Celebrating the ACIP at 50

In this issue, Walton, Orenstein, and Pickering provide a useful summary of the 50-year history of the Advisory Committee on Immunization Practices (ACIP). When the ACIP was formed in 1964, immunization recommendations for children were primarily developed by the American Academy of Pediatrics (AAP), with the American Public Health Association and other professional organizations also providing recommendations for civilian populations. The Armed Forces Epidemiological Board made recommendations for immunizations in the Armed Forces. In the early years of the ACIP, its recommendations were primarily directed toward public health agencies, which provided approximately 50% of childhood immunizations. The AAP, on the other hand, directed its recommendations at private practitioners, who provided the other 50% of childhood immunizations. Since 1984, the ACIP has also issued recommendations aimed at adults—a policy area of growing importance given the aging demographics of the U.S.

Walton et al. describe some of the differences in recommendations from these bodies that caused confusion among many practitioners, notably those relating to the age at which the second dose of measles–mumps–rubella (MMR) vaccine should be administered; the ACIP recommended administering the second dose at 4–5 years, as part of school entry immunization. By contrast, the AAP initially recommended administering the second dose at 11–12 years. Conscious efforts to ensure harmonization of vaccine recommendations among various bodies have included assuring liaison representation at ACIP meetings from bodies such as AAP, the American Academy of Family Physicians (AAP), the American College of Obstetrics-Gynecology (ACOG), and the American College of Physicians (ACP), as well as an additional 27 organizations. As a consequence, for the past 20 years there has been harmonization among the recommendations, facilitating more effective immunization of children and adults.

Another facet of the evolution of the ACIP described by Walton et al. is the increasing rigor of the process of developing recommendations. Initially, recommendations were written by ACIP members themselves in consultation with CDC staff and were relatively short. Over the years, the development of recommendations has become more formal and explicit, with work groups including ACIP members and others (including representatives of vaccine manufacturers) who review the evidence of safety and efficacy of a specific vaccine over a several-month period before drafting a recommendation for consideration by the full committee. The final recommendations represent a comprehensive review of available evidence about the disease and the vaccine.

There has also been evolution in the charter of the ACIP. The first ACIP had eight members and was chaired by the director of CDC. It now has 15 members including a lay person representing consumer concerns. None of the members is a federal employee and all are vetted for potential conflicts of interest. The committee is chaired by one of the members. In addition, there are 8 ex officio members representing federal agencies, and 31 liaison members representing organizations involved with immunization, Ex officio and liaison members do not vote.

The ACIP is also tasked with considering economic aspects of immunization and in 2007 developed guidance for health economics studies to be presented to the committee. These include the necessity for the studies to be submitted in advance of ACIP meetings to enable peer review of the methods and assumptions in the models to minimize the risk of bias. Finally, since 2010, the ACIP now uses an explicit evidence-based method for decision making about recommendations based on the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) approach, including the balance of benefits and harms, type or quality of evidence, values and preferences of the people affected, and health economic analyses.

One of the most important impacts of the ACIP is only peripherally mentioned by Walton et al. [1]—its role in determining which vaccines will be included in the Vaccines For Children (VFC) program. ACIP decisions to include a vaccine in VFC obligate the federal government to purchase adequate supplies of that vaccine for administration at no charge to children who are uninsured, on Medicaid, underinsured, or Alaska Native/Native American. This represents nearly 1/2 of the children in this country. Before the VFC was enacted, the increasing number of vaccines (and their increasing costs) made it difficult for many parents to afford immunization of their children. Consequently, the ACIP is directly responsible for assuring free vaccines to children who might otherwise not be able to be vaccinated—making the ACIP both an advisor and a guarantor.

The ACIP has also served as a model for other immunization advisory committees, including the World Health Organization’s (WHO) Strategic Advisory Group of Experts on Immunization (SAGE), and Regional and National Immunization Technical Advisory Groups (RITAG and NITAGs). The ACIP represents an important and vital asset for independent expert advice to the Centers for Disease Control and Prevention, health care and public health.
practitioners, other countries, and the U.S. public. Consequently, it is clear that the ACIP has had a major impact on vaccine recommendations, policy, and use, both in the U.S. and around the world. We are proud to have been a part of it and to celebrate 50 years of success.

ARH was Acting Executive Secretary of the ACIP from 1977 to 1979, and GAP has served as both a regular voting member of the ACIP and as a liaison representative for the American College of Physicians, and was the previous President of the Armed Forces Epidemiological Board.

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