Vaccinations in the United States: A Review of the Vaccination Injury Compensation Program

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Vaccinations in the United States have a dramatic and long standing impact against the spread of disease. However, the purpose of this study is to focus on the individuals who have been harmed by vaccines and the avenues that must be used in order to receive compensation as a result of such. Since its creation in 1986, the Vaccination Injury Compensation Program (VICP) provides no fault compensation to person injured by vaccines. The data for this research were collected from the U.S. Government Accountability Office, the HHS's Health Resources and Services Administration, the Emory Program for Vaccine Policy and Development, as well as Boston University's legislative report, in order to exam whether the VICP established a streamlined system for compensation in instances where injury has resulted from vaccination. This research concludes that the VICP did in fact create a streamlined system for compensation in instances where injury has resulted from vaccination due to the shortened average adjudication time in claims, as well as the program meeting its initial goal of the averaging three and a half years to adjudicate claims. Furthermore, the optimal way to compensate injuries would be by means of a universal

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compensation system; however, until a universal system gains political acceptance, there is a role for the National Vaccine Injury Compensation Program in the United States.

Introduction

The impact of vaccination has been dramatic in the United States; "few measures in preventive medicine can compare with the impact of vaccines" (Orenstein et. al., 2005). According to the American Academy of Pediatrics, "vaccines save lives and protect against the spread of disease. If you decide not to immunize your child, you put your child at risk to catch a disease that is dangerous or deadly" (Vaccine Safety, 2008). In the United States, most vaccine preventable diseases are at or near record lows while the number of diseases preventable by vaccination has increased (Orenstein et. al., 2005). The Center for Disease Control estimates that vaccinations will prevent more than 21 million hospitalizations and 732,000 deaths among children born in the last twenty years (CDC, 2014). However, while it is no argument that vaccines are an effective way to prevent disease, the debate over vaccinations in the United States has still been a primary topic of concern.

While it is prevalent that vaccines save lives, the purpose of this research is to examine those individuals who have been harmed as a result of vaccination. After two decades of controversy over whether and how adverse reactions to vaccines should be compensated, Congress created the National Vaccine Injury Compensation Program (VICP) in 1986 as a compromise (Mariner 1992). The federal vaccine program provides a no fault compensation to person injured by vaccines used to prevent infectious childhood diseases (Mariner 1992). According the VICP, since its first claim was filed in 1989, more than 3,887 compensation awards have been made,

totaling more than 3 billion dollars in compensation to victims of injury of vaccinations (Dane, 2015). Because the VICP awards compensation primarily for specific injuries occurring within specified time after vaccination, it is the United States' simplest program of no fault compensation (Mariner 1992). The VICP's second notable innovation was including a list of compensable injuries, known as the Vaccine Injury Table, an essential component to the resolution of any claim through the program (Mariner, 1992). The Vaccine Injury Table lists and explains injuries or conditions that are presumed to be caused by vaccines; it also lists time periods in which the first symptom of these injuries must occur after receiving the vaccine (See Figure 3) (GAO, 2014). The listed injuries were derived from epidemiologic and other studies of adverse reactions to covered vaccines and represent a best approximation of injuries actually resulting from vaccine. The table is intended to streamline the decision making process by eliminating the need for proof of causation (one of the most difficult, costly, and time consuming elements) (Mariner, 1992). In most cases, the Vaccine Injury Table makes it easier for some people to receive compensation from their VICP claim (HRSA, 2011).

This research extends upon a report by the Government Accountability Office from November 2014 to determine the effectiveness of the VICP. The purpose of this study is to use information from these reports along with the history of vaccinations to examine if the establishment of the Vaccination Injury Compensation Program has provided a streamlined system for compensation in instances where injury has resulted from vaccination.

Here, I hypothesize that the VICP's adjudication time will have shortened from the initial creation of the VICP. The VICP has

created a streamlined system for compensation in instances where injury has resulted from vaccination due to the shortened adjudication time in claims, as well as the program meeting its initial goal of the averaging three and a half years to adjudicate claims up to the 2009 fiscal year.

First, I present a literature review discussing the history of vaccinations in the United States, the key agencies involved in creating vaccination legislation, as well as an overview of the Government Accountability Office November 2014 report of the Vaccine Compensation Injury Program. Next, I will discuss the methodology used in this research, followed by an analysis of the results. Finally, I conclude that the Vaccine Compensation Injury Program did indeed, create a more streamlined system for compensation in instances where injury occurred as a result of vaccines.

Literature Review

The United States' vaccine system includes several components: vaccine discovery, development, manufacture, and distribution; regulation of vaccine development, production, and distribution; and development and implementation of vaccine use policies. Participants include all levels of government (federal, state, and local) vaccines companies, academe, medical societies, health care professionals, and insurers (Orenstein et. al., 2005).

The use of vaccines in the United States has a long legal and political history. In 1905, *Jacobsen v. Massachusetts* affirming the legal right of state legislatures to pass laws mandating use of smallpox vaccine by residents (Fisher 1999). Jacobsen and his son sued the state of Massachusetts for requiring them to receive a second smallpox vaccination or pay a fine. They argued that by forcing Jacobsen and his son to be revaccinated after a bad reaction to a

previous smallpox vaccination, was "an assault upon his person" and violated his constitutional rights. While the 1905 Supreme Court rejected the evidence Jacobsen presented to show that the smallpox vaccination can cause injury and to demonstrate that doctors cannot distinguish between those who will be harmed and those who won't, the Court acknowledged that vaccination must not be forced on a person whose physical condition would make vaccination:

> "…cruel and inhuman to the last degree. We are not to be understood as holding that the statute was intended to be applied in such a case or, if it was so intended, that the judiciary would not be competent to interfere and protect the health and life of the individual concerned" (Fisher 1999).

As noted by Fisher, while interpreting the significance of *Jacobsen v. Massachusetts*, it is important to remember that, "although the Court stated that states may enact 'such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety,' the Court also made it clear that mandatory vaccination laws must not be applied unreasonably so as to result in harm to individuals" (1999). *Jacobsen v. Massachusetts* is a fundamental case regarding mandatory vaccinations in the United States. The Supreme Court's ruling on this case paved the way for vaccination mandates for decades to come. Since *Jacobsen v. Massachusetts*, there have been hundreds of similar cases in the United States.

In 1965 Congress passed the Immunization Assistance Act, which set up categorical grant programs to provide federal funds to purchase vaccines for public health clinics and establish immunization programs. However it was not until 1971, when Dale Bumpers became Governor of Arkansas, that vaccinations became a

political tool. In 1973, Governor Bumpers and his wife, Betty, utilized the Centers for Disease Control (CDC) and the Arkansas National Guard to vaccinate every child in Arkansas. The national publicity generated by Bumpers, lead him to the US Senate in 1974 (Fisher 1999).

In 1976, President Jimmy Carter was persuaded by Dale and Betty Bumpers to establish a national campaign to enforce vaccination laws. Bumpers is credited with doubling annual federal appropriations for vaccine programs from 14.5 million to 33 million in 1978, 46 million by 1979, and 141 million by 1989. President Ronald Reagan signed the National Childhood Vaccine Injury Act into law in 1986, which acknowledged that vaccines can injure and kill individuals and created a federal vaccine compensation system. However, since 1993, federal health officials have moved to 'systematically gut the law;' today, three out of four vaccine injured children are turned away (Fisher 1999).

In 1991, The Robert Wood Johnson Foundation created All Kids Count, a national program to set up electronic vaccination registry and tracking systems to monitor and follow-up pre-school children in order to enforce mass vaccinations. In that same year, the non-profit, Every Child By Two, co-founded by Betty Bumpers and former First Lady Rosalyn Carter, was a national campaign that facilitates the creation of mechanism to vaccinate children with all government endorsed vaccines by age two. During 1991, the CDC also recommended that all newborns receive a hepatitis B vaccine at birth (Fisher 1999).

With Bill Clinton's presidential election in 1993, the "President Clinton's Immunization Initiative" was announced and planned to tag every citizen with a Unique Health Care Identifier Number at birth. Opposition to President Clinton's Immunization Initiative

eventually led to the introduction of, The Comprehensive Child Immunization Act, which established a national system to track the immunization status of children. By 1997, President Bill Clinton issued a public challenge to government and industry scientists to put vaccine for AIDS on the market by 2007. President Bill Clinton established the Dale and Betty Bumpers Vaccine Research Center and granted a 200 million dollar annual funding (Fisher 1999).

The National Vaccine Injury Compensation Program was established in 1986 as recognition that society had an obligation to those injured by vaccines. The VICP is a no fault system funded by a seventy-five-cent excise tax on each dose of vaccine (Orenstein et. al., 2005). There are currently twenty vaccines that are covered by the VICP, any of which, a parent/legal guardian or a person may file a claim with the VICP if they believe they were injured or death resulted from one of the vaccines covered by the program (GAO, 2014; HRSA, 2011). To be eligible for compensation, a petition must be filed (1) for a vaccine-related injury within three years of the first symptom of the injury (or significant aggravation of an injury), or (2) for a death within two years of the death and within four years after the first symptom of the vaccine-related injury (or significant aggravation of an injury) from which death resulted (GAO, 2014). In order to file a claim several components must be completed: submission of prenatal and birth records, medical records prior to vaccination, vaccination record (if available), post-injury hospital/emergency treatment records, post-injury out patients records, Vaccine Adverse Event Reporting System (VAERS) form (if submitted), long term records, and death records (if applicable) (HRSA, 2011).

The United States Court of Federal Claims decides who will be paid; however there are two Federal government offices who also

have a role in the VICP, the United States Department of Health and Human Services (HHS), and the United States Department of Justice (DOJ) (HRSA, 2011). For claims that are compensated, there are three adjudication categories: concession, negotiated settlement, and contested decision in favor of the petitioner. In a concession, the petitioner is found entitled to compensation because there is evidence that meets the criteria of the vaccine injury table or because it is more likely than not that the vaccine caused the injury. In negotiated settlements, the petition is resolved via negotiation between the HHS and the petitioner. However, if the petitioner does not concede that a petition should be compensated or if both parties do not agree to settle, the special master issues a decision after weighing the evidence presented by both sides (which may involve conducting a hearing) (GAO, 2014).

Although it is the primary focus of this research to conclude whether the VICP has established a more efficient method for victims of vaccine injury to be compensated, the politics surrounding vaccinations must be taken into consideration as well. Vaccine production is a costly, rigidly controlled series of processes performed in facilities that meet cGMP standards. These processes are designed and validated by the manufacturer but approved by the U.S. Food and Drug Administration (FDA). Vaccine production and distribution are almost exclusively the responsibility of vaccine companies and private distributors (Orenstein et. al., 2005). As of 2004, there were only five major commercial manufacturers of vaccines that are widely used in the Unites States and although the number of recommended vaccines has increased in the past two decades, the number of commercial manufacturers in 2004 was the same as in 1983 (Orenstein et. al., 2005).

The FDA also has the responsibility for assuring that licensed vaccines are safe and effective, as well as establishing criteria for release of vaccine. The FDA also has the authority to recall vaccines because of safety or effectiveness problems (Orenstein et. al., 2005). Recommendations for vaccines are primarily left to the Centers for Disease Control (CDC) through its Advisory Committee on Immunization Practices (ACIP) and by professional societies (Orenstein et. al., 2005).

Method

The data for this research was collected from the U.S. Government Accountability Office, the HHS's Health Resources and Services Administration, the Emory Program for Vaccine Policy and Development, and Boston University's 1992 legislative report. The method of analysis for this research was follows findings from an essential report conducted by the United States Government Accountability Office, for the Chairman and Committee on Oversight and Government Reform in the House of Representatives. The GAO used data and information from the federal agencies involved in administering the program and managing the Vaccine Injury Compensation Trust Fund, and from stakeholders. Specifically, to examine how long it has taken to adjudicate VICP claims the GAO examined VICP data and interviewed officials from the HHS's Health Resources and Services Administration (HRSA), which administers VICP; the Department of Justice (DOJ), which represents the HHS in VICP proceedings; and the U.S. Court of Federal Claims (USCFC) and the Office of Special Masters within the USFCF that adjudicates VICP claims (GAO, 2014).

While the purpose of the report by the GAO was to examine (1) how long it has taken to adjudicate claims and how claims have been adjudicated, (2) the changes to the vaccine injury table, and (3)

how the balance of and spending from the Vaccine Injury Compensation Trust Fund have changed, among other objectives, I used their data and statistics to determine if the VICP had created a streamlined system for compensation in instances where injury has resulted from vaccination.

For the purposes of this research, I used the goal of adjudication time for claims through the VICP, three and a half years or 1,300 days, to determine if the program was creating a streamlined system for compensation. If the average adjudication time was greater than three and a half years, the program would have been categorized as not establishing an effective system for victims of vaccination injury to be compensated; if the average adjudication time would have been less than three and a half years, then the VICP would be categorized as an effective way to compensate vaccination victims.

Analysis & Results

The impact of vaccination has been dramatic in the United States. Figure 1 provides the annual morbidity during the twentieth century for many of the vaccine preventable diseases of childhood, most often in the years prior to vaccine availability, compared with reports of these diseases in 2004 (Orenstein et. al., 2005). In a study by Orenstein et. al., they found that all diseases have been reduced by at least 87 percent, and most by 99 percent or more (2005). These disease reductions are associated with record or near record highs in immunization levels among young children (Orenstein et. al., 2005).

Figure 1: Comparison of Representative Twentieth-Century Annual Morbidity & Current Morbidity Form Vaccine-Preventable Diseases, United States

Disease	Twentieth-Century annual cases	2004 cases	Percent decrease
Smallpox	48,164	0	100
Diphtheria	175,885	0	100
Measles	503,282	37	99.99
Mumps	152,209	236	99.85
Pertussis	147,271	18,957	87.13
Polio (Paralytic)	16,316	0	100
Rubella	47,745	12	99.97
Congenital rubella syndrome	823	0	100
Tetanus	1,314	26	98.02
H. influenza, type b and unknown (<5 years)	20,000	172	99.14

Source: Adapted from U.S. Centers for Disease Control and Prevention, as cited in Orenstein et. al., 2005

In November 2014, the United States Government Accountability Office reported an in-depth review of the VICP and its claims since the 1999 fiscal year. The GAO was asked to examine (1) how long it has taken to adjudicate claims and how claims have been adjudicated, (2) the changes to the vaccine injury table, and (3) how the balance of and spending from the Vaccine Injury Compensation Trust Fund have changed, among other objectives.

There was a wide range in the amount of time it took to adjudicate claims through the VICP. The claim that took the shortest amount of time was two days while the claim that took the longest was 5,276 days (GAO, 2014). The GAO found that the average time it took to adjudicate a claim was five and a half years between 1999 and 2014. More than 900 of the claims filed since the fiscal year 1999 were still pending, which would cause this average to increase over time as these pending claims are resolved (GAO, 2014). As of March 31, 2014 from more than 9,800 claims filed from 1999-2014, eleven percent (1,046 claims) were pending; eleven percent (1,049 claims) took less than one year; thirteen percent (1,232 claims) took more than one year and up to two years; sixteen percent (1,523 claims) took more than two year and up to five years; fifty-one percent (4,983 claims) took more than five years to adjudicate. Figure 2 displays the information from the GAO's report (GAO, 2014).

In 2009, the VICP placed a goal of 1,300 days (about 3.5 years) to adjudicate claims. The GAO report found that of claims filed from 2009 to 2014, the average amount of adjudication time for a claim was a little more than one and a half years (587 days). A greater percent of claims filed since 2009 were resolved within one to two years. Of more than 1,400 claims made to the VICP since 2009, forty percent (949 claims) were pending; nineteen percent (448 claims) took less than one year; twenty-four percent (581 claims) took more than one year and up to two years; seventeen percent (417 claims) took more than two years and up to five years; and zero percent (2 claims) took more than five years to adjudicate. Figure 2 shows the results. The GAO report also found that in an overwhelmingly large majority of years since 2009, the VICP did meet its intended goal of averaging three and a half years to adjudicate claims (GAO, 2014).

From 1999 to 2008, of the 7,436 claims filed, the average adjudication time was 5.1 years (1,845 days). Compared to the average adjudication time of claims from 2009 to 2014 (1.6 years, 587 days), the shortened adjudication time in the VICP is evident.

Figure 2: Time Taken to Adjudicate National Vaccine Injury Compensation Program Claims Filed, as of March 31, 2014

	1999 to 2014	2009 to 2014
1 year or less	11% (1,049 claims)	19% (448 claims)
More than 1 year and up to 2 years	13% (1,232 claims)	24% (581 claims)
More than 2 year and up to 5 years	16% (1,523 claims)	17% (417 claims)
More than 5 years	51% (4,983 claims)	0% (2 claims)
Pending	11% (1,046 claims)	40% (949 claims)
Pending Time	Less than 2 years	Less than 1 year
Total Number of Claims	9,833 claims	2,397 claims
Average Adjudication Time	3.32 years (1,213 days)	1.6 years (587 days)

Source: GAO analysis of U.S. Court of Federal Claims

It is important to note that pending claims were not considered when averaging the adjudication time for claims. For claims filed from 1999 to 2014, of the pending claims, most had been pending for less than two years; from 2009 to 2014, of the pending claims, more than half had been pending for less than one year. However, the U.S. Court of Federal Claims (USCFC) found that when there were delays in adjudication claims, they typically occurred while petitioners gathered evidence for their claims. It is also important to consider that while a majority of claims filed in the

first decade of the program, since the addition of the influenza vaccine, the majority of claims filed involved vaccines not covered by the VICP (GAO, 2014). The GAO also noted that while most of the vaccines covered by the VICP are included because they are recommended for children, many of the program's petitioners in recent years have been adults who received covered vaccines (GAO, 2014).

With the federal government's involvement of vaccination standards and procedures, skepticism among critics of the VICP has continued to rise. While the GAO report found that compensation is being negotiated within a reasonable time frame, opponents of the VICP claim that, "many vaccine victims are left waiting without support and financial assistance for years on end, while their case snakes its way through red tape" (Mercola, 2014). In a statement made by the National Vaccine Information Center president, Fisher argues that the HRSA website provides statistics that two out of three individuals applying for vaccine injury compensation have been turned away empty handed; even though only about $1.8 billion dollars has been awarded to more than 2,200 plaintiffs out of some 12,000 who have applied. Skepticism arises while there is $2.7 billion dollars sitting unawarded in the VICP Trust Fund with "people suggesting all sorts of ways to use that money for all sorts of reasons other than for compensating vaccine victims" (2008).

The NVIC claims that since the establishment of the VICP, liability has become an even bigger problem with vaccines.

> "That liability protection has made it easy for the CDC and AAP to narrow contraindications to vaccination so severely that almost no health condition qualifies as a reason not to vaccinate, placing many more vulnerable children at higher risk for suffering vaccine reactions

> that are often dismissed by pediatricians and government health officials alike as "a coincidence." It is no wonder that estimates for reporting of vaccine associated health problems, hospitalizations, injuries and deaths by vaccine providers to the VAERS system is only between one and ten percent" (Fisher, 2008).

The NVIC argues that liability protection has made it easy for nine new vaccines to be added to the childhood vaccine schedule, some of them fast tracked, without any studies being conducted to evaluate the potential long term health effects of giving children an unprecedented number of vaccines throughout childhood (Fisher, 2008). The VICP's statement went on to say that,

> "there has been no attention paid by industry and government to minimizing vaccine risks, including no scientific research – as the Act called for – into identifying individuals at high risk for suffering vaccine adverse responses so their lives can be spared – speaks volumes about the disconnect between the intent of Congress to prevent vaccine injuries and deaths and the intent of those operating the federal compensation system to deny they exist" (Fisher, 2008).

According to the VICP, this is why many parents maintain the opinion that the Vaccine Injury Compensation System is a failed experiment in "tort reform" that should be repealed. They believe the vaccine injured should be able to return to the courts, where discovery is allowed, to sue vaccine manufacturers for design defect and failure to warn and sue pediatricians who carelessly implement one-size-fits-all vaccine policies rather than adhere to the precautionary principle to "First, do no harm" (Fisher, 2008).

Others argue that the government seems intent on keeping the VICP's 'public profile low,' and the lack of public awareness is now of major concern. Federal officials operating the VICP have vowed to publicize the program better, promising improvements in its literature and website, but according to critics, the VICP directors didn't began taking action on publicity until after the congressionally requested Government Accountability Office (GAO) inquiry began in November 2014 (Mercola, 2014). Skeptics of the VICP continue to argue that public outreach has been largely ignored since the program's inception (Mercola, 2014):

> "One of the most overlooked provisions of the act was the requirement that the HHS Secretary conduct public awareness and outreach programs to inform the general public about the program and the eligibility to file a claim for either a vaccine-related injury or death…this provision has been greatly ignored by the HHS Secretary" (Rohde, 2014 as cited in Mercola, 2014).

Critics of the VICP also argue that the Vaccine Injury table was a "political solution to a political problem," and that it was created to avoid disputes about whether a vaccine caused adverse reactions at all. Others argue that the table was designed to 'sidestep' the problem of relitigation in each case and compensate on the basis of medical condition (where the other eligibility criteria were met) (Mariner, 1992). Mariner argued that despite, or perhaps because of, the table's simplicity, disputes over causation have been common (1992).

Often there is disagreement over the appropriateness of including a particular condition in the table at all (Mariner, 1992). Early on, division medical reviewers conceded some discomfort with

the table; some found it difficult to assimilate the difference between actual causation of injury and the legal causation established by the table (Mariner, 1992). Petitioners were equally convinced their injuries resulted from vaccination, their attorneys easily accepted the table's concept of legal causation, and several viewed the search for alternative causation as an unnecessarily adversarial tactic. These problems demonstrate the practical difficulties of creating and applying a list of compensable injuries (Mariner, 1992). While these arguments against the VICP were taken into consideration for this research, all of the claims made in opposition of the VICP were unsubstantiated and lacked valid proof of their claims.

Conclusion

When vaccines first began to be widely used, people who experienced serious side effects from vaccination had little recourse to compensation from manufacturers, physicians, or the government. In the early 1980s after reports of serious side effects from the DTP (diphtheria, tetanus, pertussis) vaccine, questions about the safety of vaccines began to circulate. According to the Institute of Medicine Committee, "some individuals are more susceptible to suffering harm from vaccines because of biological, genetic, and environmental risk factors, but most of the time doctors cannot predict who will be harmed because there are few scientific studies that have evaluated vaccine risks for individuals" (IOM, 2012 as cited in Mercola, 2014). Parents filed lawsuits against healthcare officials and vaccine companies, some of which decided to stop making vaccines, which in turn created a vaccination shortage (HRSA, 2011).

As a result, Congress was pushed to enact the National Childhood Vaccine Injury Act of 1986. The act created the National Vaccine Injury Compensation Program (VICP) in 1989, a

compensation program for people injured by certain pharmaceutical products as "an alternative to traditional products liability and medical malpractice litigation for persons injured by their receipt of one or more standard childhood vaccines" (Department of Justice, 2014). VICP provides compensation to people for injuries and deaths associated with certain vaccines for medical and other costs (GAO, 2014). The VICP was designed to encourage childhood vaccination by "providing a streamlined system for compensation in rare instances where an injury results from vaccination" (Department of Justice, 2014).

This research sought to discover if the establishment of the National Vaccine Injury Compensation Program created a streamlined system for compensation in instances where injury has resulted from vaccination. I hypothesized that there would have been a shortened adjudication time from the VICP's initial creation and the results of this research supported that claim. The findings from this research concluded that the VICP did in fact create a streamlined system for compensation in instances where injury has resulted from vaccination due to the shortened average adjudication time in claims, as well as the program meeting its initial goal of the averaging three and a half years to adjudicate claims since the 2009.

It is important to note that this study primarily focused on data from four essential federal agencies: the U.S. Government Accountability Office, the HHS's Health Resources and Services Administration (HRSA), the Department of Justice (DOJ), and the U.S. Court of Federal Claims (USCFC) and the Office of Special Masters within the USFCF. While these sources provided valid data for this research, in order to truly determine if the VICP is creating a faster way for victims of vaccine injuries to receive compensation,

another source would need to recreate a similar study to that of the GAO's November 2014 report.

Furthermore, claims of underreporting injuries caused by vaccines to both the VICP and the VAERS should be taken into consideration as a limitation to this research. The Vaccine Adverse Event Reporting System (VAERS) is a national vaccine safety surveillance program that collects information about the adverse events and possible side effects that occur after the administration of vaccines licensed for use in the United States (VAERS, 2015). Since the creation of the VICP in 1989, there have been about 9,800 claims; in 2014 alone, over 33,000 reports were made to the VAERS (GAO, 2014; VAERS, 2015). While consideration that a large majority of these claims can range from soreness around the vaccine injection site, to death as a result of a vaccination, issues with underreporting or filing claims through the VICP are of primary concern.

While vaccines can cause injury and in rare cases, result in death, vaccines overwhelming save more lives than they hurt. The amount of claims made to the VICP since its establishment in 1989 (about 9,800), in comparison to the millions of children and people that vaccines have prevented disease from, should set a clear example of the good that vaccinations do. Understanding the risks that come with all vaccinations is an essential part of being a well-informed citizen and patient. It is important to understand that even though vaccines pose potential harm, as a nation we must continue with further advancement on vaccinations. The optimal way to compensate injuries would be by means of a universal compensation system; however, until a universal system gains political acceptance, there is a role for the National Vaccine Injury Compensation Program in the United States (Mariner 1992).

Figure 3: Vaccine Injury Table	Fiscal Year															
Vaccines	**'99**	**'00**	**'01**	**'02**	**'03**	**'04**	**'05**	**'06**	**'07**	**'08**	**'09**	**'10**	**'11**	**'12**	**'13**	**'14[1]**
Vaccines and Injuries Added to the Table before Fiscal Year 1999																
Tetanus- containing	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Pertussis- containing	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Measles, mumps, rubella in any combination	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Measles- containing	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Rubella- containing	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Polio live virus- containing	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Polio inactivated virus-containing	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hepatitis B	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hemophilus influenza type b (Hib) conjugate[2]	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o
Varicella[2]	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o
Vaccines and Injuries Added and Proposed to be Added to the Table During and After Fiscal Year 1999																
Rotavirus[3]	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	+	+
Pneumococcal conjugate	–	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o
Hepatitis A	–	–	–	–	–	–	o	o	o	o	o	o	o	o	o	o	o
Trivalent influenza[5]	–	–	–	–	–	–	o	o	o	o	o	o	o	o	o	o	o
Meningococcal	–	–	–	–	–	–	–	–	o	o	o	o	o	o	o	o	o
Human Papillomavirus	–	–	–	–	–	–	–	–	o	o	o	o	o	o	o	o	o
Vaccines and Injuries Added and Removed from the Table since Fiscal Year 1999																
Hib polysaccharide (unconjugated)	●	●	●	●	–	–	–	–	–	–	–	–	–	–	–	–	–
Rotavirus rhesus-based	–	–	–	●	●	●	●	●	●	●	●	●	–	–	–	–	–

Legend

• = at least one injury specified for this vaccine on the table at any point during the fiscal year

(+) = HHS issued a proposed rule to add an injury to the table during the fiscal year

[0] = there was no table injuries specified for this vaccine

– = the vaccine is not on the table

[1]The information in this column is up to date as of September 17, 2014

[2]Hemophilus influenza type b conjugate and varicella vaccines were added to the table effective August 6, 1997

[3]Rotavirus was added to the table effective October 22, 1998. HHS issued a proposed rule on July 24, 2013, to add an injury to the table associated with rotavirus vaccine. However, the rule was not finalized before the end of the fiscal year 2014.

[4]Pneumococcal conjugate vaccine was added to the table effective December 18, 1999.

[5]Trivalent influenza vaccine was added to the table effective July 1, 2005. All additional seasonal influenza vaccines, including quadrivalent vaccine, are covered by VICP, effective November 12, 2013.

Figure 3, Source: GAO Report 2014

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