>Percentage of all cases\textsuperscript{a}</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-19</td>
<td>40.0</td>
</tr>
<tr>
<td>20-64</td>
<td>53.1</td>
</tr>
<tr>
<td>65 +</td>
<td>6.8</td>
</tr>
</tbody>
</table>

| Percentage at high risk\textsuperscript{c} |
|----------------------------------|----------------------------------|
| 0-19                             | 6.4                              |
| 20-64                            | 14.4                             |
| 65 +                             | 40.0                             |

| U.S. average\textsuperscript{d} | 15.4 |

\textsuperscript{a}The actual number of cases will depend upon the assumed
gross attack rate. The distribution of cases was based on
lower and upper estimates of age-specific attack rates from
the 1918, 1928-29, and 1957 epidemics and pandemics (19).

\textsuperscript{b}Totals do not add to exactly 100% because of rounding.

\textsuperscript{c}Persons are categorized at high risk if they have a
preexisting medical condition that makes them more
susceptible to influenza-related complications. The percent-
ages of age groups at high risk were obtained from the
Working Group on Influenza Pandemic Preparedness and
Emergency Response (GrIPPE, unpub. data). The Advisory
Committee on Immunization Practices estimates that 27 to 31
million persons ages <65 years are at high risk for influenza-
associated complications (17).

\textsuperscript{d}Average is an age-weighted average, using each age group’s
proportion of the total U.S. population.

\textsuperscript{3}This article presents the results for one distribution of cases by age and risk group. The background paper in Appendix II,
however, contains additional results obtained by using a different distribution.

\textsuperscript{4}The Advisory Committee on Immunization Practices estimates that 27 to 31 million people ages <65 years are at high risk for
influenza-associated complications (17). ACIP also classifies all 32 million people ≥65 years as at elevated risk for influenza-
related complications (17). Further, the working group on influenza pandemic preparedness and emergency response
has assumed that approximately 19 million household members of persons at high risk should also be vaccinated to reduce the
probability of transmission to those at high risk (GrIPPE, unpub. data, 1997).
Gross Attack Rates

In the model, we used gross attack rates (percentage of clinical influenza illness cases per population) of 15\% to 35\%, in steps of 5\%. Infected persons who continued to work were not considered to have a clinical case of influenza, and were not included.

Illnesses and Deaths

The rates of adverse effects (outpatient visits, hospitalizations, deaths, and illnesses for which no medical care was sought), by age and risk group, were used to determine the number of persons in each category (Table 2) (Appendix II).

### Table 2. Variables used to define distributions of disease outcomes of those with clinical cases of influenza

<table>
<thead>
<tr>
<th>Variable</th>
<th>Lower</th>
<th>Most likely</th>
<th>Upper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not at high risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-19 yrs old</td>
<td>165</td>
<td>230</td>
<td></td>
</tr>
<tr>
<td>20-64 yrs old</td>
<td>40</td>
<td>85</td>
<td></td>
</tr>
<tr>
<td>65 + yrs old</td>
<td>45</td>
<td>74</td>
<td></td>
</tr>
<tr>
<td>High risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-19 yrs old</td>
<td>289</td>
<td>403</td>
<td></td>
</tr>
<tr>
<td>20-64 yrs old</td>
<td>70</td>
<td>149</td>
<td></td>
</tr>
<tr>
<td>65 + yrs old</td>
<td>79</td>
<td>130</td>
<td></td>
</tr>
<tr>
<td>Hospitalizations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not at high risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-19 yrs old</td>
<td>0.2</td>
<td>0.5</td>
<td>2.9</td>
</tr>
<tr>
<td>20-64 yrs old</td>
<td>0.18</td>
<td>2.75</td>
<td></td>
</tr>
<tr>
<td>65 + yrs old</td>
<td>1.5</td>
<td>3.0</td>
<td></td>
</tr>
<tr>
<td>High risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-19 yrs old</td>
<td>2.1</td>
<td>2.9</td>
<td>9.0</td>
</tr>
<tr>
<td>20-64 yrs old</td>
<td>0.83</td>
<td>5.14</td>
<td></td>
</tr>
<tr>
<td>65 + yrs old</td>
<td>4.0</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Deaths</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not at high risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-19 yrs old</td>
<td>0.014</td>
<td>0.024</td>
<td>0.125</td>
</tr>
<tr>
<td>20-64 yrs old</td>
<td>0.025</td>
<td>0.037</td>
<td>0.09</td>
</tr>
<tr>
<td>65 + yrs old</td>
<td>0.28</td>
<td>0.42</td>
<td>0.54</td>
</tr>
<tr>
<td>High risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-19 yrs old</td>
<td>0.126</td>
<td>0.22</td>
<td>7.65</td>
</tr>
<tr>
<td>20-64 yrs old</td>
<td>0.1</td>
<td>5.72</td>
<td></td>
</tr>
<tr>
<td>65 + yrs old</td>
<td>2.76</td>
<td>5.63</td>
<td></td>
</tr>
</tbody>
</table>

aClinical case definitions are cases in persons with illness sufficient to cause an economic impact. The number of persons who will be ill but will not seek medical care, are calculated as follows: Number ill = (Population x gross attack rate) - (deaths + hospitalizations + outpatients). The number of deaths, hospitalizations, and outpatients are calculated by using the rates presented in this table.

bFor Monte Carlo simulations, rates are presented as lower and upper for uniform distributions, and lower, most likely, and upper for triangular distributions (18).

### Net Returns of Vaccinating against an Influenza Pandemic

Vaccinating predefined segments of the population will be one of the major strategies for reducing the impact of pandemic influenza, and the net return, in dollars, from vaccination is an important economic measure of the costs and benefits associated with vaccination. We calculated the net return by using the following formula for each age and risk group:

\[
\text{Net returns in population} = \text{Savings from outcomes averted in population} - \text{cost of vaccination of population}
\]

The savings from illnesses and deaths averted and the cost of vaccinations are described in Appendix I. Some input variables are described below and in Appendix II.

### Input Variables

The direct medical costs (i.e., those reimbursed by third-party payers such as health insurance companies) associated with hospitalizations, outpatient visits, and drug purchases were obtained from a proprietary database containing health insurance claims data from approximately 4 million insured persons (The MEDSTAT Group, Ann Arbor, MI) (Table 3). Following the methods used by McBean et al. (28), we extracted the data for outpatient visits from the database with codes from the International Classification of Diseases, Ninth Revision (ICD-9) for pneumonia and bronchitis (ICD-9: 480-487.8), acute bronchitis (ICD-9: 466-466.1), and chronic respiratory disease (ICD-9: 490-496). Costs for inpatient care were extracted with the same codes, when recorded as the principal diagnosis and when recorded as any of the diagnoses in a patient’s chart. Further, because influenza can cause patients with preexisting medical conditions to seek inpatient care, data were extracted for the inpatient costs of treating heart-related conditions (common preexisting conditions that place a person at high risk for influenza-related complications).
### Table 3. Input variables used to calculate the economic impact (direct and indirect costs) of health outcomes due to an influenza pandemic in the United States (in 1995 US$)

<table>
<thead>
<tr>
<th>Outcome category item</th>
<th>Type of cost</th>
<th>0-19</th>
<th>20-64</th>
<th>65+</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deaths</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average age (years)</td>
<td></td>
<td>9</td>
<td>35</td>
<td>74</td>
<td>Assumed</td>
</tr>
<tr>
<td>Average present value (PV), using a 3% discount rate, of expected future lifetime earnings and housekeeping services, weighted by age and gender (30) and adjusted to 1995 dollars (by multiplying by a factor of 1.07) (16).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PV earnings lost ($)(^a)</td>
<td>Indirect</td>
<td>1,016,101</td>
<td>1,037,673</td>
<td>65,837</td>
<td>16, 30</td>
</tr>
<tr>
<td>Most likely ± min or max hospital costs ($)(^b)</td>
<td>Direct</td>
<td>3,455±2,632</td>
<td>7,605±3,888</td>
<td>8,309±3,692</td>
<td>Marketscan Database; 31.</td>
</tr>
<tr>
<td>Subtotal ($)(^c)</td>
<td></td>
<td>1,019,536</td>
<td>1,045,278</td>
<td>74,146</td>
<td></td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most likely ± min or max hospital costs ($)(^b)</td>
<td>Direct</td>
<td>2,936±2,099</td>
<td>6,016±2,086</td>
<td>6,856±3,200</td>
<td>Marketscan Database; 31.</td>
</tr>
<tr>
<td>Most likely ± min or max net pay for outpatient visits ($)(^d)</td>
<td>Direct</td>
<td>74 ± 40</td>
<td>94 ± 70</td>
<td>102 ± 60</td>
<td>Marketscan Database; 31.</td>
</tr>
<tr>
<td>Avg. copayment for outpatients visit ($)</td>
<td>Direct</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>Marketscan Database</td>
</tr>
<tr>
<td>Most likely ± min or max net payment for drug claims($)(^e)</td>
<td>Direct</td>
<td>26 ± 9</td>
<td>42 ± 30</td>
<td>41 ± 10</td>
<td>Marketscan Database</td>
</tr>
<tr>
<td>Most likely ± min or max days lost(^f)</td>
<td>Indirect</td>
<td>5 ± 2.7</td>
<td>8 ± 4.8</td>
<td>10±5.4</td>
<td>Marketscan Database; 31.</td>
</tr>
<tr>
<td>Value 1 day lost ($)(^g)</td>
<td>Indirect</td>
<td>65</td>
<td>100 or 65</td>
<td>65</td>
<td>30</td>
</tr>
<tr>
<td>Subtotal ($)(^c)</td>
<td></td>
<td>3,366</td>
<td>6,842</td>
<td>7,653</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient visits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avg. no. visits(^b)</td>
<td>Direct</td>
<td>1.52</td>
<td>1.52</td>
<td>1.52</td>
<td>Marketscan Database</td>
</tr>
<tr>
<td>Most likely ± min or max net payment per visit($)(^i)</td>
<td>Direct</td>
<td>49±13</td>
<td>38±12</td>
<td>50±16</td>
<td>Marketscan Database</td>
</tr>
<tr>
<td>Avg. copayment for outpatient visit ($)</td>
<td>Direct</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>Marketscan Database</td>
</tr>
<tr>
<td>Most likely ± min or max net payment per prescription($)(^j)</td>
<td>Direct</td>
<td>25±18</td>
<td>36±27</td>
<td>36±22</td>
<td>Marketscan Database</td>
</tr>
<tr>
<td>Avg. prescriptions per visit</td>
<td>Direct</td>
<td>0.9</td>
<td>1.8</td>
<td>1.4</td>
<td>Marketscan Database</td>
</tr>
<tr>
<td>Avg. copayment per prescription ($)</td>
<td>Direct</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>Marketscan Database</td>
</tr>
<tr>
<td>Days lost</td>
<td>Indirect</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>4,5</td>
</tr>
<tr>
<td>Value 1 day lost ($)(^g)</td>
<td>Indirect</td>
<td>65</td>
<td>100</td>
<td>65</td>
<td>30</td>
</tr>
<tr>
<td>Subtotal ($)(^c)</td>
<td></td>
<td>300</td>
<td>330</td>
<td>458</td>
<td></td>
</tr>
<tr>
<td><strong>Ill, no medical care sought</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days lost</td>
<td>Indirect</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>4,5</td>
</tr>
<tr>
<td>Value 1 day lost ($)(^g)</td>
<td>Indirect</td>
<td>65</td>
<td>100</td>
<td>65</td>
<td>30</td>
</tr>
<tr>
<td>Over-the-counter drugs ($)</td>
<td>Direct</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>Assumed</td>
</tr>
<tr>
<td>Subtotal ($)(^c)</td>
<td></td>
<td>197</td>
<td>202</td>
<td>327</td>
<td></td>
</tr>
</tbody>
</table>

\(^a\)Average present value (PV), using a 3% discount rate, of expected future lifetime earnings and housekeeping services, weighted by age and gender (30) and adjusted to 1995 dollars (by multiplying by a factor of 1.07) (16).

\(^b\)Most likely, with ± defining the minimum and maximum costs for a triangular distribution (18) for Monte Carlo analysis (13-15). The values were calculated by using cost data from Marketscan Database (The MEDSTAT Group, Ann Arbor, MI) and multiplying it by a hospital cost-to-charge ratio of 0.53. The latter ratio is a weighted average of the urban and rural (urban = 0.80, rural = 0.20) cost-to-charge ratios calculated by the Health Care Finance Administration for August 1996 (31).

\(^c\)Subtotals are the totals for each category of outcome, using the most likely estimates.

\(^d\)Most likely, with minimum and maximum values of net payments for outpatient visits up to 14 days before admission date and up to 30 days after discharge date.

\(^e\)Net payment for drug claims associated with outpatient visits up to 14 days before admission and up to 30 days after discharge.

\(^f\)Most likely, with ± defining the minimum and maximum days lost due to hospitalization for a triangular distribution (18) for Monte Carlo analysis (13-15). Calculated using length of stay in hospital data from Marketscan Database (The MEDSTAT Group, Ann Arbor, MI) and adding a total of one additional day for convalescence and pre- and posthospitalization outpatient visits for 0-19 and 20-64 years of age. For 65+ years, two additional days were added to length of stay in hospital for convalescence and pre- and posthospitalization outpatient visits.

\(^g\)For 0-19 and 65+ years age groups, a day lost to influenza was valued as equivalent to an unspecified day (30), denoting a value for time lost by caregivers and family members related to taking care of a patient in these age groups. For 20-64 years of age, 60% of days lost due to hospitalizations and related convalescence and pre- and posthospitalization outpatient visits were valued as day off work ($100/day). The remaining 40% of days lost were valued as unspecified days ($85/day). For 20-64 years of age, when patients were not hospitalized at any point during their illness (i.e., outpatient status), all days lost were assumed days off work ($100/day).

\(^h\)Net payment for drug claims associated with outpatient visits up to 30 days after discharge.

\(^i\)Net payment for drug claims associated with outpatient visits without any specified association to hospitalizations.

\(^j\)Most likely, with ± defining the minimum and maximum cost per prescription, with the number of prescriptions per visit.
risk for influenza-related illness or death. Hospital costs attributed to pneumonia and bronchitis, acute bronchitis, chronic respiratory disease, and the identified heart conditions were then estimated as weighted averages (Appendix II).

The principal indirect cost was lost productivity, which was valued by using an age- and gender-weighted average wage (Table 3) (30). The economic cost of a death was valued at the present net value of the average expected future lifetime earnings, weighted for gender and age (30). All costs were standardized to 1995 US$ values.

The cost of fully vaccinating a person (i.e., administering the number of doses necessary to protect against disease) was modeled with two assumed values, approximately $21 and $62 per person fully vaccinated (Table 4). These costs include the cost of the vaccine, as well as its distribution and administration (health-care worker time, supplies); patient travel; time lost from work and other activities; and cost of side effects (including Guillain-Barré syndrome) (Table 4) (Appendix II).

**Vaccine Effectiveness**

The assumed levels of vaccine effectiveness used to estimate the savings gained due to a vaccine-based intervention are described in Appendix I; the equation defining savings from outcomes averted contains the rate of compliance multiplied by the assumed vaccine effectiveness. In cases requiring two doses of vaccine to satisfactorily protect against influenza-related illness and death, a person was considered compliant only after both doses.

**Net Returns of Vaccination: Sensitivity Analyses**

To illustrate the importance of the death rate in determining economic outcomes, we conducted further sensitivity analyses in which the death rates for persons not at high risk were one quarter or half of those used in the main analyses (Table 2).

**Insurance Premiums**

To determine how much should be spent each year to plan, prepare, and practice to ensure that mass vaccinations can take place if needed, we considered the funding of those activities as an annual insurance premium (32). The premium would be used to pay for improving surveillance systems, ensuring sufficient supply of vaccine for high-priority groups (and possibly the entire U.S. population), conducting research to improve detection of new influenza subtypes, and developing emergency preparedness plans to ensure adequate medical care and maintenance of essential community services (32). We calculated the premium as follows (33): annual insurance premium = net returns from an intervention x the annual probability of a pandemic.

### Table 4. Cost of vaccination during an influenza pandemic, with specific costs assigned to side effects of vaccination

<table>
<thead>
<tr>
<th>Item</th>
<th>Probability of side effect</th>
<th>Cost of case</th>
<th>Lower-bound</th>
<th>Upper-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assumed cost</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of vaccination²</td>
<td></td>
<td>18</td>
<td>59</td>
<td></td>
</tr>
<tr>
<td><strong>Side effects</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild⁵</td>
<td>0.0325</td>
<td>94</td>
<td>3.05</td>
<td>3.05</td>
</tr>
<tr>
<td>GBS³</td>
<td>0.000002</td>
<td>100,800</td>
<td>0.20</td>
<td>0.20</td>
</tr>
<tr>
<td>Anaphylaxis</td>
<td>0.000000157</td>
<td>2,490</td>
<td>0.01</td>
<td>0.01</td>
</tr>
<tr>
<td><strong>Total cost per patient</strong></td>
<td></td>
<td>21.26</td>
<td>62.26</td>
<td></td>
</tr>
</tbody>
</table>

²The cost of vaccination includes the cost of the vaccine, the cost of administering the vaccine, value of time spent by a person traveling to and from the place of vaccination, and patient-associated travel costs. Included in the costs of the vaccine are any costs associated with the rapid production of a larger-than-usual number of doses and the rapid delivery and correct storage of doses at vaccination sites around the country. For $18, the costs were assumed to be $10 for vaccine + administration, $4 patient time (half hour), $4 patient travel costs. For $59, the costs were assumed to be $20 for vaccine + administration (this could include the cost of two doses), $32 patient time (two trips at 2 hours per trip), and $7 patient travel costs. For comparison, a review of 10 published articles found a range of $5 to $22 per dose of vaccine, with a medium [sic] cost of $14 per dose (10). Additional details are provided in the background paper (see Appendix II). These breakdowns are illustrations only of what might be deemed reasonable estimates of time and cost. Actual costs might vary substantially and will depend on the number of doses needed to achieve a satisfactory protective response, as well as the efficiency of giving vaccinations to millions of persons.

³Probabilities and average cost of treating each category of side effect were derived from (3).

⁵Mild side effects include sore arms due to vaccination, headaches, and other minor side effects that may require a visit to a physician or may cause the patient to miss 1 to 2 days of work.

³GBS = Guillain Barré syndrome.
Vaccination Priorities and Distribution

During the early stages of a pandemic, the supply of influenza vaccine will likely be limited. Even if sufficient vaccine is produced to vaccinate the entire U.S. population, it will take time to administer the vaccine to all, especially if two doses are required. Because a pandemic will be caused by a new subtype of influenza, two doses of vaccine may be required. Who should receive priority for vaccination until vaccine supplies are more plentiful? To illustrate the use of the model in estimating the impact of different priorities, we created sample priority lists by using three different criteria: total deaths, risk for death, and maximizing net returns due to vaccination. In choosing the criteria for priorities, society must debate the main goal of a pandemic vaccination plan: prevent deaths, regardless of age and position in society; prevent deaths among those at greatest risk (i.e., 65 years of age); or minimize the social disruption. If the last is the goal of society, the net return due to vaccination should be used to set priorities.

The model can also be used to compare the economic consequences of plans that specify which target populations are vaccinated. To illustrate this capability, we constructed four options for prioritizing vaccine distribution. For Option A, the target population is similar to current Advisory Committee on Immunization Practices (ACIP) recommendations, with production and use of vaccine similar to current, intrapandemic recommendations (17). We assumed 77.4 million vaccinees. Option B targets the number of vaccinees as outlined in Option A plus approximately 20 million essential service providers (5 million health-care workers and 15 million providers of other service) (99.2 million vaccinees). Option C aims to achieve a 40% effective coverage of the entire U.S. population (106.1 million vaccinees), and Option D, 60% effective coverage of the entire U.S. population (159.2 million vaccinees).

The number of vaccine doses required to meet each option will depend on the number of doses per person needed to obtain an immune response. If two are needed, lack of compliance with a two-dose regimen will mean that the actual number of doses needed will be higher than double the target population for each option (i.e., >40% or >60% of the population will have to receive the first dose to ensure that 40% or 60% are fully vaccinated). If two doses are required, the cost per person vaccinated will increase (Table 4).

Findings

Illnesses and Deaths

The number of hospitalizations due to an influenza epidemic ranged from approximately 314,000 (5th percentile = 210,000; 95th percentile = 417,000) at a gross attack rate of 15% to approximately 734,000 (5th percentile = 441,000; 95th percentile = 973,000) at a gross attack rate of 35% (Figure 1). The mean numbers of persons requiring outpatient-based care ranged from approximately 18 million (gross attack rate of 15%) to 42 million (gross attack rate of 35%) (Figure 1). The mean numbers of those clinically ill not seeking medical care but still sustaining economic loss ranged from approximately 20 million (gross attack rate of 15%) to 47 million (gross attack rate of 35%) (Figure 1). The estimated number of deaths ranged from approximately 89,000 (5th percentile = 55,000; 95th percentile = 122,000) at a gross attack rate of 15%, which increased to approximately 207,000 deaths (5th percentile = 127,000; 95th percentile = 285,000) at a gross attack rate of 35% (Figure 1).

Groups at high risk (approximately 15% of the total U.S. population) (Table 1) would likely be disproportionately affected by an influenza pandemic. These groups accounted for approximately 85% of all deaths, with groups at high risk in the 20- to 64-year-old age group accounting for approximately 41% of total deaths (Table 5). Groups at high risk also accounted for 38% of all hospitalizations and 20% of all outpatient visits (Table 5).

Economic Impact of an Influenza Pandemic

Without large-scale immunization, the estimates of the total economic impact in the United States of an influenza pandemic ranged from $71.3 billion (5th percentile = $35.4 billion; 95th percentile = $107.0 billion) (gross attack rate of 15%) to $166.5 billion (5th percentile = $82.6 billion; 95th percentile = $249.6 billion) (gross attack rate of 35%) (Table 6). At any given attack rate, loss of life accounted for approximately 83% of all economic losses. Outpatients, persons ill but not seeking medical care, and inpatients accounted for approximately 8%, 6%, and 3%, respectively, of all economic losses (Table 6) (Appendix II).
Figure 1: Impact of influenza pandemic in the United States: mean, minimum, maximum, and 5th and 95th percentiles of total death, hospitalizations, outpatients, and those ill (but not seeking medical care) for different gross attack rates. Note that for each gross attack rate, data are totals for all age groups and risk categories.

Net Value of Vaccination

If it cost $21 to vaccinate a person and the effective coverage were 40%, net savings to society would result from vaccinating all age and risk groups (Figure 2). However, vaccinating certain age and risk groups rather than others would produce higher net returns. For example, vaccinating patients ages 20 to 64 years of age not at high risk would produce higher net returns than vaccinating patients ages 65 years of age and older who are at high risk (Figure 2). At a cost of $62 per vaccinee and gross attack rates of less than 25%, vaccinating populations at high risk would still generate positive returns (Figure 2). However, vaccinating populations not at high risk would result in a net loss (Figure 2).
Sensitivity Analyses

At a vaccination cost of $21.26 per vaccinee, reducing the death rates to half and one quarter of the initial values (Table 2) left positive mean net returns for all age groups not at high risk. However, at a vaccination cost of $62.26 per vaccinee, reducing death rates to half and one quarter of the initial values resulted in negative mean net returns for all age groups not at high risk. The results are much less sensitive to increases in gross attack rate than to increases in death rate. For example, assuming a cost of $62.26 per vaccinee and death rates that are half the initial rates, increasing the gross attack rate from 15% to 25% still resulted in negative net returns for all age groups, regardless of assumed level of vaccine effectiveness.

Implications for Policy

The amount of the insurance premium to spend on planning, preparedness, and practice for responding to the next influenza pandemic ranged from $48 million to $2,184 million per year (Table 7). The amount was sensitive to the probability of the pandemic, the cost of vaccinating a person, and the gross attack rate. Because higher costs of vaccination reduce net returns from an intervention, increased vaccination costs reduced the premiums. Conversely, increases in gross attack rates (all other inputs held constant) increased the potential returns from an intervention and thus the amount of premiums.

When risk for death is used as the criterion for who will be vaccinated first, persons ages 65 years and older receive top priority (Table 8); however, when mean net returns due to vaccination are used as the criterion, that group receives the lowest priority (Table 8). Regardless of criteria used, persons at high risk ages 0 to 19 and 20 to 64 years would always receive priority over persons not at high risk from the same age groups (Table 8).

While Option A would ensure positive mean net returns, Option B would result in greater mean net returns (Figure 3). Changing the strategy from vaccinating specific groups (Option B) to vaccinating 40% of the population decreased mean net returns (Figure 3). Only Option D resulted in higher mean net returns.

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Table 6. Costs (direct and indirect) of influenza pandemic per gross attack rate: deaths, hospitalizations, outpatients, illnesses, and total costs (in 1995 US$)

<table>
<thead>
<tr>
<th></th>
<th>Cost per gross attack rate ($ millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15%</td>
</tr>
<tr>
<td>Deaths</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>59,288</td>
</tr>
<tr>
<td>5th percentile</td>
<td>23,800</td>
</tr>
<tr>
<td>95th percentile</td>
<td>94,907</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>1,928</td>
</tr>
<tr>
<td>5th percentile</td>
<td>1,250</td>
</tr>
<tr>
<td>95th percentile</td>
<td>2,683</td>
</tr>
<tr>
<td>Outpatients</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>5,708</td>
</tr>
<tr>
<td>5th percentile</td>
<td>4,871</td>
</tr>
<tr>
<td>95th percentile</td>
<td>6,557</td>
</tr>
<tr>
<td>Ill, no medical care soughtb</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>4,422</td>
</tr>
<tr>
<td>5th percentile</td>
<td>3,270</td>
</tr>
<tr>
<td>95th percentile</td>
<td>5,557</td>
</tr>
<tr>
<td>Grand totals</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>71,346</td>
</tr>
<tr>
<td>5th percentile</td>
<td>35,405</td>
</tr>
<tr>
<td>95th percentile</td>
<td>106,988</td>
</tr>
</tbody>
</table>

aGross attack rate = percentage of clinical influenza illness per population.
bPersons who become clinically ill due to influenza but do not seek medical care; illness has an economic impact (e.g., half day off work).
Figure 2: Mean net returns due to vaccination, by age group, for different gross attack rates and percentages of compliance. Case-age distributions are given in Table 1. Assumed vaccine effectiveness is the same as the high vaccine effectiveness defined in Appendix I.

Table 7. The mean annual insurance premium\textsuperscript{a} for planning, preparing, and practicing to respond to the next influenza pandemic

<table>
<thead>
<tr>
<th>Gross vaccination rate per vaccinee($)</th>
<th>Low vaccine effectiveness\textsuperscript{b} x 40% compliance</th>
<th>High vaccine effectiveness\textsuperscript{b} x 60% compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 in 30 years 60 years 100 years</td>
<td>1 in 30 years 60 years 100 years</td>
</tr>
<tr>
<td>15%</td>
<td>306 (122) 153 (61) 92 (37) 872 (341) 435 (170) 262 (103)</td>
<td>654 (341) 326 (170) 196 (103)</td>
</tr>
<tr>
<td>25%</td>
<td>561 (204) 280 (102) 168 (61) 1,528 (569) 762 (284) 459 (171)</td>
<td>1,311 (569) 653 (284) 394 (171)</td>
</tr>
<tr>
<td>35%</td>
<td>815 (286) 406 (142) 245 (86) 2,184 (796) 1,089 (397) 656 (239)</td>
<td>1,967 (796) 980 (397) 591 (239)</td>
</tr>
</tbody>
</table>

\textsuperscript{a}Defined here as the amount of money to be spent each year to plan, prepare, and practice to ensure that such mass vaccinations can take place if needed. See text for description of calculating premiums. The mathematically optimal allocation of such funds for each activity requires a separate set of calculations.

\textsuperscript{b}Low and high levels of vaccine effectiveness are defined in Appendix I.
than Option B. Note, however, that the 5th and 95th percentiles for each option overlapped with those of other options. Thus, the differences in mean values between the options may not occur in practice.

**Conclusions**

**Impact of an Influenza Pandemic**

Although the next influenza pandemic in the United States may cause considerable illness

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**Table 8. Setting vaccination priorities: Which age group or group at risk should be vaccinated first?**

<table>
<thead>
<tr>
<th>Priority</th>
<th>Risk for death</th>
<th>Total deaths</th>
<th>Returns due to vaccination</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (top)</td>
<td>High risk 65 + yrs</td>
<td>High risk 20 - 64 yrs</td>
<td>High risk 20 - 64 yrs</td>
</tr>
<tr>
<td>2</td>
<td>Not at high risk 65 + yrs</td>
<td>High risk 65 + yrs</td>
<td>High risk 0 - 19 yrs</td>
</tr>
<tr>
<td>3</td>
<td>High risk 0 - 19 yrs</td>
<td>High risk 0 - 19 yrs</td>
<td>Not at high risk 20 - 64 yrs</td>
</tr>
<tr>
<td>4</td>
<td>High risk 20 - 64 yrs</td>
<td>Not at high risk, 65 + yrs</td>
<td>Not at high risk 0 - 19 yrs</td>
</tr>
<tr>
<td>5</td>
<td>Not at high risk 20 - 64 yrs</td>
<td>Not at high risk 20 - 64 yrs</td>
<td>High risk 65 + yrs</td>
</tr>
<tr>
<td>6 (bottom)</td>
<td>Not at high risk 0 - 19 yrs</td>
<td>Not at high risk 0 - 19 yrs</td>
<td>Not at high risk 65 + yrs</td>
</tr>
</tbody>
</table>

*aPriorities set by risk for death are set according to lower-limit estimates of deaths per 1,000 population for each age and risk group.

*bThe priority list using the total deaths criteria was set by examining the percentage of total deaths that each age and risk group contributed to the total deaths estimated due to a pandemic. The group with the highest percentage (i.e., contributes the largest number of deaths) is listed as having the highest priority.

---

**Figure 3: Four options for responding to an influenza pandemic: mean net economic returns.** Notes: a) Bars show mean net returns for each option and assumed cost of vaccination. b) Option A: Similar to current Advisory Committee on Immunization Practices recommendations, with production and use similar to current, intra-pandemic recommendations (17). Assumed approximately 77 million vaccinees. Option B: Number of vaccinees as outlined in Scenario A plus 20 million essential service providers (5 million health-care workers + 15 million other service providers). Option C: Aim to achieve a 40% coverage of total U.S. population. Option D: Aim to achieve 60% coverage of total U.S. population (Appendix II).
and death (Figure 1), great uncertainty is associated with any estimate of the pandemic’s potential impact. While the results can describe potential impact at gross attack rates from 15% to 35%, no existing data can predict the probability of any of those attack rates actually occurring. In addition, the groups at high risk are likely to incur a disproportionate number of deaths (Table 5); 50% or more of the deaths will likely occur among persons age 65 years and older (Appendix II), a distribution also found in the influenza pandemics of 1918, 1957, and 1968 (2).

Our results illustrate that the greatest economic cost is due to death (Table 6). Therefore, all other things being equal, the largest economic returns will come from the intervention(s) that prevents the largest number of deaths. A limitation of the model is that, beyond the value of a lost day of work (Table 3), the model does not include any valuation for disruptions in commerce and society. For example, if many long-distance truck drivers were unavailable to drive for 1 or 2 weeks, there might be disruptions in the distribution of perishable items, especially food. These multiplier effects are not accounted for in this model, mainly because an estimate of an appropriate multiplier will depend on who becomes ill, how many become ill, when they become ill, and for how long they are ill.

All other factors being held constant, the net returns due to vaccination are sensitive to the combination of price and gross attack rate, with some scenarios generating negative mean returns (Figure 2). Further, some scenarios with a positive mean net return had a negative 5th percentile (Appendix II). The fact that negative results can be generated should serve as a warning that many interventions may not guarantee a net positive economic return.

Implications for Policy

The premium that could be spent each year for influenza pandemic response (planning, preparedness, and practice) depends most on the assumed probability of the pandemic (Table 7). The wide range in premiums presents a cautionary tale of the difference between possibility and probability was a key decision point in the swine flu incident of 1976-77 (34).

Vaccination priorities depend on the objectives. If preventing the greatest number of deaths is the most important goal, society should ensure that those in the groups at high risk become vaccinated first, followed by those age 65 years or older who have no preexisting medical conditions making them more susceptible to complications from influenza (Table 8). However, if maximizing economic returns is the highest priority, persons 0 to 64 years of age, regardless of risk, should be vaccinated first (Table 8). Results also illustrate the need to be precise in defining the criterion used for setting priorities. For example, stating that preventing death will be the criteria used is not sufficiently precise because different priority lists can be drawn up using death rates versus total deaths (Table 8).

The criteria used to generate the results in Table 8 do not define the entire set of possible methods of setting priorities. Society may decide to use another criterion or set of criteria. Priorities for vaccination may also depend on the epidemiology of the pandemic. For example, if the strain causing the pandemic were particularly virulent among those ages 20 to 40 years, that age group may receive highest priority. Since the epidemiology of the next pandemic is unknown, any plan must allow flexibility in determining criteria for setting priorities. Table 8 provides a starting point for debate regarding who should be vaccinated first.

The net returns for the four scenarios modeled (Figure 3) further illustrate the need to clearly set criteria, goals, and objectives for a vaccine-based intervention for the next influenza pandemic. Some may state that Options C and D represent a more egalitarian means of distributing vaccine. However, egalitarianism would cost society more since the mean net returns from Options C are lower than those from Option B (Figure 3). Option D produces higher returns than Option B (Figure 3), but vaccinating 60% of the U.S. population in a short time would be difficult, especially if two doses of vaccine are required. If two doses were required, Option D would mean producing, delivering, and administering approximately 320 million doses of vaccine in a 2- to 3-month period, which has never been accomplished in the United States.
Acknowledgments

We thank Nancy Arden, Rob Breiman, Bill Jordan, Marty Meyers, Alicia Postema, Steve Schoenbaum, Larry Schonberger, Larry Sparks, and Ray Strikas for their help and encouragement.

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References


Appendix I

For the equation in the main text defining net returns due to vaccinations, savings from outcomes averted and the costs of vaccination are calculated as follows:

\[
\text{Savings from outcomes averted} = \sum \left( \text{Number with outcome before intervention} \times \text{compliance} \times \text{vaccine effectiveness} \times \text{value of outcome prevented} \right)
\]

and;

\[
\text{Cost of vaccination} = \text{cost/vaccinee} \times \text{population} \times \text{compliance}
\]

<table>
<thead>
<tr>
<th>Disease outcomes</th>
<th>Vaccine effectiveness in preventing disease outcomes (^{ab})</th>
<th>High (^c)</th>
<th>Low (^c)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-19 yrs</td>
<td>20-64 yrs</td>
<td>65+ yrs</td>
</tr>
<tr>
<td>Death</td>
<td>0.70</td>
<td>0.70</td>
<td>0.60</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>0.55</td>
<td>0.55</td>
<td>0.50</td>
</tr>
<tr>
<td>Outpatient visits</td>
<td>0.40</td>
<td>0.40</td>
<td>0.40</td>
</tr>
<tr>
<td>Ill, no medical care sought</td>
<td>0.40</td>
<td>0.40</td>
<td>0.40</td>
</tr>
</tbody>
</table>

\(^{a}\)Vaccine effectiveness is defined as the reduction in the number of cases in each of the age and disease categories.

\(^{b}\)Within a defined age group, it was assumed that there was no difference in vaccine effectiveness between subgroups at high risk and not at high risk.

\(^{c}\)The terms high and low level of effectiveness are subjective and reflect only a judgment of the levels of effectiveness in the two scenarios relative to each other.

Appendix II

A background paper, containing additional methodological details and results, is available electronically at the following URL: http://www.cdc.gov/ncidod/EID/vol5no5/meltzerback.htm.
The Economic Impact of Pandemic Influenza in the United States: Priorities for Intervention

Martin I. Meltzer, Nancy J. Cox, and Keiji Fukuda

Centers for Disease Control and Prevention, Atlanta, Georgia, USA


Appendix I

For the equation in the main text defining net returns due to vaccinations, savings from outcomes averted and the costs of vaccination are calculated as follows:

\[
\text{Savings from outcomes averted} = \sum (\text{Number with outcome before intervention} \\ \times \text{compliance} \times \text{vaccine effectiveness} \times \$\text{value of outcome prevented})
\]

\[
\text{Outcomes} = \text{death, hospitalization, outpatient, ill, no medical care}
\]

\[
\text{age, risk group}
\]
group hospitalization, outpatient, ill, no medical care

and;

Cost of vaccination = cost/vaccinee x population x compliance age, risk group age, risk group age, risk group

Table. High and low levels of assumed vaccine effectiveness

<table>
<thead>
<tr>
<th>Disease outcomes</th>
<th>Vaccine effectiveness in preventing disease outcomes&lt;sup&gt;a&lt;/sup&gt;</th>
<th>High&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Low&lt;sup&gt;c&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-19 yrs</td>
<td>20-64 yrs</td>
<td>65 + yrs</td>
</tr>
<tr>
<td>Death</td>
<td>0.70</td>
<td>0.70</td>
<td>0.60</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>0.55</td>
<td>0.55</td>
<td>0.50</td>
</tr>
<tr>
<td>Outpatient visits</td>
<td>0.40</td>
<td>0.40</td>
<td>0.40</td>
</tr>
<tr>
<td>Ill, no medical care sought</td>
<td>0.40</td>
<td>0.40</td>
<td>0.40</td>
</tr>
</tbody>
</table>

<sup>a</sup>Vaccine effectiveness is defined as the reduction in the number of cases in each of the age and disease categories.

<sup>b</sup>Within a defined age group, it was assumed that there was no difference in vaccine effectiveness between subgroups at high risk and not at high risk.

<sup>c</sup>The terms high and low level of effectiveness are subjective and reflect only a judgment of the levels of effectiveness in the two scenarios relative to each other.

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Appendix II

This paper provides additional information on methods, data, and results and is intended to supplement the above referenced published paper.

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High risk groups:
Comparisons with other data sets

- Health outcomes: Hospitalizations
  
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  High risk:
  
Comparisons with other data sets:

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Figure 3: Impact of influenza pandemic in the United States: Mean, minimum, and maximum of total outpatients and those ill (but not seeking formal medical care) for different gross attack rates
"A thousand years in the making, the religion of technology has become the common enchantment, not only of the designers of technology but also of those caught up in, and undone by, their godly designs. . . . This popular faith, subliminally indulged and intensified by corporate, government, and media pitchmen, inspires an awed deference to the practitioners and their promises of deliverance while diverting attention from more urgent concerns. . . . Pleas for some rationality, for reflection about pace and purpose, for sober assessment of costs and benefits - for evidence even of economic value, much less larger social gains - are dismissed as irrational. From within the faith, any and all criticism appears irrelevant, and irreverent."


**Introduction**

Although there has been a number of authors have examined or reviewed the economics of influenza vaccination (6,20,22-26,35) only one previous study (5) appears in the literature that examines the economics of a planned intervention aimed at reducing the impact of an influenza epidemic in the United States. The overall objective of this study is to examine the possible economic impact of the next influenza pandemic in the United States, and then use those results to analyze the costs and benefits of interventions designed to reduce the impact. These estimates can then be used in the development of national and state-level plans to respond to an influenza pandemic.¹

The model can also be used to examine the economics of various strategies and options that might be available for the use of influenza vaccines.

**Methods**

**Objectives**

The specific objectives of the modeling effort are to:

1) provide a range of estimates regarding the number of deaths, hospitalizations, outpatients, and those ill, but not seeking medical care;

2) provide a dollar estimate of the impacts;

3) estimate the potential net present value of some possible vaccination strategies;²
4) evaluate the impact of using different criteria (e.g., death rates, economic returns to vaccination) to set vaccination priorities;

5) assess the economic impact of various scenarios regarding the total number of doses of vaccine administered, and the distribution of vaccine among different age and risk groups; and,

6) calculate an "insurance premium" that could reasonably be spent each year on planning, preparedness and practice (the 3 P's).

The intent is not to provide "the" estimate of impact, but rather to examine the effect of altering a number of variables, and evaluating how the results may effect key decisions. For example, if influenza-related deaths rates among 20-64 years old are assumed to range between 0.0675 - 0.15 per 1,000 persons, would it make economic "sense" (i.e., generate a positive net present value) to vaccinate everybody in this age group if a pandemic had an overall (gross) attack rate of, say, 15 percent? If not, would the results change if, say, the maximum death rate were doubled to 0.30 per 1,000? If doubling still does not generate a positive net present value for a "vaccinate all" strategy, then decision makers would be aware that the decision to vaccinate all 20-64 years of age would rest on a valuation of the intangibles, such as the reduction in fear of death due to influenza, and the value of human life above and beyond the economic value of lost productivity.

**Modeling approach**

Mathematically modeling the spread of, and numbers affected by, influenza is a difficult task. Differences in virology, lack of understanding of how influenza is actually spread in a community, and lack of adequate population-based data are some of the factors that have hampered efforts to produce realistic estimates of the numbers of cases that may be caused by the next influenza pandemic. Therefore, in the face of a great deal of uncertainty regarding the possible impact of an influenza pandemic, we used a Monte Carlo simulation approach. In Monte Carlo simulations, uncertainty is explicitly allowed for by using pre-specified probability distributions to describe the range and frequency of probable values of key variables. The model is run for several iterations, often 1,000 or more, and during each iteration values for each variable are drawn from their probability distributions. The results from all the iterations are then pooled and descriptive statistics (e.g., average, median, mode, 5th and 95th percentiles) can be calculated. For this paper, the impact of some variables, such as attack rates, cost of vaccine, and numbers effectively vaccinated, were examined at pre-determined intervals over fixed ranges, with values for other variables chosen from pre-determined probability distributions.

**Gross attack rates**

We defined gross attack rate as the number of clinical cases of illness (i.e., not infections) caused by influenza per unit population. Persons who become infected but show no symptoms or only very mild symptoms, such as a headache or mild nausea, are deemed not to have an economically important case of influenza (although such infections may have important epidemiological consequences). Because nobody can predict with any great certainty the attack rate of a pandemic, we modeled a range of attack rates, from 15 to 35 percent, in steps of 5
percent. The number of cases generated by a given attack rate was distributed among the U.S. population first by age and then by "high risk" status (see later).

Age group distribution of number of cases

The U.S. population (1) for 1997 was categorized into 3 age groups, 0-19 years of age, 20-64 years of age, and 65 years of age and older (Table 1). Using only three age groups simplifies modeling, and the oldest age group matches a defined "target" group for vaccination during interpandemic years (2). Since the actual age distribution of cases during an influenza pandemic is unknown, we calculated two age-related distributions of cases, or scenarios (Table 2).

Percentages of high risk cases

There are a proportion of persons who, because they have a pre-existing medical condition, are deemed as being at a higher risk of contracting an influenza-related illness with a serious health outcome (defined later). For the total U.S. population, we used lower and upper age-weighted averages of 15.4 and 24.8 percent (Table 2). These estimates are similar to the 22.5 percent figure quoted by Schoenbaum et al. (5), and the 19.6 percent for 1970-1978 used by the Office of Technology Assessment (OTA) study (6).

For age-specific estimates, we used lower and upper estimates of 6.4 and 11.1 percent for the 0-19 years old and a lower estimate of 14.4 percent for the 20-64 years old (Table 2). These estimates were obtained from the Working Group on Influenza Pandemic Preparedness and Emergency Response (GRIPPE, unpublished data). In comparison, a study in Oregon found that between 2.5 and 6.4 percent of 0-14 years old had one or more high risk conditions (7). The upper limit for the 20-64 years old and the lower and upper estimates for the 65 years and older were obtained from expert opinion (Table 2). Note that both the Advisory Committee on Immunization Practices (ACIP) (2) and GRIPPE (unpublished data) categorized all person 65 years and older as 'high risk." This categorization, however, is more to indicate high priority targets for inter-pandemic vaccination as opposed to describing the numbers of persons in that age group who are at higher risk of contracting an influenza-related illness with a serious health outcome.

Total numbers of cases

For each of the five assumed gross attack rates, the total number of cases were distributed among the age groups, using the two distribution scenarios (Table 2). Then, the number of cases in each age group were divided into "non-high" and "high risk" groups using the lower and upper estimates of age-defined percentages of high risk persons in each age group (Table 2). This strategy resulted in a total of ten different scenarios describing the possible number of cases resulting from an influenza pandemic.

Health outcomes: Four categories
Health outcomes were divided into four categories: deaths, hospitalizations, outpatients, and those ill, but not seeking medical care. The last category included only those whose illness would cause an economic impact, such as staying away from work for a half-day or more. Those who become ill, but do not stop or significantly reduce their daily activities, are not considered to have had an illness of any notable economic impact. For each age and risk group, a range of rates for each of the four outcomes were obtained from the literature or expert opinion.

**Health outcomes: Deaths**

**Non-high risk groups:** For lower and "most likely" estimates, age-weighted average excess death rates were calculated using Serfling et al.'s data (16). Lower estimates were obtained the lowest age-weighted rate found in the four epidemic periods studied, while the "most likely" estimate was the average of the age-weighted rates studied (16) (Table 3). The same data set also provided a maximum value for the 65 and older age group (Table 3). Note that, Serfling et al.'s estimates are effectively the combination of the rates for both high and non-high risk. Thus, using those rates for non-high risk will result in rates higher than might actually occur, especially in terms of lower limits. The upper limits for the 0-19 years old were the age-weighted average rate for the 0-4 and 5-24 year olds rate per 1,000 cases, assumed by Schoenbaum et al. (5), converted to rates per 1,000 general population (see later for notes on conversion methodology) (Table 3). Data from Serfling et al. were used to set the upper limit for the 20-64 years old (Table 3).

**High risk groups:** In Oregon (17) death rates for those aged 45-64 years ranged from 0.1 per 1,000 (with one high risk condition) to 5.72 per 1,000 (for those with 2 or more high risk conditions). Those aged 65 and older had rates of 2.76 per 1,000 (one high risk condition) to 5.63 per 1,000 (2 or more high risk conditions). These rates were used as ranges for 20-64 years old and 65 years and older, respectively (Table 3). Data regarding the death rate among 0-19 years old with high risk conditions are scarce. The Office of Technology (OTA) report (6) estimated the risk of pneumonia-related deaths among those 44 years and under with medically attended heart conditions was 1.0 per 1,000 of the general high risk population. Among those 44 years and under, those with a high risk condition (i.e., medically attended heart condition) were calculated to have a relative risk of 9.09 of dying from pneumonia when compared to those without a high risk condition (6). It was assumed, therefore, that the rate of death per 1,000 high risk population among the 0-19 years old was 9 times greater than the rates used for the non-high risk population of the same age.

**Comparisons with other data sets:** Kavet (20), in examining the impact of epidemics in 1962-63, 1965-66 and 1968-69 (with 1966-67 as the non-epidemic reference year) estimated non-age, non-risk specific mortality rates of 0.14-0.249 per 1,000 general population. Glezen (3) reported similar rates for 65 years and over, and an age-weighted (1) average rate of 6.75 per 100,000 for 20-64 years old. For 45-64 years old, the death rate in Oregon 0.02 per 1,000, and 0.09 per 1,000 for 65 and older (17). In France, from 1980-81 to 1989-90, the average death rates among those aged 75 years and older ranged from 4.81 to 0.28 per 1,000 (23). All of these estimates are encompassed in either the rates used for the non-high or high risk groups (Table 3). When considering the economics of vaccinating elderly patients in nursing homes, Patriarca et al. (25) assumed a probability of death after infection, with no hospitalization, of 0.16. This is
approximately 5 times greater than the rate per 1,000 cases for 65 years and older used here (Table 3), and far greater than most death rates reported for the elderly. The difference can probably be attributed to the fact that almost the entire population in a nursing home is likely to have one or more high risk conditions. In 1974-1982, in Houston, Texas, (18) there was a fairly steady age distribution of percentage of total influenza-related deaths. Deaths among the 65 years and older accounted for an average of 62.5 percent (range: 55-75 percent) of all influenza-related deaths. Kavet (20) reported similar percentages for the three epidemics which he studied. The 20-64 years old had 29.6 percent (range: 20-33 percent) and 0-19 years old accounted for 7.9 percent (range: 5-12 percent) (18).

Health outcomes: Hospitalizations

Non-high risk: The excess hospitalizations due to influenza were obtained from Mullooly and Barker (7,12), with data from Schoenbaum et al. (5) used to define upper limits. The latter study used estimates obtained from a Delphi panel, but their estimates appear to include "background," non-epidemic hospitalizations as opposed to excess hospitalizations. The lower limits for the 0-19 years old age group were derived from the combined male and female excess rates for 5-14 years of age (7), while the "most likely" rates are the rates for the entire 0-14 years of age (7) (Table 3). The upper limit for the 0-19 years old were the age-weighted average rate per 1,000 cases (see later for notes on conversion methodology) for the 0-4 years and 5-24 years old age groups as assumed by Schoenbaum et al. (5) (Table 3). The lower limits of excess hospitalizations for the 20-64 years age group were taken from the average 1968-69 and 1972-73 epidemic excess hospitalization rates for the 15-44 and 45-65 year old age groups in Oregon (Table 3) (12). The upper limits for the 20-64 years old were calculated using the data set (5) and methodology employed to calculate the upper limits for the 0-19 years old (Table 3). Mullooly and Barker's data were used to obtain the upper and lower limits for the 65 and older age group (12) (Table 3).

High risk: The same methodology and data sets used to set hospitalization rates for non-high risk patients were also used to set the rates of hospitalizations for the high risk groups (Table 3).

Comparisons with other data sets: It is noted that the Office of Technology Assessment report (6) used the Mullooly and Barker data sets (7,12). Glezen (3), without categorizing patients by risk, reports rates of hospitalizations for acute respiratory disease as approximately 4.2, 0.8, 0.5 per 1,000 for the <5, 5-9, and 10-19 year age groups, respectively. This produces a population-weighted average for the 0-19 year olds of 1.5 per 1,000 population. This rate is lower than the upper limit used here for 0-19 years old with non-high risk (Table 3). From the same data set (3), the age-weighted hospitalization rate for 20-64 years of age was 1.1 per 1,000, and the rate for 65 years and older was 7.5 per 1,000. These rates are lower than the upper rates used in this study for those categorized as "high risk" (Table 3). Barker's (21) estimates of national excess hospitalization rates, averaged over 5 epidemics from 1970-78, are within the ranges used here for the "non-high risk" group (Table 3). The only exception is the rate of 3.7 per 1,000 found for 65 years and older, which is higher than given in Table 3 for non-high risk, but is below the range used for "high risk."
The highest recorded estimates of hospitalizations appear in a study by McBean et al (19). They calculated the rate of hospitalizations for influenza and influenza-related conditions for a sample of Medicare patients (i.e., 65 years and older) from 1989-1991. Unlike the studies referenced above, which compared rates from epidemic to non-epidemic years, McBean et al. compared hospitalization rates of influenza "seasons" (e.g., December to March) to an interim period (e.g., May - September). They found excess rates (using their definition of excess) of up to 14.25 per 1,000 for patients hospitalized with influenza and pneumonia as the primary diagnosis, and rates of up to 19.4 per 1,000 for patients hospitalized with influenza or pneumonia as any part of the diagnosis. These rates are approximately 4 times greater than the rates that we used for "non-high risk" 65 years and older, but similar to the rate we used of 13 per 1,000 for those 65 and older categorized as "high risk" (Table 3).

Health outcomes: Outpatient (ambulatory care)

Non-high risk groups: An age-weighted average rate for 0-19 years old was obtained using the rates reported by Glezen (3) for <5, 5-9, 10-14 and 15-19 years old (Table 3). The rate of medically attended illnesses for the 20-64 year old age group were derived from the excess contact rates for 45-64 year age group in Oregon, where excess was defined as the increased visits due to the 1968-69 and 1972-73 epidemics compared to the 1970-71 period (12) (Table 3). The same data source (12) provided the excess outpatient visits for those 65 years and older (Table 3).

High risk groups: Although some studies have considered hospitalization rates by category of risk (see later), there are no studies that consider outpatient (ambulatory) visits by risk category. Therefore, it was decided to calculate the rates by multiplying all the rates used for the non-high risk groups by an arbitrarily defined factor of 1.75. It was found, by trial and error, that any factor noticeably higher than that (e.g., 2.0), resulted in more than 100 percent of the high risk population requiring outpatient care.

Comparisons with other data sets: Hospitalizations and outpatient visits: Kavet (20), in studying the epidemics of 1962-63, 1965-66 and 1968-69 (with 1967-68 as a non-epidemic reference year), found that between 41.7 and 51.3 percent of all cases required some medical attention (e.g., outpatient visit or hospitalization). These percentages were not broken down by age groups or risk categories. However, these total average rates are similar to, or encompassed by, to the sum of outpatients and hospitalizations rates used in this study (Table 3).

Health outcomes: Ill (no formal medical care)

Besides those that will die, or require hospitalization, or require outpatient (ambulatory) visits, there will be a number of persons who will become clinically ill but not seek formal medical care (e.g., a visit to a physicians office). These clinically ill people will, however, generate economic impact, primarily in days lost from work or school, and the use of over-the-counter medications. Note that this definition of clinically ill excludes those that will develop mild symptoms (e.g., nausea, headache, low-grade fever), but essentially still continue their daily activities.
The numbers of persons in each age group who will incur a clinical case that will have economic impact was calculated by using the following formula:

\[
\text{Number ill}_{\text{age}} = \left( \text{U.S. population}_{\text{age}} \times \text{gross attack rate} \right) - \left( \text{number dead}_{\text{age}} + \text{number hospitalized}_{\text{age}} + \text{number requiring outpatient services}_{\text{age}} \right)
\]

where \( \text{age} = \) number of persons in each of the three age groups (for \( \text{U.S. population}_{\text{age}} \), see Table 1).

Converting from general population rates to rates per clinically ill population

The data reported for outpatient (ambulatory) visits, hospitalizations and deaths are presented in rates per 1,000 general population (Table 3). These summarize the risk of a particular health outcome for any member of the general population, and the rates reflect the impact of a particular attack rate(s). Presumably, a given rate per 1,000 general population changes with attack rate. That is, the rate of, say, deaths per 1,000 non-high risk persons aged 20-64 years will change with changes in attack rate. We are not aware of any published study that contains a statistical analysis of the correlation between attack rate and the rate of a given health outcome. This lack of data is problematic, as one of the goals of this paper is to examine the potential impact of pandemic influenza assuming a range of pre-set gross attack rates (see earlier). Thus, the data regarding health outcomes must be converted to rates per unit population with clinical illness. That is, for the population that becomes clinically ill, the rates must reflect the probability of outpatient (ambulatory) visits, hospitalizations and deaths.

To convert rates based on a general population to rates based on a clinically-ill population, the following formula was used:

\[
\text{Rate per unit clinically ill population (X}_{\text{clinically ill}}) = \text{Rate per unit general population (X}_{\text{general}}) / \text{conversion factor}.
\]

Where \( X_{\text{clinically ill}} \) is the rate of interest per 1,000 clinically ill persons (e.g., hospitalizations for influenza related illnesses among 0-19 years old per 1,000 clinically ill 0-19 years old). \( X_{\text{general}} \) is the rate for the outcome of interest per 1,000 population, ill and not ill combined (e.g., hospitalizations for influenza illnesses per 1,000 population aged 0-19 years).

The key to applying the above equation is determining the conversion factor. One logical candidate for the conversion factor is the attack rate that created the rate per unit general population (\( X_{\text{general}} \)). Such data are rare, because it implies that there would be active surveillance among the general population, asking the populace if they have suffered any influenza-like illnesses during a specified time period. In order to disregard illnesses that patients may report as influenza, but are actually due to non-influenza pathogens, a sub-sample of the population would have to be tested for evidence of influenza infection (e.g., take nasal swabs and culture). Further, because the virulence of influenza can change dramatically from year to year (13), such a study
would have to be conducted over several years. Lacking such data, we used the equation above to derive rates per clinically ill population using upper and lower limits of attack rates calculated for the general population from Texas for 1976-1984 (3), and Seattle for 1975-1979 (3,14) (Table 3). These data were the closest in time and geography to the data used to calculate the population based data rates (Table 3). Note that we assumed that the conversion calculations was the same for both non-high and high risk groups. For comparison, Kavet (20) provides data allowing the conversion of mortality rates per general population to case fatality rates. His non-age, non-risk specific conversion factors for deaths for the three epidemics studied were 0.11, 0.14, and 0.26 equivalent to 11%, 14%, 16%, respectively). The last two estimates are within the ranges used here (Table 3), whilst the conversion factor of 0.11 is very close to the lower limit of 0.12 used here for the age groups 20-64 years and 65+ years (Table 3).

Resource use: Direct medical costs: Database

The direct medical costs associated with hospitalizations, outpatient visits and drug purchases related to outpatient visits were obtained from the MarketScan, proprietary health insurance claims database (The MEDSTAT Group, Ann Arbor, MI). The database available to us contains health insurance claims data from approximately 4 million covered lives, most of whom obtain coverage as part of their employment with large companies. These data are collected from over 100 health care payers, servicing 45 major metropolitan areas. For 1995, the database has 287,000 inpatient records and 42.8 million outpatient claims. To extract direct medical costs from the database, we used the same International Classification of Disease, ninth revision (ICD-9) codes as used by McBean et al. (19) (Table 4). Simple descriptive statistics describing the extracted data were calculated using either spreadsheet software (Excel, Microsoft, WA) or a statistical package (SAS, SAS Institute, NC).

Resource use: Standardizing year of costs to 1995

To calculate descriptive statistics over the three years of available cost data, data from 1993 and 1994 were inflated to equivalent 1995 prices. The medical care portion of the consumer price index was used to inflate prices to 1995 equivalents. The factor for 1993 was 1.095 and for 1994 the factor was 1.045 (1).

Resource use: Valuing death due to influenza

It was assumed that the average age of death was the mid-point of each of the three age groups (i.e., 9, 35, and 74 years). For each average age of death, a life lost was valued at the average present value, discounted at 3%, of future expected life-time earnings and housekeeping services (27). This average was calculated using wages of full-time employees, weighted for gender composition of the U.S. workforce, and assumed a 1% per annum growth rate in productivity (27). The original estimates were converted from 1990 dollars to 1995 dollars by multiplying by a factor of 1.07, which represents the average increase from 1990 to 1995 (in constant 1992 dollars) in total and per capita personal income (1).

Resource use: Inpatient care associated with death
It was assumed that the majority of deaths would occur after some use of hospital resources (i.e., death would occur after a stay in a hospital). For each of the three age groups the average age, length of stay and net payment were obtained from the medical cost database for each of the predefined ICD-9 codes used to describe influenza and influenza-related illnesses (Table 4). Following the methodology of McBean et al. (19), the data were then subdivided into those whose principal diagnosis was either influenza, pneumonia or acute bronchitis ("Principal diagnosis only"), and those whose had these diseases coded as either the principal diagnosis or one of the first four diseases entered in the coding sheet ("All diagnoses"). Since influenza may also cause a patient to be hospitalized with a pre-existing condition (i.e., influenza "triggers" an underlying problem), the inpatient costs for those with heart-related conditions (Table 4) were also extracted from the data base. A weighted average for each age group of these three categorizations of outcomes was then calculated as follows:

\[
\text{Weighted average age group } = \frac{\text{number of claims in a category age group}}{\text{total claims for all categories age group}} \times \text{(value age group)}
\]

The results are presented in Table 5, and were then added to the value of a human live lost due to influenza.

**Resource use: Hospitalized patients**

Costs for those patients who would be hospitalized due to an influenza pandemic, but will not die, were obtained from the medical cost database for all those patients whose diagnoses (i.e., ICD-9 codes) included influenza, pneumonia or acute bronchitis (Table 4). Further, it was assumed that a hospitalized patient, who eventually recovered from a case of influenza, would also generate outpatients visits before and after hospitalization. In order to generate a composite estimate of inpatient and outpatient resources used, for each individual hospitalized, records of outpatient visits and drug claims up to 14 days prior to a admission date, and 30 days after discharge, were identified and added to individual net hospital payments. Length of stay during hospitalization was also obtained from the database, and to this number one day was added to allow for convalescence for the 0-19 and 20-64 years age groups. For the 65+ years age group, two days were added for post-hospitalization convalescence. Results are given in Table 6, and it can be seen that the average length of stay was 4, 7 and 8 days for the 0-17, 18-64, and 65+ year age groups, respectively. Adding the assumed post-hospitalization period of convalescence, the number of work-days lost are: 5, 8 and 9 days for the 0-17, 18-64, and 65+ year age groups, respectively.

The number of days of work lost due to hospitalization extracted from the MarketScan database can be compared to estimates used by Kavet (20). Kavet, using data from the National Health Survey, assumed that average length of hospital stay was 9 days, with 2.9-3.8 days of bed disability per case, and 5.0-6.2 days of restricted activity per case. These loses resulted in 3.2-3.4 days lost from work per case and 2.8-4.7 days lost from school per case. In a small study (22) covering 130 unvaccinated textile factory employees, 93 workdays (average: 0.71 workday/employee) were lost due to influenza-like illness. Also a factor is the idea that, during a pandemic, the number of people requiring some form of hospitalization will be so great that
hospitals will be forced to increase patient turnover by reducing average length of stay. Thus, average length of stay obtained from data collected during inter-pandemic years may overestimate the amount of hospital resources used per patient during a pandemic.

Resource use: Outpatients

The direct medical resources used by an ambulatory patient includes the average number of physician visits per case of influenza, the co-payment associated with each visit, the net payment made by the insurance company, and any drug claims (see earlier). Records of outpatient claims matching the pre-selected ICD-9 codes for influenza, pneumonia and acute bronchitis (Table 4) were used to calculate the distribution of visits-per-case to a physician for each calendar year in the database (1993-1995) (Figure 3). Then, to compare results from a calendar year to those associated with part of an influenza "season," the average number visits per patient for October to December, 1993 were calculated. To allow for errors in the data set (e.g., several patients entered with same identification number), the means were calculated for three different frequencies, each with a pre-specified maximum (truncated) number of visits (< 20, < 7, < 3 visits) (Table 7). The same data also provided the average age of patient making an outpatient visit, the average co-payment, and the average net payment to physician paid by a third party payer for services provided (Table 8). The number of work days lost by a patient who requires outpatient care was based on the numbers used by Kavet (20) (see later).

Resource use: Drug claims related to outpatient visits

Patients who had one or more outpatient visits in either 1994 or 1995 for influenza, pneumonia or acute bronchitis (Table 4), were matched to drug claim data for 1994 and 1995 (Table 7). Some drug claims identified in this manner may not be related to the outpatient visits for influenza, pneumonia or acute bronchitis. It was assumed, however, that the sample sizes were sufficiently large so that the average costs would "reasonably" represent the relevant drug costs associated with influenza and influenza-related outpatient visits. The average number of drug claims per outpatient visit for each age group was calculated by dividing the number of claims by the number of visits (Table 9).

Resource use: Ill, no medical care sought

Patients who have a clinical illness due to influenza but do not seek medical care still use resources, principally in the form of time off work, and perhaps some non-prescription (over-the-counter) medications. The value of non-prescription medications was assumed to be $2 per case, and the number of days lost was based on the number used by Kavet (20) (see later).

Resource use: Correlations between age, length of hospital stay, and net payment

Person correlation coefficients were calculated to test for potentially statistically significant relationships between age, length of stay in hospital, and net payment for hospitalizations. Significant relationships of these variables would indicate the need to incorporate such relationships into the Monte Carlo model. The results (Table 10), however, showed that the only
correlation of practical importance was between net payment and length of stay (R = 0.64 or 0.61, P > 0.0001). Although the correlation coefficients between age of patient and the other two variables were statistically significant, the coefficients were judged to be too small to be of much practical significance (Table 10).

Calculating the economic impact of an influenza pandemic

Using the data reported in Tables 5 through 9, and data from Kavet (20) regarding workdays lost for a person with an illness requiring outpatient visits (discussed above), economic cost, by age group, was calculated for an individual case of each of the four outcome categories (death, hospitalization, outpatients, ill no medical care sought) (Table 11). For each category of outcome, the cost per individual outcome was then multiplied by the estimated number of outcomes (see earlier), and then summed together to give a total cost of a pandemic, assuming no large-scale effective intervention occurs.

Returns to vaccination: Cost of vaccination

The total cost of vaccinating against an influenza pandemic is dependant upon the cost of vaccination, the target group(s) selected, and compliance rate(s). We divided the U.S. population into the 6 age and risk groups defined earlier, with the cost of vaccinating each group calculated separately. Based on the compliance rate of influenza vaccination among persons aged 65 years or older in the U.S. (29), two compliance rates, 40 and 60 percent, were chosen. It is noted that while the U.S. average rate for persons aged 65 years and older is 58 percent, the average among the states ranges from 44 to 70 percent (29). It was assumed that compliance rates were equal among all age and risk groups, although the model does have the capacity to allow for different compliance rates for each age and risk group.

The cost of vaccination includes the cost of the vaccine, the cost of administering the vaccine, value of time spent by an individual traveling to and from the place of vaccination, travel costs, and the costs of treating adverse side effects. The latter includes costs associated with treating effects of Guillian-Barré Syndrome (GBS). The incidence rates and costs of treatment of an individual case of mild-side effects, anaphylaxis, and GBS were obtained from a previous study (6).

A number of factors will effect the total cost of vaccination, and include the number of doses required,\(^2\) the cost of rapid production of a larger-than-usual number of doses, the rapid delivery and correct storage of doses at vaccination sites around the country, the cost of administration, and the length of time each patient may have to wait in order to receive a dose (i.e., long lines of waiting patients. In order to illustrate the impact of different costs upon the net value of vaccination, two costs of vaccination were assumed ($18 and $59 per vaccinee), to which were added specific estimates of the costs of treating side effects (Table 12). The two total costs of vaccination modeled were $21.26 and $62.26 per vaccinee (Table 12). The value of a patient's time was based on the value of an 8 hour day "unspecified" work day, valued at $64 per day (27). The cost of travel ($4) was assumed. As probable costs of vaccination in a pandemic become better defined, the model has the capacity to use any other defined estimate.
Returns to vaccination: Vaccine effectiveness

Economic returns to vaccination are dependent upon vaccine effectiveness to prevent each of the four outcomes modeled (death, hospitalization, outpatient visits and ill with no medical care sought). Although there are some data from controlled trials regarding the effectiveness of influenza vaccination in preventing clinical outcomes, those data invariably refer to experiments conducted during inter-pandemic periods. There are no published data from controlled trials measuring the effectiveness of an influenza vaccine during a pandemic situation. Given that a pandemic will most likely be caused by a new subtype of influenza, vaccine effectiveness under such situations is speculative. Therefore, two scenarios of vaccine effectiveness by age group and health outcome were constructed, labeled "high" and "low" levels of effectiveness (Table 13). Within each age group it was assumed that there would be no difference in vaccine effectiveness between those at "high risk" and those at "non-high risk" (Table 2). The model has the capacity to evaluate the outcomes using different values for vaccine effectiveness for each age group and health outcome.

Returns to vaccination: Net returns of vaccinating against influenza

One important measure of the economics associated with vaccinating against an influenza pandemic is the net returns, in dollars, to vaccination. This was calculated using the following formula for each age and risk group:

\[
\text{Net returns}_{\text{age, risk group}} = \text{Savings from outcomes averted in population}_{\text{age, risk group}} - \text{cost of vaccination of population}_{\text{age, risk group}}
\]

Where:

\[
\text{Savings from outcomes averted}_{\text{age, risk group}} = \sum_{\text{outcomes}} (\text{number with outcome}_{\text{death, hospitalization, outpatient, ill, no medical care}} \times \text{before intervention}_{\text{age, risk group}} \times \text{compliance}_{\text{age, risk group}} \times \text{vaccine effectiveness}_{\text{outcome}} \times \text{$value of outcome}_{\text{death, hospitalization, outpatient, ill, no medical care prevented}})
\]

and;

\[
\text{Cost of vaccination}_{\text{age, risk group}} = \text{$cost/vaccinee} \times \text{population}_{\text{age, risk group}} \times \text{compliance}_{\text{age, risk group}}
\]

The numbers of persons within a given age and risk group with one of the four outcomes before any intervention are obtained by running the portion of the model that estimates the impact of a pandemic (Tables 1 -3 ). The variables used to define the value of a given outcome are given in Table 11, the cost of vaccination in Table 12, and vaccine effectiveness in Table 13. Compliance rates were initially set at 40 and 60 percent. As discussed earlier, most of these variables can be adjusted in age or risk or both specific groups. The calculations were also made for the two different age distributions (Table 2).

Returns to vaccination: Sensitivity analyses
Because the model was run using ranges for the attack rates and other input variables (see Tables 1-3, 11, 12, 13), the results can be considered as a set of sensitivity analyses. To illustrate the importance of the death rate in determining economic outcomes, further sensitivity analyses were conducted by altering the death rates (Table 3). The average death rates for the non-high risk groups was altered (reduced) so that they were 0.25 or 0.50 of the death rates used in the original analyses (Table 3).

Implications for policy: "Insurance premiums" and the three P's

The analyses of the costs and benefits of a vaccination-based intervention during a pandemic implicitly assumes that such an intervention could occur if needed. This paper is part of a planning process whose end product is intended to improve the likelihood of a well-organized and effective response to a pandemic. The plan includes improvements in surveillance systems, ensuring sufficient supply of vaccine to vaccinate high-priority groups (and possibly the entire U.S. population), investigating the feasibility of liability programs for vaccine manufacturers, research to improve detection of new influenza sub-types, research into the acceleration of the availability of new and existing vaccines and antiviral agents, developing a communications network that can rapidly disseminate a wide variety of information in different media forms to different target audiences, and developing emergency preparedness plans to ensure that there will be adequate medical care and that essential community services will be maintained (30). Meeting these goals can be described as enacting the 3 P's (planning, preparedness, and practice).

A question arising from such a list of goals is: What is a "reasonable" amount to spend each year to ensure that these goals are reached? Similar to an earlier study on the economics of intervention programs, the annual cost of paying for the 3 P's can be considered as an "insurance premium." The purpose of such an insurance premium is to ensure that the 3 P's have been accomplished and that a planned vaccination intervention can actually take place. An annual "insurance premium" to pay for the 3 P's can be calculated as follows: (32)

\[
\text{Annual } \text{"insurance premium"} = \text{net returns from an intervention} \times \text{annual probability of pandemic occurring}
\]

The net returns from an intervention are those calculated using the formulae described earlier. The actual returns will be, of course, impacted by a number of variables that cannot be controlled. For example, the gross attack rate before intervention (the percentage of the total U.S. population that would become clinically ill) is beyond human control, as is the probability of a pandemic. Even vaccine effectiveness may have an element of chance. Thus, "premiums" were calculated for a range of gross attack rates (15, 25 and 35 percent), three different probabilities of a pandemic occurring in a given year (1 in 30, 1 in 60, and 1 in 100 years), two different scenarios regarding vaccine effectiveness (Table 13), and two possible costs of vaccination (Table 12).

Implications for policy: Using different criteria to set vaccination priorities
If an influenza pandemic should occur, it is possible that initially there may be a limited supply of influenza vaccine. Even if there were a sufficient supply of vaccine to ensure that the entire U.S. population could be vaccinated, it will take some time to actually administer the vaccine to all, especially if two doses are required to ensure a "satisfactory" immune response. These factors raise the question of who should receive priority for vaccination, at least until vaccine supplies are more plentiful. For example, an argument could be made that all health care workers (e.g., nurses, practicing physicians, paramedics, etc.), and essential service providers (police, fire, phone, electric and gas workers, air traffic controllers, etc.) should be among the first to be vaccinated. However, the logic behind using essential services as "the" criteria for setting priorities will not cover the majority of the population.

To illustrate the implications of using various criteria to set priorities, three different criteria were chosen to create sample priority lists: Net returns to vaccination, percentage of total deaths, and risk of death. A priority list constructed using net returns to vaccination will give the highest priority (top rank) to the age-risk group that "produces" the highest net return to vaccination. Similarly, the highest percentage of total deaths and death rate will give the highest priority to the age-risk group with the largest number of deaths and the highest death rate, respectively. The different criteria imply a different set of values would be used in deciding who receives top priority for vaccination. Society must debate what is the main goal in deciding who is to have top priority during a pandemic plan: Is the goal to prevent deaths, regardless of age and position in society, which implies use of the death rate as the deciding criterion? Or, does society wish to focus on trying to prevent total numbers of deaths (i.e., use percentage of total deaths as the criterion)? Minimizing economic impact and ensuring that society does not collapse implies that net returns to vaccination should be used to set priorities.

Implications for policy: Four scenarios regarding vaccine availability and distribution

The model can be used to compare the potential benefits of different plans each designed to ensure that various amounts of vaccine will be available. To illustrate this capability, and to provide policy makers with some valuation associated with different options, four scenarios or options with different levels of guaranteed amounts of vaccine were constructed. Each option contains assumptions concerning the targeted population (Table 14). Each option was estimated using age distribution scenario A (Table 2), two gross attack rates (15 and 25 percent), and two estimates of the cost-of-vaccination ($21.26 and $62.26, Table 12). Further, for each option, vaccine effectiveness was assumed to result, for all age groups, in a 50 percent reduction in deaths and hospitalizations, and a 40 percent reduction in outpatient visits and illnesses not requiring formal medical care. Obviously, the model can be recalculated using different assumptions, or new scenarios can be constructed. Each option has potentially different implications regarding the level of involvement from Federal, state and local government agencies. The four options are:

Option A: Similar to current Advisory Committee on Immunization Practices (ACIP) recommendations, with production and use similar to current, intra-pandemic recommendations (2). Assumed approximately 77 million vaccinees.
Option B: Number of vaccinees as outlined in Scenario A plus an additional 20 million essential service providers (5 million health care workers + 15 million other service providers).

Option C: Aim to achieve a 40 percent coverage in each age and risk group, regardless of occupation.

Option D: Aim to achieve 60 percent coverage in each age and risk group, regardless of occupation.

Results

Deaths

Figure 2 shows the mean, 5th, 95th, minimum and maximum number of estimated deaths and hospitalizations for the two age distribution scenarios (Table 2). For case-age distribution Scenario A, the number of deaths due to an attack rate of 15 percent was approximately 89,000 (5th percentile = 55,000; 95th percentile = 122,000), and at an attack rate of 35 percent a mean of approximately 207,000 deaths was calculated (5th percentile = 127,000; 95th percentile = 285,000) (Figure 2). At an attack rate of 15 percent, the minimum and maximum deaths were approximately 44,000 and 135,000, respectively. At an attack rate of 35 percent, the minimum and maximum deaths were approximately 102,000 and 315,000, respectively (Figure 2).

For age distribution scenario B, which has the higher percentage of cases in the 65 and older and 0-19 years old age groups (Table 2), the number of deaths at any given attack rate was approximately 43 percent higher than that calculated for Scenario A. For example, at an attack rate of 15 percent, the mean number of deaths was approximately 128,000 (5th percentile = 75,000; 95th percentile = 181,000), with a minimum and maximum of approximately 56,000 and 202,000. At an attack rate of 35 percent, the mean number of deaths was approximately 300,000 (5th percentile = 175,000; 95th percentile = 422,000), with a minimum and maximum of approximately 132,000 and 472,000.

Hospitalizations

For age distribution scenario A (Table 2), the calculated number of hospitalizations ranged from a mean of approximately 314,000 (5th percentile = 210,000; 95th percentile = 417,000) at a gross attack rate of 15 percent, to a mean of approximately 734,000 (5th percentile = 441,000; 95th percentile = 973,000) at a gross attack rate of 35 percent (Figure 2). The estimates of hospitalizations for age distribution scenario B were approximately 11 percent than those calculated for age distribution scenario A (Figure 2).

Outpatients

For age distribution scenario A (Table 2), the mean numbers of persons requiring outpatient-based care ranges from approximately 18 million at a gross attack rate of 15 percent, to 42 million at a gross attack rate of 35% (Figure 3). For age distribution scenario B, the number of
outpatient cases was approximately 7 percent greater than those calculated for age distribution scenario A. (Figure 3).

*Ill (no formal medical care sought)*

For age distribution scenario A (Table 2), the mean numbers of those clinically ill who will not seek formal medical care, but still suffer some economic loss, ranges from approximately 20 million at a gross attack rate of 15%, to 47 million at a gross attack rate of 35 percent (Figure 3). For age distribution scenario B, the number of outpatient cases was approximately 6 percent greater than those calculated for age distribution scenario A. (Figure 3).

*Burden of impact among the high risk groups*

Although those in the high risk groups constitute approximately 15 - 25 percent of the total U.S. population (Table 2), they bear a disproportionate burden of the potential impact of an influenza pandemic. On average, high risk groups will account for approximately 85-90 percent of all deaths (Table R1). By age group, the high risk 20-64 years old will bear the largest proportion of deaths, accounting for approximately 41-43 percent of total deaths (Table R1). It is also important to note that, for each age group, there is a wide range between the 5th and 95th percentiles (Table R1). For example, for age distribution scenario A, although the high risk 20-64 years of age were calculated to account for a mean of 40.9 percent of all deaths, the 5th percentile is approximately 11 percent, and the 95th percentile is approximately 61 percent (Table R1). High risk groups will also account for 38-52 percent of all hospitalizations and 20-30 percent of all outpatient visits (Table R1).

*Burden of death by age group*

The distribution by age group of total deaths is give in Table R2. For age distribution scenario A, those aged 65 years and older ("non-high" and "high" risk combined) accounted for a mean of approximately 39 percent of all deaths (5th percentile = 28 percent; 95th percentile = 63 percent). The minimum and maximum percentage for this age group were approximately 24 and 76 percent. The 20-64 year age group was calculated, on average, to account for about 5 percent more deaths than the 65+ year old age group, with a mean of 47 percent of all deaths for age distribution scenario A (Table R2). The 0-19 age group accounted, on average, for less than 15 percent of all deaths, although a maximum of approximately 41 percent was calculated for age distribution scenario B (Table R2).

*Estimated economic costs due to an influenza pandemic: No intervention*

In the absence of a large-scale intervention, the estimates of the total economic impact in the U.S. of an influenza pandemic range from an average of $71.3 billion (5th percentile = $35.4 billion; 95th percentile = $107.0 billion) for a gross attack rate of 15 percent, to an average of $166.5 billion (5th percentile = $82.6 billion; 95th percentile = $249.6 billion) for a gross attack rate of 35 percent (Table R3). At any given attack rate, loss of life due to an epidemic accounts for approximately 83 percent of all economic losses, with outpatients, ill not seeking medical
care, and inpatient care accounting for approximately 8, 6, and 3 percent, respectively (Table R3).

**Distribution of economic impact: Direct and indirect costs**

Except for hospitalizations, indirect losses (primarily lost productivity, see Table 11) account for at least 65 percent of all economic losses (Table R4). In the case of deaths and ill, no medical care sought, indirect costs accounted for 99 percent of all costs (Table R4). Direct costs accounted for 89 percent of all costs associated with hospitalizations (Table R4). Across all health outcomes, indirect costs accounted for a weighted average of 94 percent of all economic costs (Tables R3, R4). Deaths among the high risk groups account for approximately 70 percent (5th percentile = 47 percent; 95th = 83 percent) of all economic losses (Table R5).

**Net value of vaccinating against an influenza pandemic**

The net value of vaccinating against an influenza pandemic varies substantially by age-risk group, gross attack rate, assumed distribution of cases across age groups (Table 2), assumed vaccine effectiveness, compliance, and cost of vaccination (Tables R6 - R9). At a cost of vaccination of $21.26, and a "high" level of vaccine effectiveness, the mean net value of vaccinating against a pandemic is always positive, regardless of the value of the other variables (e.g., compliance, gross attack rate, distribution of cases by age) (Tables R6-R7). For example, under the stated assumptions, the smallest positive return occurs when vaccinating 40 percent of the 65+ year old age group at "non-high risk," with a net present value of $46 million (5th percentile = $15 million; 95th percentile = $76 million) (Table R7).

However, when assuming a "low" vaccine effectiveness (Table 13), a gross attack rate of 15 percent, and Scenario B for the distribution of cases by age (Table 2), the 5th percentiles are negative (-$20 million) for the age group 65 + years, with non-high risk (Table R9). That is, under those assumptions, there is a 5 percent or greater possibility that vaccinating persons who are non-high risk and 65 years and older will generate a net loss to society.

When the cost of vaccination is $62.26 per vaccinee, at a gross attack rate of 15 percent, vaccinating all non-high risk age groups will generate net losses (Tables R6-R9). Under these assumptions, all but two net return are negative even at the 95th percentile, regardless of level of compliance, vaccine effectiveness, and age distribution of cases. The two exceptions occur in the age group 0-19 years, and for age distribution Scenario B (Table R7). However, for even these two situations, the 85th percentiles are negative (data not shown).

When the gross attack rate is increase to 25 percent, and assuming a "high" level of vaccine effectiveness, the non-high risk 0-19 and 20-64 age groups all have positive mean net returns, although some of the 5th percentiles are negative (Tables R6, R7). At the same gross attack rate, with a "low" level of vaccinee effectiveness, all non-high risk age groups have negative mean net returns, although some 95th percentiles are positive (Tables R8, R9). For "low" vaccine effectiveness, and regardless of other variables modeled, the non-high risk 65 years and older age group still generates negative mean net returns at a gross attack rate of 35 percent (Tables R8,
R9). All other age groups, in contrast, generate positive mean net returns at 35 percent gross attack rate, although some 5th percentiles are still negative (Tables R6-R9).

Note that the high risk groups, regardless of age, always generate positive mean net returns, and that, in the majority of scenarios modeled, the 5th percentiles are also positive (Tables R6-R9).

**Sensitivity analyses: Impact of reducing death rates**

At a vaccination cost of $21.26 per vaccinee, reducing the death rates (Table 3) to 0.50 and 0.25 of the initial values still left positive mean net returns for all non-high risk age groups (Figure 4). However, at a cost of vaccination of $62.26 per vaccinee, reducing death rates to 0.50 and 0.25 of the initial values resulted in negative mean net returns for all non-high risk age groups (Figure 4). Note that, compared to changes in the death rate, the results are relatively insensitive to increases in gross attack rate (in the range of 15 to 25 percent). For example, at a cost of vaccination of $62.26 per vaccinee, and a death rate at 0.50 of the initial rates used, increasing the gross attack rate from 15 to 25 percent still results in a negative net returns for all age groups and levels of vaccine effectiveness (Figure 4).

**Implications for policy: "Insurance premiums" to pay for the three P's**

The amount of money that could "reasonably" be spent each year to ensure that the U.S. has "adequately" planned, prepared, and practiced (the 3 P's) for the next influenza pandemic ranges from $48 million per year (s.d. $37 million) to $2,184 million per year (s.d. $796 million) (Table R10). The lowest estimate arises by assuming that the probability of a pandemic is equivalent to 1 in 100 years, the gross attack rate will be 15 percent, the cost of vaccination will be $62.26 per vaccinee, a compliance rate of 40 percent, and a "low" level of vaccine effectiveness (defined in Table 13). Conversely, the highest estimate occurs when it is assumed that the probability of a pandemic is equivalent to 1 in 30 years, the gross attack rate will be 35 percent, the cost of vaccination will be $21.26 per vaccinee, a compliance rate of 60 percent, and a "high" level of vaccine effectiveness (defined in Table 13).

The assumed probability of a pandemic is one of the most important variables defining the size of the "premium." For example, the premiums increase by more than 3 times when the probability of a pandemic is increased from 1 in 100 years to 1 in 30 years (for a given gross attack rate, cost of vaccination, and level of vaccine effectiveness).

**Implications for policy: Using different criteria to set vaccination priorities**

Table R11 provides three lists of priority groups using three different criteria - risk of death, percentage distribution of deaths, and economic returns to vaccinating against influenza. The use of the three different criteria produced notable differences. For example, when risk of death is used to set priorities, persons aged 65 + years will receive top priority (Table R11). But, when mean net economic returns to vaccination are used as the criterion, then persons age 65 + years will receive the lowest priority (Table R11). Regardless of criteria used, the high risk groups for
0-19 and 20-64 years will always receive priority over non-high risk persons from the same age group (Table R13).

Implications for policy: Four scenarios regarding vaccine availability and distribution

While Option A, vaccinating some 77 million persons (see earlier for description of options), will ensure positive mean net returns, vaccinating an additional 20 million essential service personnel will result in increased mean net returns (Figure 5). Changing the vaccination strategy from targeting specific groups (Option B), to aiming to vaccinate 40 percent of the population regardless of occupation results in a decrease in mean net returns (Figure 5). Only Option D, vaccinating 60 percent of the population, will result in higher mean net returns.

An important feature to note in Figure 5 are the relatively wide ranges encompassed by the 5th and 95th percentiles. For example, at a gross attack rate of 15 percent, and a cost of vaccination of $62.26 per vaccinee, the 5th percentiles for all options are less than $1 billion, while the 95th percentiles are all above $14 billion (Figure 5). The minimum value for each option under those specific assumptions is less than $0 (i.e., a net loss) (data not shown).

Discussion and conclusions

Impact of an influenza pandemic

The next influenza pandemic in the U.S. may cause considerable impact in terms of loss of life, hospitalizations, outpatient visits and persons becoming ill but seeking no medical care (Figures 2 and 3). However, it must be clearly understood that there is a great deal of uncertainty associated with any estimate of the potential impact of an influenza pandemic. For example, while the results portray the potential impact for gross attack rates ranging from 15 to 35 percent, there are no data that describe the probability of any of those attack rates actually occurring in the next pandemic. This uncertainty should temper any reaction or policy relating to responses to a potential pandemic. The "Swine Flu Affair" (33) of 1976 clearly demonstrated the perils attached to making the switch from possibility to certainty (i.e., probability = 1.00).

The two other important points to remember when considering the impact of a pandemic are that the high risk groups are likely to bear a disproportion burden of the deaths (Table R1), and that 50 percent or more of the deaths are likely to occur among persons aged less than 65 years (Table R2). This finding is similar to a recent review of the distribution of deaths caused by the influenza pandemics of 1918, 1958, and 1968 (34).

With regard to measuring the economic impact associated with a pandemic, the results clearly illustrate that the greatest economic burden is due to death (Tables R3 and R4). This result is influenced by both the death rates (Table 3) and the economic values accorded to death (Table 11). The value of death used should be considered as a measure of the economic opportunity cost associated with a death. The implication is that the opportunity cost exists regardless of the employment status of anybody who may actually die. It is also important to note that the opportunity cost, as used, is not a measure of any intrinsic value that society may place on a life.
Such a valuation is perhaps best left to a full and open debate. The resultant economic impact
due to deaths means that, all other things being equal, the largest economic returns will come
from the intervention(s) that prevents the largest number of deaths.

Careful attention should be paid to the fact that, beyond the value of a lost day of work (Table
11), the model does not include any valuation for disruptions in commerce and society due to an
influenza pandemic. For example, if a large number of long distance truck drivers were all
unavailable to drive for, say, two weeks, there may be difficulties in ensuring distribution of
perishable items, especially food. Short term disruptions might not cause a lasting economic
impact, but it is possible that some persons may suffer long-term consequences because of short
disruptions caused by influenza. These "multiplier effects" are not accounted for in this model,
mainly because an estimate of an appropriate multiplier will depend on who becomes ill, how
many become ill, when they become ill, and for how long they are ill.

Returns to vaccination

All other factors being held constant, the net return to vaccination is sensitive to the combination
of price and gross attack rate (Tables R6-R9, Figure 4). Regardless of gross attack rate assumed
(in the range 15 - 35 percent), a vaccination price of $21.26 per vaccinee is almost always certain
to generate a positive net return, even at the 5th percentile. At a cost of $62.26 per vaccinee, a
gross attack rate will almost certainly generate net losses among non-high risk groups (Tables
R6-R9).

Perhaps the most important element of the estimates of the net returns are the potentially wide
ranges covered between the 5th and 95th percentiles (Tables R6-R9). Some of the 5th and 95th
percentile values go from less than 50 percent to more than 70 percent of the means. Given the
uncertainty surrounding the values of the input variables (Tables 3, 11, 12, 13), these ranges
could be considered by some to be relatively narrow. However, the fact that some 5th percentiles
are negative should serve as a warning to any decision maker that many interventions may not
guarantee a net positive return.

Relative importance of input variables

The results of the net returns (Tables R6-R9, Figure 4) can be used to rank the input variables in
terms of their relative influence in determining the net value of vaccination. Such a ranking is, of
course, only valid for the ranges used for the inputs (Tables 3, 11, 12, 13). The variables that
cause the largest percentage changes in net returns are: death rate (Figure 4), cost of vaccination
per vaccinee, and gross attack rate (Tables R6-R9). The next most important variable is vaccine
effectiveness, which is more important than compliance, but compliance is more important than
age distribution of cases (Table 2).

Implications for policy: "Insurance premiums" for the 3P's

The size of the "premium" that could be used as a measure of what could logically be spent each
year to plan, prepare and practice (3 P's) for the next influenza pandemic depends most on the
assumed probability of occurrence (Table R12). The results presented in Table R12 present a cautionary tale of the difference between possibility and probability of an influenza pandemic occurring. Assuming that an influenza pandemic could actually occur, the numbers in Table R12 can be used to argue that it is legitimate for society to spend some money each year on the 3 P's. What cannot be currently stated with any certainty is the degree of probability of such a pandemic occurring, nor the number of people who will succumb to clinical illness. Defining the difference between possibility and probability was a key decision point in the "swine 'flu affair" of 1976-1977 (33).

**Implications for policy: Setting priorities**

The results presented in Table R11 illustrate that priorities for vaccination depend upon the objective function chosen. If preventing the most number of deaths possible is seen as the most important function of an intervention, then society should ensure that all those in the high risk groups become vaccinated first, followed by those of non-high risk, aged 65 + years (Table R11). However, if maximizing economic returns to vaccination is defined as the objective for setting priorities, then those aged 0-64 years of age, regardless of risk, should be vaccinated first.

The results also illustrate the need to be rather precise in defining the criteria used for setting priorities. For example, stating that "preventing death" will be the criteria used is not sufficiently precise, because different priority lists can be drawn up using death rates versus actual deaths (or percentages of total deaths) (Table R11). It should also be carefully noted that the criteria used to generate the results presented in Table R11 do not define the entire set of possible methods of prioritization. Society may decide to use another criterion or a set of criteria. Thus, rather than be used to absolutely set priorities, Table R11 provides a starting point for debate within society regarding the setting of priorities.

**Implications for policy: Four scenarios regarding vaccine availability and distribution**

The net returns for the four scenarios modeled (Figure 5) further illustrate the need to clearly set criteria, goals and objectives for a vaccine-based intervention for the next influenza pandemic. Option C and Option D aim for 40 percent coverage, and 60 percent coverage, respectively, regardless of age or risk group. Some may state that these options represent a more egalitarian, or "fair," means of distributing vaccine. However, such egalitarianism would cost society as the net returns to Options C are lower than those from Option B (Figure 5).

Option D does produce higher returns than Option B, but it is questionable if 60 percent of U.S. society could be successfully vaccinated in the appropriate time span (2-3 months?) needed to generate the net returns shown in Figure 5. Achieving 60 percent coverage of the U.S. population will be especially difficult if 2 doses of vaccine are needed to provide "satisfactory" protection. Giving two doses for 60 percent of the U.S. population is equivalent to almost 320 million doses (Table 14). More doses would probably be needed since it is likely that not everybody who will receive a first dose will return for a second dose (i.e., compliance between the first and second doses will decrease). Thus, in order to achieve a 60 percent effective coverage, more than 60 percent of the population will need to receive the first dose. Also, spoilage will also increase the
total number of doses that must be produced. It should not be forgotten that, at no point in
history, has +320 million doses of vaccine been delivered and administered to the U.S.
population in a 2 - 3 month time period.

Summary of some main points

- The next influenza pandemic could cause very large numbers of deaths, hospitalizations,
  outpatient visits, and persons becoming ill, but not seeking medical care (Figures 1, 2).
  The actual numbers depend upon a wide variety of factors, but it may be difficult to
greatly improve the accuracy of the estimates.
- The mean estimated economic impact of an influenza pandemic will range from $71 -
  $166 billion (Tables R3). Approximately 80 percent of the estimated loss is due to loss of
life (Tables R4 R5).
- Beyond valuing work lost due to an influenza pandemic, estimates of losses presented
here do not include any losses due to disruption of commerce or society. Such losses will
depend directly upon how the pandemic spreads through society (i.e., who becomes ill,
how many become ill, when they become ill, and for how long they are ill).
- Death rates, cost of vaccination per vaccinee, and gross attack rate are the most important
variables impacting the net returns to vaccination.
- At a cost of vaccination of $21 per vaccinee, and a "high" level of vaccine effectiveness
(Table 13), the mean net value of vaccinating against a pandemic is always positive,
regardless of the value of the other variables (e.g., compliance, gross attack rate,
distribution of cases by age) (Tables R6 R7).
- A cost of approximately $62 per vaccinee may result in net losses among certain age and
risk groups if the gross attack rate is less than 25 percent lower (Tables R6 R9).
- In a large scale vaccination campaign, conducted in a relatively short span of time, and
using a vaccine they may require 2 doses to provide "satisfactory" protection, vaccination
may cost more than $20 per vaccinee.
- Deciding how much should rationally be spent each year (an annual "insurance
premium") on planning, preparing and practicing (3 P's) for the next pandemic should
depend upon an evaluation of the probability of a pandemic occurring (Table R10).
- In setting plans and making preparations for the next pandemic, the possibility of a
pandemic should not be confused with the probability of occurrence. The wide range of
values for most of the results (Tables R6 R10, Figures 2,3,4) adds emphasis to the fact
that the impact of the next influenza pandemic is largely unknown.
- Society should prepare to debate the criteria of who should be vaccinated first against the
next influenza pandemic (Table R11). A key starting point for such a debate will be the
definition of the objective(s) of a pandemic influenza vaccination intervention.
- In order to set realistic objectives for a vaccine-based intervention, there are two key
points that must be clearly understood: a) it may require two doses of vaccine to
"satisfactorily" immunize a person; and, b) there is likely to be a relatively short time
period between delivery of large quantities of vaccine and the "arrival" of the pandemic.
These two factors may limit the number of people that can be effectively vaccinated
before the pandemic arrives.
A short time period before pandemic arrives, and initial limitation of supplies of vaccine, does not mean that vaccination programs should be halted after the "arrival" of the pandemic. It is, however, probably realistic to expect that vaccine effectiveness will decrease among those vaccinated during the midst of a pandemic (some will be vaccinated after becoming infected, too late to stimulate a sufficiently protective immune response).

References


Table 1: U.S. population estimates used to define impact of influenza

<table>
<thead>
<tr>
<th>Age group</th>
<th>Numbers</th>
<th>Percentage of total (%)</th>
</tr>
</thead>
</table>

Publisher: CDC; Journal: Emerging Infectious Diseases
Article Type: Research; Volume: 5; Issue: 5; Year: 1999; Article ID: 99-0507
DOI: 10.321/eid0505.990507; TOC Head: Research
### Table 2: Two scenarios of age distributions of cases and percentage of high risk population used to examine the impact of pandemic influenza in the United States

<table>
<thead>
<tr>
<th>Age group</th>
<th>Distribution A: % of all cases</th>
<th>Distribution B: % of all cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-19 yrs old</td>
<td>40.0</td>
<td>46.0</td>
</tr>
<tr>
<td>20-64 yrs old</td>
<td>53.1</td>
<td>46.7</td>
</tr>
<tr>
<td>65 + yrs old</td>
<td>6.8</td>
<td>7.3</td>
</tr>
<tr>
<td>Totals</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Assumed percentage at "high risk"**

<table>
<thead>
<tr>
<th>Age group</th>
<th>Lower &quot;Most Upper Probability&quot;</th>
<th>Upper &quot;Most Upper Probability&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-19 yrs old</td>
<td>6.4</td>
<td>11.1</td>
</tr>
<tr>
<td>20-64 yrs old</td>
<td>14.4</td>
<td>25.0</td>
</tr>
<tr>
<td>65 + yrs old</td>
<td>40.0</td>
<td>55.0</td>
</tr>
<tr>
<td>U.S. average</td>
<td>15.4</td>
<td>24.8</td>
</tr>
</tbody>
</table>

Note: 1) The scenarios were calculated using upper and lower estimates of age-specific attack rates from 1918, 1928-29, and 1957.

2) The actual number of cases will depend upon the assumed gross attack rate (see text for further details).

3) Totals may not exactly add to 100 percent due to rounding up.

4) Average is an age-weighted average, using each age group's proportion of the total U.S. population.

### Table 3: Variables used to define distribution of health outcomes of those with clinical cases of influenza

<table>
<thead>
<tr>
<th>Variable</th>
<th>Rates per 1,000 general population</th>
<th>Rates per 1,000 cases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lower &quot;Most Upper Probability&quot;</td>
<td>Lower &quot;Most Upper Probability&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Outpatient visits (per 1,000)

**"Non-high risk"**
- 0-19 yrs old (rate): 165 likely" distribution: 230 Uniform 471 likely" distribution: 548 Uniform
- 20-64 yrs old (rate): 40 likely" distribution: 85 Uniform 333 likely" distribution: 370 Uniform
- 65 + yrs old (rate): 45 likely" distribution: 74 Uniform 375 likely" distribution: 389 Uniform

**"High risk"**
- 0-19 yrs old (rate): 289 likely" distribution: 403 Uniform 825 likely" distribution: 958 Uniform
- 20-64 yrs old (rate): 70 likely" distribution: 149 Uniform 583 likely" distribution: 647 Uniform
- 65 + yrs old (rate): 79 likely" distribution: 130 Uniform 656 likely" distribution: 682 Uniform

### Hospitalizations (per 1,000)

**"Non-high risk"**
- 0-19 yrs old (rate): 0.2 likely" distribution: 0.5 Triangular 2.9 likely" distribution: 0.57 Uniform 6.9 likely" distribution: Uniform
- 20-64 yrs old (rate): 0.18 likely" distribution: 2.75 Uniform 1.5 likely" distribution: 12.0 Uniform
- 65 + yrs old (rate): 1.5 likely" distribution: 3.0 Uniform 12.5 likely" distribution: 15.8 Uniform

**"High risk"**
- 0-19 yrs old (rate): 2.1 likely" distribution: 2.9 Triangular 9.0 likely" distribution: 6.0 Uniform 21.4 likely" distribution: Uniform
- 20-64 yrs old (rate): 0.83 likely" distribution: 5.14 Uniform 6.9 likely" distribution: 22.3 Uniform
- 65 + yrs old (rate): 4.0 likely" distribution: 13 Uniform 33.3 likely" distribution: 68.4 Uniform

### Deaths (per 1,000)

**"Non-high risk"**
- 0-19 yrs old (rate): 0.014 likely" distribution: 0.024 Triangular 0.125 likely" distribution: 0.041 Uniform 0.07 likely" distribution: 0.30 Uniform
- 20-64 yrs old (rate): 0.025 likely" distribution: 0.037 Triangular 0.09 likely" distribution: 0.21 Uniform 0.31 likely" distribution: 0.41 Uniform
- 65 + yrs old (rate): 0.28 likely" distribution: 0.42 Triangular 0.54 likely" distribution: 2.3 Uniform 3.51 likely" distribution: 4.52 Uniform

**"High risk"**
- 0-19 yrs old (rate): 0.126 likely" distribution: 0.22 Triangular 7.65 likely" distribution: 0.4 Uniform 0.6 likely" distribution: 21.9 Uniform
- 20-64 yrs old (rate): 0.1 likely" distribution: 5.72 Uniform 0.8 likely" distribution: 24.9 Uniform
- 65 + yrs old (rate): 2.76 likely" distribution: 5.63 Uniform 23 likely" distribution: 29.6 Uniform

### Conversion factors

- 0-19 yrs old: 0.35 likely" distribution: 0.42 Uniform
- 20-64 yrs old: 0.12 likely" distribution: 0.23 Uniform
- 65 + yrs old: 0.12 likely" distribution: 0.19 Uniform

Notes: 1) Cases defined here as those persons with a clinical illness sufficient to cause an economic impact.
2) Conversion factor used to convert rates per 1,000 general population to rates per 1,000 cases (Equation 1, text). The factors are equivalent to attack rates within the general population. Thus, a conversion factor of 0.35 is equivalent to a 35% attack rate.

Sources: See text.

**Table 4: International Classification of Diseases, Ninth Revision (ICD-9) codes used to extract medical costs for inpatient, outpatient and related drug claims.**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9 code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia and influenza</td>
<td>480-487.8</td>
</tr>
<tr>
<td>Acute bronchitis</td>
<td>466-466.1</td>
</tr>
<tr>
<td>Chronic respiratory disease</td>
<td>490-496</td>
</tr>
</tbody>
</table>

**Heart-related diagnoses**

- Acute ischemic heart disease                       | 410-411.90, 413-413.9 |
- Chronic ischemic heart disease                      | 412, 414.0, 414.8, 414.9, 416-416.9 |
- Heart rhythm disorders                              | 426-427.9      |
- Congestive heart failure                            | 428-428.9      |

**Table 5: Average age of patients, length of stay, and net payments (standard deviations) of an inpatient hospitalization, by type of diagnosis and age: 1993-95 combined data**

<table>
<thead>
<tr>
<th>Type of diagnosis</th>
<th>Age group</th>
<th>n</th>
<th>Avg. age of patient</th>
<th>Avg. length of stay</th>
<th>Avg. net pay.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza, pneumonia, bronchitis, and chronic respiratory: Principal diag. only</td>
<td>0-17 years</td>
<td>10,253</td>
<td>3.9 (4.8)</td>
<td>3.5 (3.6)</td>
<td>4,789 (8,146)</td>
</tr>
<tr>
<td></td>
<td>18-64 years</td>
<td>22,793</td>
<td>50.4 (11.6)</td>
<td>6.2 (7.9)</td>
<td>9,691 (18,166)</td>
</tr>
<tr>
<td></td>
<td>65 + years</td>
<td>1,063</td>
<td>69.6 (4.7)</td>
<td>7.9 (9.7)</td>
<td>11,047 (15,673)</td>
</tr>
<tr>
<td>Influenza, pneumonia, bronchitis, and chronic respiratory: All diag.</td>
<td>0-17 years</td>
<td>12,836</td>
<td>4.1 (5.0)</td>
<td>4.0 (6.1)</td>
<td>6,007 (14,604)</td>
</tr>
<tr>
<td></td>
<td>18-64 years</td>
<td>44,457</td>
<td>51.6 (5.0)</td>
<td>7.1 (6.1)</td>
<td>12,622</td>
</tr>
<tr>
<td>Age Group</td>
<td>Diagnoses</td>
<td>Weighted Average Charge (1000s)</td>
<td>Standard Deviation (1000s)</td>
<td>Total Claims</td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>-----------</td>
<td>-------------------------------</td>
<td>---------------------------</td>
<td>--------------</td>
<td></td>
</tr>
<tr>
<td>65+ years</td>
<td>Heart related conditions: All diag.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-17 years</td>
<td></td>
<td>2,339</td>
<td>69.3</td>
<td>6.3</td>
<td>14,139</td>
</tr>
<tr>
<td>18-64 years</td>
<td></td>
<td>96,033</td>
<td>54.5</td>
<td>5.3</td>
<td>15,710</td>
</tr>
<tr>
<td>65+ years</td>
<td></td>
<td>4,705</td>
<td>69.1</td>
<td>6.6</td>
<td>17,140</td>
</tr>
<tr>
<td>Weighted averages</td>
<td></td>
<td>13,986</td>
<td>4.2</td>
<td>4.0</td>
<td>6,481</td>
</tr>
<tr>
<td>18-64 yrs</td>
<td></td>
<td>140,490</td>
<td>53.8</td>
<td>5.8</td>
<td>14,359</td>
</tr>
<tr>
<td>65+ yrs</td>
<td></td>
<td>7,044</td>
<td>69.2</td>
<td>7.1</td>
<td>15,677</td>
</tr>
</tbody>
</table>

Notes: 1) Illness defined using the following ICD-9 codes in Table 4.
2) 1993 and 1944 cost data were inflated to 1995 using the medical care component of the consumer price index (Table 752, U.S., Bureau of Census, ref. 1).
3) Net payment made by health care payer to provider(s) of health care services.
4) ICD-9 code (Table 4) for either influenza, pneumonia, acute bronchitis, or chronic respiratory disease was entered as principal diagnosis (i.e., main diagnosis).
5) ICD-9 code (Table 4) for either influenza, pneumonia, acute bronchitis, or chronic respiratory disease was entered as either principal diagnosis (i.e., main diagnosis) or one of the first four diseases coded.
6) ICD-9 code for all heart-related conditions identified in Table 4 was entered as either principal diagnosis (i.e., main diagnosis) or one of the first four diseases coded.
7) For each age group and each variable, weighted averages were calculated as the sum of proportion of claims under each "type of diagnosis" times the value of the variable. In order to reduce overlap, the number of cases of "Influenza, . . .All diag." was first reduced by removing the number of claims under "Influenza . . .Principal daig. only".

Source: MarketScan database, The MEDSTAT Group.

**Table 6: Average inpatient and outpatient charges and drug claims (standard deviations) associated with each inpatient admission for influenza or pneumonia or acute bronchitis: 1993-95 combined data**
Table 7: Number and frequency of outpatient visits for diagnoses of influenza, pneumonia and acute bronchitis:¹ 1993-95 data

<table>
<thead>
<tr>
<th>Max. # visits/patient/year</th>
<th># of identified patients</th>
<th>% of identified patients</th>
<th>Total visits</th>
<th>Weighted average of visits/patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993-95 combined</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 20</td>
<td>687,349</td>
<td>100.0</td>
<td>1,673,726</td>
<td>2.44</td>
</tr>
<tr>
<td>&lt; 7</td>
<td>655,622</td>
<td>95.4</td>
<td>1,331,868</td>
<td>2.03</td>
</tr>
<tr>
<td>&lt; 3</td>
<td>558,360</td>
<td>81.2</td>
<td>846,327</td>
<td>1.52</td>
</tr>
<tr>
<td>1995 only</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 20</td>
<td>262,720</td>
<td>100.0</td>
<td>632,456</td>
<td>2.41</td>
</tr>
</tbody>
</table>

Notes: 1) Illness defined using the following ICD-9 codes in Table 4.

2) 1993 and 1994 cost data were inflated to 1995 using the medical care component of the consumer price index (Table 752, U.S., Bureau of Census, ref. 1).

3) Number of admissions for which at least one outpatient visit was identified.

4) Net payment made by health care payer to provider(s) of health care services.

5) Outpatient claims linked to inpatients using patient ID numbers. Average includes all outpatient claims for 14 days prior to admission date and up to 30 days after discharge.

6) Drug claims linked to patient ID numbers. The total number of drug claims identified was less than the number of identified inpatient admissions. The number of drug claims identified were: 0-17 years - 3,682 claims; 18-64 years - 8,594 claims; 65 + years - 376 claims (total - 12,652 claims).
### Table 8: Average age of patients and costs (standard deviations) of an outpatient visit, by age group, for diagnoses of influenza, pneumonia and acute bronchitis: 1994-95 data

<table>
<thead>
<tr>
<th>Age group</th>
<th>n (# of claims)</th>
<th>Average age of patient (years)</th>
<th>Average co-payment ($)</th>
<th>Average net payment ($)(^3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-17 years</td>
<td>357,071</td>
<td>6.5</td>
<td>4.63</td>
<td>49.17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(5.4)</td>
<td>(17.01)</td>
<td>(97.05)</td>
</tr>
<tr>
<td>18-64 years</td>
<td>883,484</td>
<td>45.2</td>
<td>4.49</td>
<td>37.68</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(12.0)</td>
<td>(21.54)</td>
<td>(125.35)</td>
</tr>
<tr>
<td>65 + years</td>
<td>16,505</td>
<td>68.9</td>
<td>4.19</td>
<td>50.03</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(4.4)</td>
<td>(18.81)</td>
<td>(220.47)</td>
</tr>
</tbody>
</table>

Notes: 1) Illness defined using the following ICD-9 codes: 480-487.9, 466-466.1

2) 1994 cost data were inflated to 1995 using a factor of 1.045, the medical care component of the consumer price index (Table 752, U.S., Bureau of Census, ref. 1).

3) Net payment made by health care payer to provider(s) of health care services.

Source: MarketScan database, The MEDSTAT Group.
### Table 9: Average payments (standard deviations) for drug claims made by patients with an outpatient visit for influenza, pneumonia and acute bronchitis: 1994-95 data\(^1\)

<table>
<thead>
<tr>
<th>Age group</th>
<th>n (# drug claims)</th>
<th>Average supply (days)</th>
<th>Average copayment ($)</th>
<th>Average net payment(^2)</th>
<th>Average number prescript. per visit(^3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-17 years</td>
<td>173,263</td>
<td>14</td>
<td>3.41</td>
<td>24.57</td>
<td>0.90</td>
</tr>
<tr>
<td></td>
<td>(13)</td>
<td>(6.81)</td>
<td></td>
<td>(57.80)</td>
<td></td>
</tr>
<tr>
<td>18-64 years</td>
<td>870,173</td>
<td>24</td>
<td>3.67</td>
<td>36.41</td>
<td>1.89</td>
</tr>
<tr>
<td></td>
<td>(21)</td>
<td>(5.31)</td>
<td></td>
<td>(166.78)</td>
<td></td>
</tr>
<tr>
<td>65 + years</td>
<td>11,970</td>
<td>26</td>
<td>3.86</td>
<td>37.35</td>
<td>1.37</td>
</tr>
<tr>
<td></td>
<td>(20)</td>
<td>(6.05)</td>
<td></td>
<td>(68.87)</td>
<td></td>
</tr>
<tr>
<td>1994</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-17 years</td>
<td>136,954</td>
<td>15</td>
<td>3.13</td>
<td>25.08</td>
<td>0.83</td>
</tr>
<tr>
<td></td>
<td>(14)</td>
<td>(7.86)</td>
<td></td>
<td>(86.11)</td>
<td></td>
</tr>
<tr>
<td>18-64 years</td>
<td>716,199</td>
<td>24</td>
<td>3.47</td>
<td>35.04</td>
<td>1.70</td>
</tr>
<tr>
<td></td>
<td>(20)</td>
<td>(14.57)</td>
<td></td>
<td>(94.59)</td>
<td></td>
</tr>
<tr>
<td>65 + years</td>
<td>10,994</td>
<td>27</td>
<td>3.14</td>
<td>35.93</td>
<td>1.42</td>
</tr>
<tr>
<td></td>
<td>(20)</td>
<td>(2.83)</td>
<td></td>
<td>(40.7)</td>
<td></td>
</tr>
</tbody>
</table>

Notes: 1) Illness defined using the following ICD-9 codes: 480-487.9, 466-466.1

2) Net payment made by health care payer to provider(s) of health care services.

3) Calculated by dividing the number of drug claims (prescriptions) by the number of outpatient visits for each age group and year.

Source: MarketScan database, The MEDSTAT Group.

### Table 10: Pearson correlation coefficients\(^1\) for inpatient care related to influenza, pneumonia, and acute bronchitis: 1994 and 1995 data\(^2\)
Table 11: Inputs used to calculate the economic impact (direct and indirect costs) of an influenza pandemic in the U.S. (1995 U.S.$)

<table>
<thead>
<tr>
<th>Outcome category</th>
<th>Item</th>
<th>Type of cost</th>
<th>0-19 years</th>
<th>20-64 years</th>
<th>65+ years</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Deaths</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average age (years)</td>
<td>9</td>
<td>35</td>
<td>74</td>
<td>Assumed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PV earnings lost ($)&lt;sup&gt;1&lt;/sup&gt;</td>
<td>indirect</td>
<td>1,016,101</td>
<td>1,037,673</td>
<td>65,837</td>
<td>Refs: 1, 27</td>
<td>Marketscan Database®; Ref. 28. (Table 5)</td>
</tr>
<tr>
<td>&quot;Most likely&quot; + min or max hospital costs ($)&lt;sup&gt;2&lt;/sup&gt;</td>
<td>direct</td>
<td>3,435</td>
<td>7,605</td>
<td>8,309</td>
<td>Markethoscan Database®; Ref. 28. (Table 5)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Sub-total ($)&lt;sup&gt;3&lt;/sup&gt;</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><img src="https://via.placeholder.com/150" alt="image" /></td>
</tr>
<tr>
<td></td>
<td>1,019,536</td>
<td>1,045,278</td>
<td>74,146</td>
<td><img src="https://via.placeholder.com/150" alt="image" /></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Most likely&quot; + min or max hospital costs ($)&lt;sup&gt;2&lt;/sup&gt;</td>
<td>direct</td>
<td>2,936</td>
<td>6,016</td>
<td>6,856</td>
<td>Markethoscan Database®; Ref. 28. (Table 6)</td>
<td></td>
</tr>
</tbody>
</table>

Notes: 1) Probability under H₀: R = 0 in parentheses.
2) 1994 cost data inflated to equivalent 1995 values using a factor of 1.045, the medical care component of the consumer price index (ref. 1).
3) Principal diagnosis means that the ICD-9 codes (Table 4) for either influenza, pneumonia, or acute bronchitis must be entered as main diagnosis. All diagnoses means that the codes can be entered as either main diagnosis or any of the first for diseases in the code sheet.
"Most likely" ± min or max net pay for outpatient visits ($)\(^4\) & 2,099 & 2,086 & 3,200 & 74 ± 40 & 94 ± 70 & 102 ± 60 & Marketscan Database®; Ref. 28. (Table 6) \\
Avg. co-payment for outpatient visit ($) & direct & 5 & 4 & 4 & Marketscan Database® (Table 8) \\
"Most likely" ± min or max net payment for drug claims($)\(^5\) & direct & 26 ± 9 & 42 ± 30 & 41 ± 10 & Marketscan Database® (Table 6) \\
"Most likely" ± min or max days lost\(^6\) & indirect & 5 ± 2.7 & 8 ± 4.8 & 10 ± 5.4 & Marketscan Database®; Ref. 28. (Table 6) \\
Value 1 day lost ($)\(^7\) & indirect & 65 & 100 or 65 & 65 & Ref. 27 \\
Sub-total ($)\(^3\) & & 3,366 & 6,842 & 7,653 & \\

**Outpatient**

Avg. no. visits & direct & 1.52 & 1.52 & 1.52 & Marketscan Database® (Table 7; Figure 3) \\
"Most likely" ± min or max net payment per visit($)\(^8\) & direct & 49 ±13 & 38 ± 12 & 50 ± 16 & Marketscan Database® (Table 8) \\
Avg. co-payment for outpatient visit ($) & direct & 5 & 4 & 4 & Marketscan Database® (Table 8) \\
"Most likely" ± min or max net payment per prescription($)\(^9\) & direct & 25 ± 18 & 36 ± 27 & 36 ± 22 & Marketscan Database® (Table 9) \\
Avg. prescriptions per visit\(^8\) & direct & 0.9 & 1.8 & 1.4 & Marketscan Database® (Table 9) \\
Avg. co-payment per prescription ($) & direct & 3 & 3 & 3 & Marketscan Database® (Table 9) \\
Days lost & indirect & 3 & 2 & 5 & Refs. 20; 22 \\
Value 1 day lost ($)\(^7\) & indirect & 65 & 100 & 65 & Ref. 27 \\
Sub-total ($)\(^3\) & & 300 & 330 & 458 & \\

**Ill, no medical care sought**

Days lost & indirect & 3 & 2 & 5 & Refs. 20; 22 \\
Value 1 day lost ($)\(^7\) & indirect & 65 & 100 & 65 & Ref. 27 \\
Over-the-counter drugs ($) & direct & 2 & 2 & 2 & Assumed \\
Sub-total ($)\(^3\) & & 197 & 202 & 327 & \\

Notes: 1) Present value (PV), using a discount rate of 3% of expected future lifetime earnings and housekeeping services, adjusted to 1995 dollars. Haddix et al. (Appendix I in Ref. 27) estimated the present value of wages, using 1990 data. Using Ref. 1 (Tables 705, 706), the average increase (in constant 1992 $) in total personal income in the U.S. and per capita personal income from 1990-1995 was 7%. Thus, data from Ref. 27 were multiplied by 1.07.
2) "Most likely," with ± defining the minimum and maximum costs for a triangular distribution for Monte Carlo analysis. The values were calculated using cost data from Marketscan Database®, The MEDSTAT Group, and multiplying it by a hospital cost-to-charge ratio of 0.53. The ratio is a weighted average of the urban and rural (urban = 0.80, rural = 0.20) cost-to-charge ratios calculated by the Health Care Finance administration (HCFA) for August, 1996 (Ref. 28).

3) Sub-totals of are the totals for each category of outcome, using the "most likely" estimates. A distribution of subtotals is constructed by using the minimum and maximum values provided for some of the items within the outcome category.

4) "Most likely," with minimum and maximum values of net payments for outpatient visits up to 14 days prior to admission date and up to 30 days after discharge date.

5) Net payment for drug claims associated with outpatient visits up to 14 days prior to admission and up to 30 days after discharge.

6) "Most likely," with ± defining the minimum and maximum days lost due to hospitalization for a triangular distribution for Monte Carlo analysis. Calculated using length-of-stay in hospital data from Marketscan Database®, and adding a total of one additional day for convalescence and pre- and post-hospitalization outpatient visits for 0-19, and 20-64 years of age. For 65 + years, two additional days were added to length-of-stay in hospital for convalescence and pre- and post-hospitalization outpatient visits.

7) For 0-19 and 65+ years age groups, a day lost to influenza was valued as equivalent to an "unspecified" day (Appendix I in Ref. 27), denoting a value for time lost by care givers and family members related to taking care of a patient in these age groups. For 20-64 years of age, 60% of days lost due to hospitalizations and related convalescence and pre- and post-hospitalization outpatient visits were valued as "day off work" ($100/day). The remaining 40% of days lost were valued as "unspecified" days ($65/day). For 20-64 years of age, when patients were not hospitalized at any point during their illness (i.e., outpatient status), all days lost were assumed "days off work" ($100/day).

8) "Most likely," with minimum and maximum values of net payments for outpatient visits without any specified association to hospitalizations.

9) "Most likely," with ± defining the minimum and maximum cost per prescription, with the number of prescriptions per visit.

Table 12: Two scenarios for the cost of vaccination during an influenza pandemic, with specific costs assigned to side-effects of vaccination.

<table>
<thead>
<tr>
<th>Item</th>
<th>Probability of side effect</th>
<th>$/ case of side-effect</th>
<th>Lower cost scenario ($/patient)</th>
<th>Upper cost scenario ($/patient)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assumed cost of vaccination (excluding side effects)</td>
<td></td>
<td></td>
<td>18</td>
<td>59</td>
</tr>
<tr>
<td><strong>Side effects</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>0.0325</td>
<td>94</td>
<td>3.05</td>
<td>3.05</td>
</tr>
<tr>
<td>GBS</td>
<td>0.000002</td>
<td>100,800</td>
<td>0.20</td>
<td>0.20</td>
</tr>
</tbody>
</table>
Anaphylaxis 0.000000157 2,490 0.01 0.01

Total costs/patient 21.26 62.26

Notes: 1) The cost of vaccination includes the cost of the vaccine, the cost of administering the vaccine, value of time spent by an individual traveling to and from the place of vaccination, and patient associated travel costs. Included in the costs of the vaccine are any costs associated with the rapid production of a larger-than-usual number of doses, and the rapid delivery and correct storage of doses at vaccination sites around the country. For $18, the costs were assumed to be broken down as follows: $10 for vaccine + administration, $4 patient time (one-half hour), $4 patient travel costs. For $59, the costs were assumed to be broken down as follows: $20 for vaccine + administration (this could include the cost of 2 doses), $32 patient time (2 trips at 2 hours per trip), $7 patient travel costs. Note that, for comparison, a review of 10 published papers found a range of $5 - $22 per dose of vaccine, with a "medium" [sic] cost of $14 per dose (10). These breakdowns are illustrations only of what might be deemed "reasonable" estimates of time and cost. Actual costs might vary substantially, and will depend on the number of doses needed to achieve a "satisfactory" protective response, as well as how efficiently vaccinations can be give to millions of people.

2) Probabilities and average cost of treating each category of side effect were derived from the Office of Technology report (3).

3) Mild side-effects include sore arms due to vaccination, headaches, and other "minor" side effects that may require a visit to a physician, or may cause the patient to miss 1-2 days of work.

4) GBS = Guillian Barré Syndrome.

Table 13: Two scenarios for vaccine effectiveness in preventing health outcomes by age group

<table>
<thead>
<tr>
<th>Health outcomes</th>
<th>Vaccine effectiveness in preventing health outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&quot;High&quot; level of effectiveness³</td>
</tr>
<tr>
<td></td>
<td>0-19 yrs</td>
</tr>
<tr>
<td>Death</td>
<td>0.75</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>0.55</td>
</tr>
<tr>
<td>Outpatient visits</td>
<td>0.40</td>
</tr>
<tr>
<td>Ill, no medical care sought</td>
<td>0.40</td>
</tr>
</tbody>
</table>

Notes: 1) Vaccine effectiveness is defined as the reduction in the number of cases in each of the age and health outcome categories.

2) Within a defined age group, it was assumed that there was no difference in vaccine effectiveness between "high" risk and "non-high" risk sub-groups.

3) The terms "high" and "low" level of effectiveness are subjective and reflect only a judgement of the levels of effectiveness in the two scenarios relative to each other.

Table 14: Four scenarios regarding vaccine availability and distribution: Percentage and numbers vaccinated by age and risk group
### Table R1: Burden of impact, by age group, of an influenza pandemic among high risk groups relative to total impact

<table>
<thead>
<tr>
<th>Category of impact</th>
<th>Age group</th>
<th>Age distribution A: Percentage of total cases that are High Risk</th>
<th>Age distribution B: Percentage of total cases that are High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mean</td>
<td>5th</td>
</tr>
<tr>
<td>Death</td>
<td>0-19 yrs</td>
<td>9.0</td>
<td>1.4</td>
</tr>
<tr>
<td></td>
<td>20-64 yrs</td>
<td>40.9</td>
<td>11.1</td>
</tr>
<tr>
<td></td>
<td>65 + yrs</td>
<td>34.4</td>
<td>22.7</td>
</tr>
</tbody>
</table>
### Table R2: Distribution, by age group, of deaths due to an influenza pandemic

<table>
<thead>
<tr>
<th>Age group</th>
<th>Percentage of total deaths</th>
<th>Age distribution A:</th>
<th>Percentage of total deaths</th>
<th>Age distribution B:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean 5th 95th Min. Max.</td>
<td>Mean 5th 95th Min. Max.</td>
<td>Mean 5th 95th Min. Max.</td>
<td>Mean 5th 95th Min. Max.</td>
</tr>
<tr>
<td>0-19 yrs</td>
<td>11.5 3.2 23.1 1.2 32.7</td>
<td>14.3 3.3 29.3 1.1 41.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-64 yrs</td>
<td>47.4 20.5 65.2 13.2 70.3</td>
<td>46.5 17.2 66.2 9.2 71.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65 + yrs</td>
<td>41.1 27.8 62.5 24.0 76.4</td>
<td>39.3 25.9 62.0 21.9 78.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table R3: Economic impact (direct and indirect costs) of influenza pandemic per gross attack rate: Deaths, hospitalizations, outpatients, illnesses and total costs (1995 U.S.$)

<table>
<thead>
<tr>
<th>Cost per gross attack rate(^1) ($ millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15%</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>Deaths</td>
</tr>
<tr>
<td>Mean</td>
</tr>
<tr>
<td>5(^{th}) percentile</td>
</tr>
<tr>
<td>95(^{th}) percentile</td>
</tr>
<tr>
<td>Hospitalizations</td>
</tr>
<tr>
<td>Mean</td>
</tr>
<tr>
<td>5(^{th}) percentile</td>
</tr>
<tr>
<td>95(^{th}) percentile</td>
</tr>
<tr>
<td>Outpatients</td>
</tr>
</tbody>
</table>
Mean 5,708 7,611 9,513 11,416 13,318
5th percentile 4,871 6,495 8,119 9,742 11,366
95th percentile 6,557 8,742 10,928 13,113 15,299

**Ill, no medical care sought**

Mean 4,422 5,896 7,370 8,844 10,317
5th percentile 3,270 4,360 5,450 6,540 7,629
95th percentile 5,557 7,409 9,262 11,114 12,967

**Grand Totals**

Mean 71,346 95,128 118,910 142,692 166,474
5th percentile 35,405 47,206 59,008 70,810 82,611
95th percentile 106,988 142,650 178,313 213,975 249,638

Notes: 1) Estimates are for age distribution scenario A (Table 2).

2) Gross attack rate refers to the proportion of the total U.S. population that becomes clinically ill due to influenza such that their illness causes an economic impact.

3) Ill, no medical care sought is defined as persons who become clinically ill due to influenza, and that illness results in an economic impact (e.g., half day off work). However, these persons do not seek health care as an outpatient or an inpatient.

**Table R4: Proportion of costs attributable to direct and indirect cost items, by category of health outcome and age group**

<table>
<thead>
<tr>
<th></th>
<th>0-19 years</th>
<th>20-64 years</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Direct (%)</td>
<td>Indirect (%)</td>
<td>Direct (%)</td>
</tr>
<tr>
<td><strong>Deaths</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>0.3</td>
<td>99.7</td>
<td>0.7</td>
</tr>
<tr>
<td>5th percentile</td>
<td>0.2</td>
<td>99.5</td>
<td>0.5</td>
</tr>
<tr>
<td>95th percentile</td>
<td>0.5</td>
<td>99.8</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>89.3</td>
<td>10.7</td>
<td>89.6</td>
</tr>
<tr>
<td>5th percentile</td>
<td>81.6</td>
<td>5.7</td>
<td>84.7</td>
</tr>
<tr>
<td>95th percentile</td>
<td>94.3</td>
<td>18.2</td>
<td>94.0</td>
</tr>
<tr>
<td><strong>Outpatients</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>34.9</td>
<td>65.1</td>
<td>40.3</td>
</tr>
<tr>
<td>5th percentile</td>
<td>31.0</td>
<td>61.4</td>
<td>28.5</td>
</tr>
<tr>
<td>95th percentile</td>
<td>38.6</td>
<td>69.0</td>
<td>55.4</td>
</tr>
</tbody>
</table>
Ill, no medical care sought

<table>
<thead>
<tr>
<th></th>
<th>Mean 1.0</th>
<th>99.0</th>
<th>1.1</th>
<th>98.9</th>
<th>0.6</th>
<th>99.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>5th percentile</td>
<td>1.0</td>
<td>99.0</td>
<td>0.7</td>
<td>98.2</td>
<td>0.6</td>
<td>99.4</td>
</tr>
<tr>
<td>95th percentile</td>
<td>1.0</td>
<td>99.0</td>
<td>1.8</td>
<td>99.3</td>
<td>0.6</td>
<td>99.4</td>
</tr>
</tbody>
</table>

Notes: 1) See Table 11 for description of direct and indirect cost items.
2) For each age group and health outcome, the means of the direct and indirect costs should add to 100%. Any difference will be due to rounding the results to the first decimal place. The 5th and 95th percentiles will not necessarily add to 100%.

Table R5: Proportion of total costs attributable to deaths by risk category: Non-high and "high"¹

| Percentage of costs attributable to death (all ages) Non-high risk |
|------------------------|---------------------|---------------------|---------------------|
|                        | (%)                 | (%)                 | (%)                 |
| Mean                   | 10.8                | 70.1                | 80.9                |
| 5th percentile         | 6.0                 | 46.7                | 65.7                |
| 95th percentile        | 19.4                | 82.7                | 89.1                |

Notes: 1) "High" risk is defined as those patients who have one or more pre-existing medical conditions (e.g., emphysema) that make them prone to severe outcomes if they have a clinical case of influenza. Non-high risk are all those who are not categorized as "high" risk.

Table R6: Total net value of vaccinating against an influenza pandemic by level of compliance, age-risk group, cost of vaccination, and gross attack rate: Age distribution scenario A,¹ "high" level of vaccine effectiveness²

<table>
<thead>
<tr>
<th>Vaccination compliance</th>
<th>$21.26 cost of vaccination⁴ Gross attack rate (%)⁵</th>
<th>$62.26 cost of vaccination⁴ Gross attack rate (%)⁵</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, risk group⁶</td>
<td>15 25 35</td>
<td>15 25 35</td>
</tr>
<tr>
<td>40% compliance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-19 yrs: Non-high risk</td>
<td>618 1,426 2,232 -525 282 1,089</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(262; 836; 1,412; -884; -305; 266;)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1,122 2,259 3,395 -31 1,103 2,235</td>
<td></td>
</tr>
</tbody>
</table>

Mean (5th; 95th percentiles) net value of vaccination

($ millions, 1995 $)³
<table>
<thead>
<tr>
<th></th>
<th>0-19 yrs: Non-high risk</th>
<th>20-64 yrs: Non-high risk</th>
<th>64 + yrs: Non-high risk</th>
<th>60% compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk</td>
<td>927</td>
<td>2,137</td>
<td>3,348</td>
<td>927</td>
</tr>
<tr>
<td>20-64 yrs: Non-high risk</td>
<td>2,082</td>
<td>4,529</td>
<td>6,975</td>
<td>2,082</td>
</tr>
<tr>
<td>High risk</td>
<td>17,218</td>
<td>28,957</td>
<td>40,696</td>
<td>17,218</td>
</tr>
</tbody>
</table>
Table R7: Total net value of vaccinating against an influenza pandemic by level of compliance, age-risk group, cost of vaccination, and gross attack rate: Age distribution scenario B, \(^\text{1}\) "high" level of vaccine effectiveness\(^\text{2}\)

<table>
<thead>
<tr>
<th>Vaccination compliance</th>
<th>Gross attack rate (%)(^\text{5})</th>
<th>Mean (5(^{\text{th}}); 95(^{\text{th}}) percentiles) net value of vaccination ($ millions, 1995 $)(^\text{3})</th>
<th>$21.26 \text{ cost of vaccination}^\text{4}$</th>
<th>$62.26 \text{ cost of vaccination}^\text{4}$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15</td>
<td>25</td>
<td>35</td>
<td>15</td>
</tr>
<tr>
<td>40(^{\text{th}}) compliance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-19 yrs: Non-high risk</td>
<td>730</td>
<td>1,612</td>
<td>2,494</td>
<td>-412</td>
</tr>
</tbody>
</table>

Notes: 1) Table 2 provides the definition of distribution scenario A.
2) Table 13 provides the assumed levels of vaccine effectiveness, by the four health outcomes studied, that define "high" level of vaccine effectiveness.
3) Mean, 5\(^{\text{th}}\), and 95\(^{\text{th}}\) percentiles calculated using a Monte Carlo model incorporating the input variables specified in Tables 3 and 11. Estimates are to the nearest million \$.
4) Elements defining cost of vaccination presented in Table 12.
5) Gross attack rate is defined as the number of clinical cases of illness caused by influenza that will result in an economic impact.
6) Percentage of population in risk groups, by age category, is given in Table 2.
<table>
<thead>
<tr>
<th>Age Group</th>
<th>High risk</th>
<th>20-64 yrs: Non-high risk</th>
<th>64 + yrs: Non-high risk</th>
<th>60% compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High risk</td>
<td>High risk</td>
<td>High risk</td>
<td>0-19 yrs: Non-high risk</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(1,096; 2,418; 83,741; -621; 701; 2,022)</td>
</tr>
<tr>
<td>High risk</td>
<td>4,840</td>
<td>(737; 1,267; 1,798; 634; 1,161; 1,695; 10,658; 17,799; 24,945; 10,615; 17,814; 25,014)</td>
<td>911</td>
<td>(575; 1,674; 2,777; -1,574; -494; 571; 1,250; 2,769; 4,292; -808; 638; 2,100)</td>
</tr>
<tr>
<td>20-64 yrs: Non-high risk</td>
<td></td>
<td>17,507</td>
<td>830</td>
<td>(722; 1,298; 1,872; 444; 1,031; 1,609; 941; 1,655; 2,372; 692; 1,404; 2,113)</td>
</tr>
<tr>
<td>64 + yrs: Non-high risk</td>
<td></td>
<td></td>
<td>830</td>
<td>(722; 1,298; 1,872; 444; 1,031; 1,609; 941; 1,655; 2,372; 692; 1,404; 2,113)</td>
</tr>
<tr>
<td>60% compliance</td>
<td></td>
<td></td>
<td></td>
<td>1,895</td>
</tr>
<tr>
<td>0-19 yrs: Non-high risk</td>
<td></td>
<td></td>
<td></td>
<td>1,895</td>
</tr>
<tr>
<td>High risk</td>
<td>7,268</td>
<td>12,170</td>
<td>7,102</td>
<td>12,004</td>
</tr>
<tr>
<td>20-64 yrs: Non-high risk</td>
<td></td>
<td></td>
<td></td>
<td>7,268</td>
</tr>
</tbody>
</table>

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DOI: 10.321/eid0505.990507; TOC Head: Research
Table R8: Total net value of vaccinating against an influenza pandemic by level of compliance, age-risk group, cost of vaccination, and gross attack rate: Age distribution scenario A, "low" level of vaccine effectiveness

<table>
<thead>
<tr>
<th>Vaccination compliance</th>
<th>Mean (5th; 95th percentiles) net value of vaccination (S millions, 1995 $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, risk group</td>
<td>$21.26 cost of vaccination $62.26 cost of vaccination</td>
</tr>
<tr>
<td>15</td>
<td>25</td>
</tr>
</tbody>
</table>

Notes: 1) Table 2 provides the definition of distribution scenario B.
2) Table 13 provides the assumed levels of vaccine effectiveness, by the four health outcomes studied, that define "high" level of vaccine effectiveness.
3) Mean, 5th, and 95th percentiles calculated using a Monte Carlo model incorporating the input variables specified in Tables 3 and 11. Estimates are to the nearest million $.
4) Elements defining cost of vaccination presented in Table 12.
5) Gross attack rate is defined as the number of clinical cases of illness caused by influenza that will result in an economic impact.
6) Percentage of population in risk groups, by age category, is given in Table 2.
40% compliance

<table>
<thead>
<tr>
<th>Group</th>
<th>0-19 yrs: Non-high risk</th>
<th>20-64 yrs: Non-high risk</th>
<th>64 + yrs: Non-high risk</th>
<th>High risk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>329</td>
<td>1,557</td>
<td>-814</td>
<td>1,313</td>
</tr>
<tr>
<td></td>
<td>(127; 616; 1,102)</td>
<td>(-1,023; -532; -469)</td>
<td>(593; 1,382; 2,173)</td>
<td>(217; 400; 581; 106)</td>
</tr>
<tr>
<td>High risk</td>
<td>1,313</td>
<td>3,140</td>
<td>1,203</td>
<td>2,226</td>
</tr>
<tr>
<td></td>
<td>(2,890; 4,856)</td>
<td>(6,620; 2,776)</td>
<td>(4,743; 6,703)</td>
<td>(2,226; 4,856)</td>
</tr>
<tr>
<td>20-64 yrs: Non-high risk</td>
<td>702</td>
<td>3,050</td>
<td>-1,339</td>
<td>1,876</td>
</tr>
<tr>
<td></td>
<td>(390; 1,376; 2,358)</td>
<td>(-1,669; -703; 287)</td>
<td>(1,013; 2,380; 3,754)</td>
<td>(2,380; 4,856)</td>
</tr>
<tr>
<td>High risk</td>
<td>6,554</td>
<td>15,640</td>
<td>6,053</td>
<td>11,097</td>
</tr>
<tr>
<td></td>
<td>(1,031; 1,883; 2,739)</td>
<td>(5,21; 1,393; 2,247)</td>
<td>(6,554; 11,097)</td>
<td>(2,380; 4,856)</td>
</tr>
<tr>
<td>64 + yrs: Non-high risk</td>
<td>32</td>
<td>277</td>
<td>-259</td>
<td>155</td>
</tr>
<tr>
<td></td>
<td>(4; 120; 234)</td>
<td>(-321; -202; 84)</td>
<td>(60; 188)</td>
<td>(188; 319)</td>
</tr>
<tr>
<td>High risk</td>
<td>269</td>
<td>809</td>
<td>5</td>
<td>539</td>
</tr>
<tr>
<td></td>
<td>(215; 456; 696)</td>
<td>(-73; 174; 417)</td>
<td>(324; 625)</td>
<td>(625; 927)</td>
</tr>
</tbody>
</table>

60% compliance

<table>
<thead>
<tr>
<th>Group</th>
<th>0-19 yrs: Non-high risk</th>
<th>20-64 yrs: Non-high risk</th>
<th>64 + yrs: Non-high risk</th>
<th>High risk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>493</td>
<td>2,336</td>
<td>-1,221</td>
<td>1,415</td>
</tr>
<tr>
<td></td>
<td>(193; 928; 1,658)</td>
<td>(-1,531; -794; -65)</td>
<td>(893; 2,077; 3,261)</td>
<td>(1,970; 3,340)</td>
</tr>
<tr>
<td>High risk</td>
<td>1,970</td>
<td>4,710</td>
<td>1,805</td>
<td>3,340</td>
</tr>
<tr>
<td></td>
<td>(323; 592; 866)</td>
<td>(158; 432; 705)</td>
<td>(4,334; 7,283)</td>
<td>(7,283; 10,233)</td>
</tr>
</tbody>
</table>

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DOI: 10.321/eid0505.990507; TOC Head: Research
### Table R9: Total net value of vaccinating against an influenza pandemic by level of compliance, age-risk group, cost of vaccination, and gross attack rate: Age distribution scenario B, \(^1\) "low" level of vaccine effectiveness\(^2\)

<table>
<thead>
<tr>
<th>Vaccination compliance</th>
<th>Mean (5(^{th}); 95(^{th}) percentiles) net value of vaccination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, risk group(^6)</td>
<td>(($) millions, 1995 ($))(^3)</td>
</tr>
<tr>
<td></td>
<td>($)21.26 cost of vaccination(^4)</td>
</tr>
</tbody>
</table>

Notes:

1) Table 2 provides the definition of distribution scenario A.

2) Table 13 provides the assumed levels of vaccine effectiveness, by the four health outcomes studied, that define "low" level of vaccine effectiveness.

3) Mean, 5\(^{th}\), and 95\(^{th}\) percentiles calculated using a Monte Carlo model incorporating the input variables specified in Tables 3 and 11. Estimates are to the nearest million \(\$\).

4) Elements defining cost of vaccination presented in Table 12.

5) Gross attack rate is defined as the number of clinical cases of illness caused by influenza that will result in an economic impact.

6) Percentage of population in risk groups, by age category, is given in Table 2.
### 40% compliance

<table>
<thead>
<tr>
<th></th>
<th>15</th>
<th>25</th>
<th>35</th>
<th>15</th>
<th>25</th>
<th>35</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>0-19 yrs: Non-high risk</strong></td>
<td>415</td>
<td>1,087</td>
<td>1,758</td>
<td>-728</td>
<td>-56</td>
<td>616</td>
</tr>
<tr>
<td></td>
<td>(195;</td>
<td>(730;</td>
<td>(1,261;</td>
<td>(-953;</td>
<td>(-418;</td>
<td>(114;</td>
</tr>
<tr>
<td></td>
<td>704)</td>
<td>1,566</td>
<td>2,430</td>
<td>-439</td>
<td>426</td>
<td>1,287)</td>
</tr>
<tr>
<td><strong>High risk</strong></td>
<td>2,632</td>
<td>4,424</td>
<td>6,217</td>
<td>2,522</td>
<td>4,314</td>
<td>6,107</td>
</tr>
<tr>
<td></td>
<td>(447;</td>
<td>(782;</td>
<td>(1,114;</td>
<td>(335;</td>
<td>(677;</td>
<td>(1,009;</td>
</tr>
<tr>
<td></td>
<td>5,776)</td>
<td>9,662</td>
<td>13,557)</td>
<td>5,664)</td>
<td>9,555)</td>
<td>13,439)</td>
</tr>
<tr>
<td><strong>20-64 yrs: Non-high risk</strong></td>
<td>320</td>
<td>1,239</td>
<td>2,159</td>
<td>-1,721</td>
<td>-802</td>
<td>118</td>
</tr>
<tr>
<td></td>
<td>(69;</td>
<td>(841;</td>
<td>(1,610;</td>
<td>(-2,038;</td>
<td>(-1,245;</td>
<td>(-468;</td>
</tr>
<tr>
<td></td>
<td>571)</td>
<td>1,539</td>
<td>2,715)</td>
<td>-1,414)</td>
<td>-365)</td>
<td>698)</td>
</tr>
<tr>
<td><strong>High risk</strong></td>
<td>10,041</td>
<td>16,908</td>
<td>23,775</td>
<td>9,539</td>
<td>16,407</td>
<td>23,274</td>
</tr>
<tr>
<td></td>
<td>(1,648;</td>
<td>(2,908;</td>
<td>(4,166;</td>
<td>(1,145;</td>
<td>(2,420;</td>
<td>(3,676;</td>
</tr>
<tr>
<td></td>
<td>18,431)</td>
<td>30,888</td>
<td>43,328)</td>
<td>17,921)</td>
<td>30,384)</td>
<td>42,839)</td>
</tr>
<tr>
<td><strong>64 + yrs: Non-high risk</strong></td>
<td>6</td>
<td>112</td>
<td>217</td>
<td>-285</td>
<td>-180</td>
<td>-75</td>
</tr>
<tr>
<td></td>
<td>(-20;</td>
<td>(80;</td>
<td>(179;</td>
<td>(-345;</td>
<td>(-243;</td>
<td>(-141;</td>
</tr>
<tr>
<td></td>
<td>33)</td>
<td>142</td>
<td>253)</td>
<td>-225)</td>
<td>-117)</td>
<td>-9)</td>
</tr>
<tr>
<td><strong>High risk</strong></td>
<td>456</td>
<td>852</td>
<td>1,247</td>
<td>193</td>
<td>588</td>
<td>983</td>
</tr>
<tr>
<td></td>
<td>(382;</td>
<td>(732;</td>
<td>(1,082;</td>
<td>(98;</td>
<td>(454;</td>
<td>(809;</td>
</tr>
<tr>
<td></td>
<td>533)</td>
<td>976</td>
<td>1,421)</td>
<td>288)</td>
<td>725)</td>
<td>1,164)</td>
</tr>
</tbody>
</table>

### 60% compliance

<table>
<thead>
<tr>
<th></th>
<th>15</th>
<th>25</th>
<th>35</th>
<th>15</th>
<th>25</th>
<th>35</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>0-19 yrs: Non-high risk</strong></td>
<td>623</td>
<td>1,630</td>
<td>2,637</td>
<td>-1,091</td>
<td>-84</td>
<td>923</td>
</tr>
<tr>
<td></td>
<td>(297;</td>
<td>(1,099;</td>
<td>(1,898;</td>
<td>(-1,428;</td>
<td>(-622;</td>
<td>(180;</td>
</tr>
<tr>
<td></td>
<td>1,059)</td>
<td>2,353</td>
<td>3,646)</td>
<td>-651)</td>
<td>638)</td>
<td>1,931)</td>
</tr>
<tr>
<td><strong>High risk</strong></td>
<td>3,948</td>
<td>6,637</td>
<td>9,325</td>
<td>3,783</td>
<td>6,472</td>
<td>9,160</td>
</tr>
<tr>
<td></td>
<td>(665;</td>
<td>(1,168;</td>
<td>(1,668;</td>
<td>(505;</td>
<td>(1,002;</td>
<td>(1,496;</td>
</tr>
</tbody>
</table>
8,664) 14,497) 20,331)  8,495) 14,335) 20,171)
20-64 yrs: Non-high risk 481  1,859  3,238 -2,581 -1,202  176
(91; (1,253; (2,398; (-3,051; (-1,863; (-693;
868)  2,477)  4,085) -2,117) -537)  1,067)
High risk 15,061  25,363  35,664  14,309  24,610  34,911
(2,446; (4,324; (6,226; (1,707; (3,569; (5,447;
27,694)  46,391)  65,080)  26,913)  45,626)  64,388)
64 + yrs: Non-high risk 10  167  325 -426 -270 -112
(-30; (120; (269; (-517; (-363; (-210;
50)  214)  382) -338) -176)  -12)
High risk 684  1,278  1,871  289  882  1,475
(574; (1,098; (1,621; (149; (683; (1,213;
803)  1,473)  2,143)  435)  1,092)  1,756)
Notes: 1) Table 2 provides the definition of distribution scenario B.
2) Table 13 provides the assumed levels of vaccine effectiveness, by the four health outcomes studied, that define "low" level of vaccine effectiveness.
3) Mean, 5th, and 95th percentiles calculated using a Monte Carlo model incorporating the input variables specified in Tables 3 and 11. Estimates are to the nearest million $.
4) Elements defining cost of vaccination presented in Table 12.
5) Gross attack rate is defined as the number of clinical cases of illness caused by influenza that will result in an economic impact.
6) Percentage of population in risk groups, by age category, is given in Table 2.

Table R10: The annual "insurance premium" for planning, preparing and practicing to respond to the next influenza pandemic: Differences due to probability of event, attack rate, vaccine effectiveness, compliance and cost of vaccination

<table>
<thead>
<tr>
<th>Gross attack rate</th>
<th>Cost of vaccination</th>
<th>&quot;Low&quot; vaccine effectiveness x 40% compliance</th>
<th>&quot;High&quot; vaccine effectiveness x 60% compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Probability of pandemic</td>
<td>Probability of pandemic</td>
<td></td>
</tr>
</tbody>
</table>
1 in 30 years 1 in 60 years 1 in 100 years 1 in 30 years 1 in 60 years 1 in 100 years

15% $21/vaccinee 306 153 92 872 435 262
(122) (61) (37) (341) (170) (103)
$62/ vaccinee 162 81 48 654 326 196
(122) (61) (37) (341) (170) (103)

25% $21/vaccinee 561 280 168 1,528 762 459
(204) (102) (61) (569) (284) (171)
$62/ vaccinee 416 207 125 1,311 653 394
(204) (102) (61) (569) (284) (171)

35% $21/vaccinee 815 406 245 2,184 1,089 656
(286) (142) (86) (796) (397) (239)
$62/ vaccinee 670 334 201 1,967 980 591
(286) (142) (86) (796) (397) (239)

Note: 1) The "insurance premium" is defined here as the amount of money to be spent each year to plan, prepare and practice (the 3 P's) to ensure that such mass vaccinations can take place if needed. The premium is calculated as follows: \[ \text{Annual "insurance premium" = net returns from vaccination \times annual probability of pandemic occurring.} \] The net returns to vaccination are given in Tables R6-R9.

2) Although the "premium" is to pay for planning, practicing and preparing a response to the next influenza pandemic, the mathematically optimal allocation of such funds requires a separate set of calculations.

3) "Low" and "high" levels of vaccine effectiveness are defined in Table 13.

Table R11: Setting priorities: Samples of lists to decide which age and risk group should be vaccinated first

<table>
<thead>
<tr>
<th>Priority</th>
<th>Risk of death</th>
<th>Percentage of deaths</th>
<th>Returns to vaccination</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (top)</td>
<td>High risk 65 + yrs</td>
<td>High risk 20 - 64 yrs</td>
<td>High risk 20 - 64 yrs</td>
</tr>
<tr>
<td>2</td>
<td>Non-high risk 65 + yrs</td>
<td>High risk 65 + yrs</td>
<td>High risk 0 - 19 yrs</td>
</tr>
<tr>
<td>3</td>
<td>High risk 0 - 19 yrs</td>
<td>High risk 0 - 19 yrs</td>
<td>Non-high risk 20 - 64 yrs</td>
</tr>
<tr>
<td>4</td>
<td>High risk 20 - 64 yrs</td>
<td>Non-high risk 65 + yrs</td>
<td>Non-high risk 0 - 19 yrs</td>
</tr>
<tr>
<td>5</td>
<td>Non-high risk 20 - 64 yrs</td>
<td>Non-high risk 20 - 64 yrs</td>
<td>High risk 65 + yrs</td>
</tr>
<tr>
<td>6 (bottom)</td>
<td>Non-high risk 0 - 19 yrs</td>
<td>Non-high risk 0 - 19 yrs</td>
<td>Non-high risk 65 + yrs</td>
</tr>
</tbody>
</table>
Notes: 1) Priorities set by "risk of death" are set according to lower-limit estimates of deaths per 1,000 population for each age and risk group (see Table 3).

2) Priorities set using percentage distribution of total deaths. Data from Tables R1 and R2.

3) The priorities based on returns to vaccination use the mean net value from vaccination (Tables R6-R9).

**Figure legends**

**Figure 1**: Frequency of outpatient visits per patient for influenza, pneumonia and acute bronchitis: 1993-95

Note: ICD-9 codes used to define conditions and extract data are given in Table 4. N= 689,866 individual patients identified. Source: MarketScan database, MEDSTAT Group.

**Figure 2**: Impact of influenza pandemic in the United States: Mean, minimum, maximum, 5\(^{th}\) and 95\(^{th}\) percentiles of total deaths and hospitalizations for different gross attack rates

Notes: A) age distributions of cases given in Table 2. B) For each gross attack rates, data are totals for all age groups and risk categories.

**Figure 3**: Impact of influenza pandemic in the United States: Mean, minimum, and maximum of total outpatients and those ill (but not seeking formal medical care) for different gross attack rates

Note: For each gross attack rates, data are totals for all age groups and risk categories.

**Figure 4**: Sensitivity analysis: Mean net returns to vaccination, by age group, for different death rates, vaccine effectiveness, and percentage compliance: Non-high risk patients

Notes:

1) Initial mean death rates (proportion = 1.00) used for non-high risk patients were: 0-19 years 0.055/ 1,000 general population; 20-64 years 0.051/ 1,000 general population; 65 + years 0.413/ 1,000 general population (see Table 3). Other death rates used were proportions of these rates (0.25 and 0.50).

2) Values defining vaccine effectiveness ("high" and "low") are given in Table 13.

3) Scenario A of age-distribution of cases was used (Table 2).

**Figure 5**: Four options to respond to an influenza pandemic: Mean net economic returns

Notes:

1) Bars show mean net returns for each option and assumed cost of vaccination.

2) Option A: Similar to current Advisory Committee on Immunization Practices (ACIP) recommendations, with production and use similar to current, intra-pandemic recommendations. Assumed approximately 77 million vaccinees. Option B: Number of vaccinees as outlined in Scenario A plus an additional 20 million essential service providers (5 million health care workers + 15 million other service providers). Option C:
Aim to achieve a 40 percent coverage in each age and risk group. Option D: Aim to achieve 60 percent coverage in each age and risk group. See Table 14 for further details.

1A complete plan detailing a response to an influenza pandemic should include items such as a definition of a pandemic, "trigger" points that will initiate various steps in the response plan, and details regarding how to actually deploy the intervention. While a U.S. Federal influenza pandemic plan is still being developed, a guide for state and territorial health officials to aid them in developing plans for their jurisdictions is available at the following Internet website (printed copies can be obtained from the author): http://www.cdc.gov/nip/temp/pandemic-flu.htm

2We limited our examination of possible interventions to those involving influenza vaccines. We did not consider the use of anti-viral drugs for influenza prophylaxis. The reasons for the omission include: a) possible lack of supplies; b) first priority for such drugs may be for treatment; and, c) the side-effects from the drugs, particularly amantadine, make them unsuitable for long term prophylaxis for many occupations, such as drivers, heavy construction operators etc.

3Although it is recommended that persons age 9 years or older need only one dose of the currently available vaccine, children under 9 years may require 2 doses to elicit a "satisfactory" immune response (2). In a pandemic, which will be caused by a new subtype of influenza, it may be that everybody will require 2 doses in order to induce a "satisfactory" immune response, such that the vaccinee is protected against disease, or at least has a less severe health outcome.

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