JCVI JOINT COMMITTEE ON VACCINATION AND IMMUNISATION

JCVI Secretariat
UKHSA, 5th floor
10 South Colonnade
London
E14 5EA

Lara Wong
Founder
Clinically Vulnerable Families

29 November 2024

Dear Lara,

**Re: Open Letter: Maintain Covid-19 Vaccine Access for All Clinically Vulnerable People**

Thank you for your letter of 19 November 2024 to the Joint Committee on Vaccination and Immunisation (JCVI) Secretariat regarding the recently published JCVI advice on groups eligible for COVID-19 vaccination in 2025 and Spring 2026.

The role of the JCVI is to advise UK health departments on immunisations for the prevention of infections and/or disease following due consideration of the evidence on the burden of disease, on vaccine safety and efficacy, and on the impact and cost effectiveness of immunisation strategies. The JCVI works to develop consensus advice based on consideration of scientific evidence. That advice is provided to Government to inform, develop and make policy. The JCVI is not a policy maker in its own right.

Due to a combination of naturally acquired and vaccine-derived immunity in the population (hybrid immunity), and the emergence of SARS-CoV-2 variants with lower disease severity, COVID-19 is now a relatively mild disease for most people, though it can still be unpleasant. This ongoing increase in population immunity permits the development of a more targeted programme aimed at those at higher risk of developing serious disease (hospitalisation and/or mortality) arising from COVID-19. Older persons, residents in care homes for older adults, and those who are immunosuppressed continue to be at highest risk of severe COVID-19.

For COVID-19 vaccination in autumn 2025 and spring 2026, the JCVI have returned to considering standard cost effectiveness, in line with other routine vaccinations in the national immunisation programme, including influenza. Cost-effectiveness is a form of health economic evaluation that analyses the health benefits relative to the costs of a vaccination policy. The JCVI operates within a framework similar to that used by the National Institute for Health and

Care Excellence (NICE) to support optimal use of health service resources. Using the NICE approach, a vaccination programme can be considered cost effective if the health benefits (both the direct health benefits to those vaccinated and the indirect health benefits to the unvaccinated population) are greater than the opportunity costs, measured in terms of the health benefits associated with programmes that may be displaced to fund the new vaccination programme. JCVI are required to consider the cost-effectiveness of a vaccine as part of their Code of Practice. The perspective on benefits for JCVI's standard methodology is for health benefits only; meaning non-health benefits of vaccination to the individual and society, such as to economic productivity, are not assessed. Further questions about the requirement for JCVI to consider cost-effectiveness and the areas that are included should be directed to the Department of Health and Social Care (DHSC).

Focusing on the available UK epidemiological data, alongside vaccine effectiveness and cost-effectiveness, has led to a more refined approach to the COVID-19 immunisation programme, with a focus on individuals where there is good, recent evidence of a high risk of hospitalisation and/or mortality. Further details of this cost-effectiveness assessment can be found in the preprint by Keeling et al, 2024[1].

As noted in the JCVI statement, the advice for universal vaccination from age 75 is provided as an example and is subject to procurement and delivery at a cost-effective price. It is important to emphasize that JCVI has no role in the procurement or delivery of COVID-19 vaccines, or any other vaccine. The example price of £25 per vaccine (vaccine product + delivery) is an indicative estimate used by the JCVI and the actual vaccine price may differ. The JCVI cannot comment on the availability or price of vaccines on the private market.

At their meetings this autumn, the Committee recognized that COVID-19 risk groups were currently very broad and heterogeneous. It was agreed that a further stratification of risk groups to determine individuals who were at higher-risk compared to lower-risk of serious COVID-19 outcomes may be informative, however the data to carry out this analysis were insufficient. For Long COVID/post-COVID syndromes, further evidence on vaccine effectiveness of additional doses for the prevention of post-COVID syndromes and on identifying groups particularly at-risk for developing post-COVID syndromes is still needed. JCVI recently published an updated list of Research Recommendations[2]. Within this list the Committee has suggested that research be undertaken to reassess the clinical risk groups for COVID-19 and investigate whether vaccination could prevent or impact on post-COVID syndromes.

[1] https://www.medrxiv.org/content/10.1101/2024.11.08.24316972v2
[2] https://app.box.com/s/xr0fneas34m99awuey1rs82r0xzbx6ph/file/1699184099305

In your letter, you compared COVID-19 vaccination eligibility to seasonal flu vaccination eligibility. It is important to note that seasonal influenza follows a significantly different epidemiological pattern to SARS-CoV-2, as can be seen in UKHSA Respiratory DataMart reporting[3]. Seasonal influenza peaks in winter on a yearly basis, with a low baseline level throughout the year. In contrast, SARS-CoV-2 has a relatively higher baseline level throughout the year, with low, broad peaks emerging independently of seasons. These viruses also differ in their pathogenicity. One benefit of using standardised cost-effectiveness assessments across different immunisation programmes, is to enable similar decision-thresholds to be applied to different vaccine-preventable conditions.

You also highlighted the World Health Organization (WHO) advice for COVID-19. The WHO is an international body which publishes public health advice intended to cover many countries with different epidemiological and vaccination history, as well as approaches to COVID-19 vaccination. This is highlighted in the *Roadmap on uses of COVID-19 vaccines in the context of Omicron and high population immunity*[4], where it states: "When deciding to implement booster doses, each country needs to take into account the age structure of the population; the current and potential burden of severe COVID-19 disease and hospitalizations; the availability and access to vaccines including variant-containing vaccines; as well as opportunity costs, coverage rates with the initial doses, and community acceptance of boosters."

The JCVI has no role in eligibility for antiviral treatments, and as such cannot provide more detail on those recommendations.

The JCVI continues to keep the COVID-19 vaccination programme under review.

Yours sincerely

**JCVI Secretariat**
UK Health Security Agency
jcvi@ukhsa.gov.uk

On behalf of

Professor Sir Andrew J Pollard
FRCPCH, PhD, FMedSci, FRS
Chair of the JCVI
Professor of Paediatric Infection and Immunity, University of Oxford

Professor Wei Shen Lim, KBE
Deputy Chair of the JCVI
Chair of the JCVI COVID-19 sub-committee
Consultant Respiratory Physician & Honorary Professor of Respiratory Medicine, University of Nottingham

[3] https://www.gov.uk/government/statistics/national-flu-and-covid-19-surveillance-reports-2024-to-2025-season
[4] https://www.who.int/publications/i/item/WHO-2019-nCoV-Vaccines-SAGE-Prioritization-2023.2