


**IMPROVING
VACCINATION
COVERAGE RATES IN
ADULT POPULATIONS:
A HANDBOOK FOR
HEALTH MANAGERS
AND POLICYMAKERS**



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This modular handbook equips health managers and public health professionals with evidence, resources, and guidance to replicate and adapt proven strategies and ultimately close gaps in vaccination coverage for adult populations.

This edition (2026) has a particular focus on pneumococcal vaccination and includes case studies related to accessibility and policy, namely vaccination in pharmacies, the political process of vaccine legislation, the use of digital reminder schemes, and advocacy in public health. This EHMA Handbook highlights aspects of each case study that have the potential to inspire other national/regional health systems in Europe, with an emphasis on **simplicity, visibility, measurability, and sustainability**.

Users looking to improve their existing adult vaccination programmes are encouraged to review these case studies, which are supplemented with extensive expertise from interviews with the professionals who worked directly on each case.

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Introduction: Adult vaccination needs a systems upgrade

Europe's population aged 65 and over already exceeds 20% of the continent's total population, and this proportion is projected to approach 33% by 2050.¹ These older adults bear a disproportionate share of vaccine-preventable disease burden caused by the most common infectious diseases, yet vaccination coverage against key respiratory pathogens remains sub-optimal:



Seasonal influenza: The median vaccination coverage rate among older adults in the EU was 45.7% in 2023–2024, with only two Member States reaching the EU and WHO target of 75% coverage.²



Pneumococcal disease: The average vaccination coverage rates in Europe are 17.95% for adults in clinical risk groups and 24.20% for older adults while coverage rates for children are at a much higher 88.30%.³



COVID-19 annual dose: The median vaccination coverage rate in Europe among adults 60 years and older was 8.7 % in 2024–2025.⁴



RSV: The first vaccine for older adults was approved by EMA in July 2023, and vaccination coverage data is not yet reliable.

Taking pneumococcal disease as an illustrative example: hospitalised older adults face a 12–13% 30-day mortality and more than 90% have chronic comorbidities.⁵ Pneumococcal disease also exacerbates the burden of non-communicable diseases (NCDs) because people with chronic conditions are at higher risk of infection, which in turn increases their risk of suffering additional clinical complications.⁶ Considering the direct and indirect effects of pneumococcal disease, immunisation needs to be an integral part of our broader public health strategies.

Within this context, this EHMA Handbook aims to help health managers and public health professionals translate policy ambition into real-world impact, drawing on proven models and case studies to help close adult immunization gaps and contribute to healthy ageing across Europe. From a societal perspective, this is particularly relevant as governments struggle to navigate a changing economic outlook through a focus on building competitiveness, a goal that will not be achieved without securing the mental and physical well-being of their populations.⁷

¹ Eurostat 2024. https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Population_structure_and_ageing

² ECDC Survey Report: <https://www.ecdc.europa.eu/en/publications-data/survey-report-national-seasonal-influenza-vaccination-recommendations>

³ International Longevity Centre UK. 2023. <https://ilcuk.org.uk/european-pneumococcal-vaccination-a-progress-report/#:~:text=There%20are%20disparities%20in%20pneumococcal,groups%20receive%20the%20pneumococcal%20vaccination>

⁴ ECDC COVID 19 Vaccine Report: <https://www.ecdc.europa.eu/en/publications-data/covid-19-vaccination-coverage-eueea-during-2024-25-season-campaigns>

⁵ Vila-Corcoles et al., 2008; Cheong & Song, 2024

⁶ Fukuda et al. 2022. <https://www.sciencedirect.com/science/article/pii/S1201971221012637>

⁷ Szczepańska-Woszczyzna et al. 2024. <https://www.ceeol.com/search/article-detail?id=1254893>

Background: Infectious respiratory disease prevention in adult populations in Europe

Policy landscape

Across Europe, the policy scaffolding for adult immunisation has advanced faster than its translation into sustained, system-level practice. At the EU level, instruments such as the **2018 Council Recommendation on strengthened cooperation against vaccine-preventable diseases**⁸ and the **EU-JAV Joint Action on Vaccination** expanded consensus on shared goals, routine data reporting, and exchange of best practices.

The most recent European initiative to include policy provisions related to prevention is the **EU Cardiovascular Health Plan (The Safe Hearts Plan)**, the content of which was released in December 2025. This proposed strategy from the European Commission directly acknowledges the importance of prevention through vaccination in broader health system action, stating that ‘Vaccination against infections, e.g. influenza, SARS-CoV-2, RSV, pneumococcal disease... is an effective measure to prevent cardiovascular complications in high-risk groups.’ This will be addressed by a flagship proposal for a Council recommendation on vaccination against respiratory infections as a preventive measure for cardiovascular diseases, and support for Member States in identifying target populations and improving vaccination monitoring and coverage. The Plan also notes that ECDC will provide guidance and capacity-building to strengthen national immunisation information systems and registries for CVD-risk groups, as well as targeted training to healthcare professionals on the link between key vaccine-preventable diseases and CVD.

While this level of political intent is promising for future developments, the current reality in most Member States is that adult vaccination programmes for many respiratory pathogens still operate without clear, harmonised coverage targets or the funding and delivery arrangements that make such targets achievable. In other words, Europe has some policy intent but has seen uneven implementation and a lack of urgency.

Where action has occurred, it often demonstrates the power of **simple rules and stable financing**. Italy’s **National Prevention Plan** embedded a **75% coverage target for pneumococcal vaccination** in adults aged 65+ in 2017, and regions such as Veneto and Lombardia have implemented this with clear age-based offers and local delivery plans.⁹ These examples matter because they show that adult vaccination coverage targets, which are more familiar in paediatric settings, can be defined for older cohorts and then embedded into regional contracting, primary-care workflows, and seasonal campaigns.

Civil society and expert groups have also stepped in to fill technical and advocacy gaps. The European Society of Cardiology has come out with a **Consensus Statement** explicitly describing the pivotal role of vaccination in the prevention of cardiovascular events. The **Adult Immunisation Board (AIB)**, a standing group of European experts, has positioned itself as a central reference point for evidence, implementation guidance, and progress monitoring on adult vaccination programmes, supporting national managers with practical, cross-country learning.

⁸ Council of the EU 2018: [https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32018H1228\(01\)](https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32018H1228(01))

⁹ Italian Ministry of Health. 2023. <https://www.quotidianosanita.it/allegati/allegato1679488094.pdf>

As a further show of progress, the European Commission has announced an **upcoming EU call for tenders** for a policy study on strategies to increase vaccine uptake in adult populations, following up on its larger **Overcoming Obstacles to Vaccination** project and signalling a renewed focus on the specific operational barriers that persist for older adults and risk groups.

Taking pneumococcal disease as an illustrative example, recent analyses by the **International Longevity Centre (ILC) U.K.** underline three policy levers that most countries have yet to adopt systematically: (1) **life-course recommendations** that cover older adults, clinical risk groups, and children; (2) **full public funding** so adults face no point-of-care charges; and (3) **annual reporting obligations** to the ECDC (or to WHO/Europe for non-EU countries) so progress and gaps are visible year on year.¹⁰ ILC's **Pneumococcal Atlas** confirms wide **east-west and within-region variation** in both recommendations and funding: only **about 60% of countries** recommend vaccination for older adults, clinical-risk adults, and children, and **just 15 countries** fully reimburse or cover pneumococcal vaccination for all three groups.¹¹ That heterogeneity translates directly into uneven uptake and persistent inequity.

The Danish experience, which is expanded upon later in this handbook, highlights a different policy challenge: **discontinuity**. Denmark's **adult pneumococcal NIP expired in January 2023** and was not renewed, leaving a widening protection gap for older cohorts and risk groups as immunity wanes.¹² Because the expired programme did not cover all older adults, a portion of the 65+ population never received a dose; additionally, by **2026**, an estimated **1.1 million Danish adults vaccinated during the temporary programme will require revaccination** to avoid renewed risk. As European health systems aim to stabilise winter pressures and promote healthy ageing, **policy durability** will determine whether adult programmes can hold the gains they make.

Finally, policy attention has focused extensively on **workforce and care setting** as enablers, not ends in themselves. The ECDC has repeatedly urged countries to pair vaccination of higher-risk groups with **vaccination of healthcare workers**, and to reinforce **infection-prevention measures in healthcare settings** to reduce nosocomial transmission in winter seasons.¹³

Complementary stakeholder positions reinforce these priorities, with a broad consensus supporting the **EHMA Call to Action** on a **75% vaccination coverage rate target for pneumococcal vaccination**, with many calling on governments to also adopt **national pneumococcal vaccination programmes with full funding**, and on the **ECDC** to make **annual, disaggregated reporting** a standard requirement for EU/EEA countries. Together, these moves point toward a maturing policy landscape—one that recognises a life-course approach to immunisation and specific considerations for adult vaccination: **age-based where possible, risk-based where necessary, fully financed, and transparently measured.**

¹⁰ European Pneumococcal Vaccination: A Progress Report. ILC 2023.

¹¹ Pneumococcal Vaccination Atlas. ILC 2025. <https://pneumoniaatlas.org/>

¹² Pneumococcal Disease 2020–2023, SSI.

¹³ ECDC urges immunisation and other measures as Europe enters respiratory virus season. ECDC 2025.

Vaccination coverage & surveillance landscape

If policy sets the ambition, **surveillance** shows us whether health systems are closing the gap. Europe's surveillance picture remains **fragmented for adult cohorts**, and that fragmentation is reflected in persistently low vaccination coverage rates. On influenza, which is typically a bellwether for adult programme performance, the **2023/24 season** saw most countries fall well below the **75%** WHO and EU target for older adults, with many reporting **coverage under 50%**. Only a small group approached or met the benchmark (e.g., Denmark at 76%, Ireland 75%, Portugal 71%, Sweden 68%), and among **healthcare workers** the median was lower still, near **32%**.¹⁴ Against this backdrop, the ECDC's seasonal advisories emphasise the public-health return on vaccinating **higher-risk groups and healthcare workers**, paired with well-run infection-control in care settings. This is complemented by findings about the societal return on investment in adult immunisation programmes, which have been estimated to **return their initial costs 19 times over, a figure that rises to 33x when looking specifically at pneumococcal vaccines**.¹⁵

Again, taking **pneumococcal vaccination** as an illustrative example, the **data deficit** for adult immunisation programmes represents a significant challenge to effectively protecting public health. According to ILC's cross-country compilation, **98% of countries** reported on **childhood** pneumococcal vaccination, but **only 26%** collected any data for **clinical-risk adults and older adults**.¹⁶ The gap is not trivial: it deprives managers of the most basic tools like **denominators, timely uptake curves, and equity cuts**, and makes it difficult to target catch-up efforts or defend budgets. Where adult data do exist, they are sobering. **Average vaccination coverage rates** are **18%** for clinical-risk adults and **24%** for older adults, in stark contrast to **88%** in children.¹⁷ These figures mirror what managers see at the clinical level: strong paediatric rails, but adult pathways that are still opt-in, fee-exposed, or dependent on ad-hoc seasonal campaigns.

Country-level lenses can further illustrate how **measurement, funding, and awareness** interact. In **Portugal**, older adults bear the brunt of invasive pneumococcal disease: those **≥65** account for **more than 60%** of confirmed cases, and **84% of hospitalisations for bacterial pneumonia** occur in adults **≥60 years old**. Portugal also records the **highest pneumonia mortality rate in Europe (57.7 per 100,000)**, underlining the stakes for timely adult vaccination.¹⁸ Public awareness also lags behind this disease burden: while **96%** of adults **>50** say they know what pneumonia is, **only 40%** know a **vaccine exists**, and just **26%** of those **≥65** consider themselves at high risk even though most meet medical criteria for vaccination. Not surprisingly, **annual adult pneumococcal vaccination** in those **≥65 years** old has hovered around **10%**, with projections suggesting that **less than half** of older adults would be vaccinated even by 2029 without policy change.¹⁹ These Portuguese data exemplify a wider European pattern: where adults pay at the point of care and where **registries do not routinely report adult uptake**, vaccination remains low and inequitable.

¹⁴ ECDC urges immunisation and other measures as Europe enters respiratory virus season. ECDC 2025.

¹⁵ Office for Health Economics. 2024. <https://www.ohe.org/publications/the-socio-economic-value-of-adult-immunisation-programmes/>

¹⁶ Pneumococcal Vaccination Atlas. ILC 2025. <https://pneumoniaatlas.org/>

¹⁷ European Pneumococcal Vaccination: A Progress Report. ILC 2023.

¹⁸ Observatório Nacional Doenças Respiratórias 2023. APCSD. https://www.apcsd.pt/docs/FundPulmao-ONDR_2023.pdf

¹⁹ PneuVUE. Ipsos 2016.

Case study: Involving pharmacists in adult vaccination programmes in France

Stakeholders interviewed for this case study

Community pharmacists (rural/urban), pharmacist educators/union officers, GP association leaders and practice managers, public-health managers, payer medical advisers, immunisation IT product leads, hospital pharmacists, older-adult and chronic-disease advocates.

Background

France's pharmacy-based vaccination programme grew out of broader European efforts to diversify immunization delivery beyond traditional settings and professions to improve the accessibility of vaccination. In two départements in 2017 the French Ministry of Health began piloting influenza vaccination in community pharmacies to improve access in rural and underserved areas, with expansion of this program across the country in 2019. This programme was expanded again in 2021 during the COVID-19 pandemic. Building on early success and positive patient feedback, stakeholders including the National Council for the Preservation of Heritage Establishments (CNGECP) and the French Pharmacy Union advocated for permanent establishment of this programme. Starting in 2023, trained pharmacists were officially authorised to prescribe and administer all vaccines in the national schedule to adolescents (from 11 years old) and adults.²⁰ This marked a milestone towards delivering more preventive care in community settings to offer better access to at-risk older adults.

At a glance:



Low baseline coverage: As an example, pneumococcal vaccine uptake among at-risk French adults was estimated to be between 4.5–20% before September 2022.



Efficacy of pharmacist involvement: In a review of 36 studies, all of them found an increase in vaccine coverage when pharmacists were involved in the immunization process, regardless of role (educator, facilitator, administrator) or vaccine administered (e.g., influenza, pneumococcal).²¹



Cost-effectiveness of pharmacist involvement: A 2023 systematic review found that pharmacy-based immunisation (PBI) programmes lowered the direct costs per adult influenza and pneumococcal vaccination by 16–26%.²²

²⁰ Haute Autorité de Santé: https://www.has-sante.fr/jcms/p_3312462/fr/elargissement-des-competences-en-matiere-de-vaccination-des-infirmiers-des-pharmaciens-et-des-sages-femmes-chez-les-adolescents-de-plus-de-16-ans-et-les-adultes

²¹ Isenor et al. 2016: <https://pubmed.ncbi.nlm.nih.gov/27765379/>

²² Romero-Mancilla et al. 2023: <https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2023.1152556/full>

The Health Manager's Playbook for pharmacy-based adult vaccination

Example scenarios where this playbook can be applied:

- Regions aiming to expand capacity to pharmacies.
- Countries piloting pharmacist vaccination before national rollout.
- Jurisdictions with rural or peri-urban access gaps.
- Programmes targeting co-administration gains.
- Payers looking for cost-effective uptake.
- Health systems needing GP-pharmacy harmony.
- Programmes preparing for seasonal surges.

Design principles that transfer:

Simplicity at a milestone age

A single, age-triggered recommendation (e.g., “one pneumococcal dose at 65”) yields faster uptake than complex step sequences. France’s 2025 calendar change is a practical example of how policy simplicity powers operational scale in community settings.²³

Authorise the whole act

Where law permits, allow trained pharmacists (or nurses in retail clinics) to complete assessment + administration + documentation + GP notification under one SOP. Fragmentation at any point (e.g., needing a separate prescription visit) hurts eventual conversion rates. France’s 2023 decree is a useful reference for scope drafting.²⁴

Ensure transparency with primary care

Shared records (national immunisation registry or patient EHR) and automatic notifications to nominated GPs helps to defuse tensions between different layers of care provision, supporting continuity of care.

²³ Calendrier vaccinal: Quels changements pour 2025? <https://www.service-public.gouv.fr/particuliers/actualites/A16520>

²⁴ Décret n. 2023-736. <https://www.legifrance.gouv.fr/jorf/id/JORFTEXT000047948973>

Design principles that transfer:



Phase 0 – Coalition & guardrails

Form a tight steering group (pharmacy body, GP body, public health authority, payer, patient rep). Approve a two-page '**Conditions of Participation**': trained vaccinator on duty, privacy space, anaphylaxis kit + drill, standard consent, registry entry, GP notification, and adverse event following immunization (AEFI) reporting route. (In France these elements are formalised by decrees/arrêtés; use them as drafting inspiration.)

Expert tip: Run a 90-minute tabletop (anaphylaxis + data/notification rehearsal). Trust went up immediately in pilots when everyone saw the same practices work end-to-end.



Phase 1 – Engineer the 60-second “say-yes-now” journey

Configure point-of-service systems to flag eligibility when the citizen's ID/insurance card is read. Train staff in a three-line script such as the one in the example below (adapted to the realities of your local context):

1. Inform: “At 65, your risk from pneumococcal infection rises – guidelines recommend one dose of the vaccine.”
2. Recommend: “We can do it safely here now; it takes ~10 minutes.”
3. Close: “Shall we do it today? We'll add it to your record and notify your GP.”

Offer co-administration (e.g., pneumococcal vaccination alongside influenza vaccination in season) where clinically appropriate; standardise observation and after-care.

Expert tip: Display clear out-of-pocket cost (or “free”) at the counter; uncertainty about costs leads to vaccine aversion.



Phase 2 – Simplify data flows

Establish a minimum viable information flow: site record » national immunisation record » GP notification » payer claim. Start with a simple weekly dashboard covering doses, eligible-to-vaccinated conversion, co-administration rate, AEFIs, and equity gaps where data allows (rural/urban, migration background). Don't wait for the perfect national system; a regional spreadsheet or dashboard is fine early on.



Phase 3 – Finance for throughput & equity

Plainly tariff the admin and documentation of the act of vaccination. Add small, simple equity micro-incentives (e.g., outreach days in low-coverage postcodes) suited to your local context and data availability. Incentives can also be extended directly to pharmacists to promote their active engagement in vaccine promotion. Where pharmacy vaccination is not yet legal, offer a nominal “check-and-refer” fee when pharmacies verify eligibility and successfully book citizens into authorised sites



Phase 4 – Launch in waves, learn fast

Onboard 10–20 pharmacies first, then scale in monthly cohorts. Implement monitoring concepts like mystery-patient checks and near-miss logs to create conditions for continuous programme improvement. Publish monthly progress (including on equity factors) to sustain momentum.

Challenges to watch out for:

Professional friction (GPs)

- Cure = automatic registry visibility + prompt back-referrals for complex cases.

Seasonal overload

- Cure = establish predictable vaccination hours and occasional weekends (Oct–Nov); rotate staff between nearby sites.

Geographical coverage gaps

- Cure = host local vaccination pop-ups with municipal partners; move inventories as a cluster.

IT/billing problems

- Cure = run a systems pilot with a handful of claims before launch; distribute a laminated “quick-fix”

Case study: The policy process to include the pneumococcal vaccine in the Austrian National Immunisation Programme

Stakeholders interviewed for this case study

NITAG members/secretariat; Ministry public health and finance officials; Länder/region public-health directors; social insurer medical directors and contracting teams; GP and specialist society leaders; municipal health leaders; patient/senior NGOs; HTA/health-economics experts; parliamentary health-committee advisers; registry product owners.

Background

Austria's journey towards recommending and fully funding pneumococcal vaccination for older adults reflects a decades-long evolution of adult immunisation policy. Since the Austrian Agency for Health and Food Safety (AGES) recommended pneumococcal vaccines for adults ≥ 60 years in 2018, persistence from patient groups, professional societies (notably the Austrian Society for Pneumology or ÖGP), and other civil society stakeholders gradually raised awareness of coverage gaps. Despite strong clinical guidance, the absence of reimbursement via the national immunization programme kept uptake modest. For several years, a coalition of relevant stakeholders in Austria had been advocating to make access to pneumococcal vaccination free for all adults, aligning Austria with top-performing European vaccination programmes for adults.

Following from this momentum, Austria's National Vaccination Committee (NIG) officially made the recommendation that pneumococcal vaccination for adults be included in the NIP.²⁵ The ultimate decision-making authority, the Bundes-Zielsteuerungskommission (federal government, Länder, and social insurance/BZK), agreed in July 2025 to adopt this recommendation and make both the pneumococcal and herpes zoster vaccination available free of charge for adults ≥ 60 years old and defined risk groups, beginning at the end of 2025.²⁶ The BZK's announcement was echoed by the national health portal and social insurance communications, signalling cross-institutional commitment. The decision also accounts for the use of existing infrastructure - especially the e-Impfpass registry - to simplify implementation and accountability.²⁷

At a glance:



Recommendation vs. reimbursement: AGES has recommended pneumococcal vaccination for people ≥ 60 years old and older since 2018, but four years later, cost barriers limit the vaccination coverage rate to 11% of high-risk adults.²⁸

²⁵ Nationales Impfgremium. 2025

²⁶ Impfprogramm. 2025

²⁷ Impfpass. 2025

²⁸ Vaccines4Life. <https://www.vaccines4life.com/wp-content/uploads/2021/05/IAPVP-Report-Austria.pdf>



Impact of schedule inclusion: In a comprehensive study of NIPs in Europe, higher coverage rates were seen when NIPs were expanded to include free pneumococcal vaccination for older adults.²⁹ Pneumococcal vaccination programmes for adults have also been estimated to generate a 33-1 return on investment.³⁰



The power of civil society: Advocacy efforts by the Austrian Society for Pneumology (ÖGP), patient organizations (PVÖ, Seniorenbund), and physician's associations (e.g. Ärztekammer Wien) helped to persuade the Austrian NITAG towards a recommendation for reimbursement for adults aged 60+, which came into effect on 1 November 2025.

²⁹ Arya et al, 2023. <https://pmc.ncbi.nlm.nih.gov/articles/PMC10760380/>

³⁰ Office for Health Economics, 2024 <https://www.ohe.org/wp-content/uploads/2024/04/Socio-Economic-Value-of-Adult-Immunisation.pdf>

The Health Manager's Playbook for policy and advocacy around adult vaccination

Example scenarios where this playbook can be applied:

- Coalitions seeking a formal public programme expansion.
- Budget authorities demanding predictability.
- Jurisdictions standardising reimbursement nationally.
- Countries building public accountability.
- Parliamentary committees needing cross-party support.
- Regions planning co-administration strategies.
- Systems facing staff turnover or election cycles.

An actionable advocacy roadmap:



Step 1 – Create a Decision Map

Write one page showing the full scope of what reaching a fully reimbursed vaccine programme will require from different stakeholders:

- NITAG = technical recommendation
- Ministry = policy proposal
- Budget authority (steering council / payers) = funding decision
- Delivery system (GPs, public clinics; pharmacies if/when authorised) = implementation
- Registry = public dashboard with integrated tracking and monitoring to understand the impact of programming and address any gaps

Expert tip: Open all relevant meetings with a review of the Decision Map; it keeps activity focused on what actions are needed to move the process forwards.



Step 2 – Build a broad stakeholder coalition with a clear message

Bring together GP and specialist societies (pneumology, geriatrics, infectious diseases, GP), social insurers, regional public-health directors, municipal health managers, patient organisations, and employer groups. Work towards agreement on a 1-page shared message that focuses on key aspects of political persuasion:

1. The burden in older adults (e.g. hospitalisations, short-term mortality),
2. A simple structure for the proposed programme (e.g. milestone age such as 60 or 65; single-dose PCV where aligned with national advice),
3. Considerations for equity & predictability (free at point of care, sustainable budgeting).

Expert tip: Publish monthly minutes of coalition activities. Transparency between stakeholders helped to build credibility with decision-makers and media in Austria.



Step 3 – Produce a fit-for-purpose evidence & budget pack

Produce a policy brief presenting the most compelling available data on the health and economic burden of disease. Use local data where available and supplement with EU/EEA reports that underline the social and financial case for reimbursing an adult immunisation programme.

- Prepare an 'economic note' for decision-makers: programme cost, likely admissions avoided, and budget impact over 3–5 years under milestone-age uptake.
- Prepare an 'operational note' for decision-makers: delivery venues, recording in the national registry, targeting tools (invitations, public dashboards), and a co-administration rule (e.g., opportunistic pneumococcal vaccination during influenza visits).

Expert tip: Health ministry officials often respond to one graph in particular: "cost vs hospitalisations avoided over five years."



Step 4 – Open the policy window

Disseminate the prepared materials with strategic timing, such as alongside a seasonal pressure (e.g., winter respiratory infections burden) or the announcement of wider policy actions like a new healthy-ageing strategy.

- Stack endorsements from key stakeholders: Austria's July 2025 communications illustrate how layered and consistent endorsement announcements create momentum.
- Host site visits for decision-makers with the aim of showing them first-hand the potential impact of the proposed vaccination programme (clinic morning, GP chart review of unvaccinated 60+). Tangible experiences can have more impact than written publications.



Step 5 – Ensure a comprehensive policy decision

While any policy discussion is ongoing, ensure the final resolution text goes into sufficient detail by publishing important guidelines and keeping pushing policymakers for continued transparency.

- Details to specify include naming specific age cohorts (≥ 60 ; medical-risk), funding sources, start windows, and a duty to report coverage through existing channels.
- Publish a delivery blueprint outlining ideal approaches to procurement, provider contracts, co-administration with influenza/COVID, digital invitations, and equity considerations.

Objections to expect:

“We can’t afford it.”

- Cure = Conduct a simplified cost-effectiveness analysis to budget a 3-5 year net cost. For example, avoided hospitalisations and bed-days can be subtracted from programme costs, as well as the costs of cases avoided with vaccination. Highlight broad socio-economic returns for society (33x ROI). Phase cohorts (start ≥ 70 or high-burden regions) if needed to demonstrate value to decision-makers.

“Political turnover will stall the programme.”

- Cure = Lock decisions in durable formats. Seek cross-party sponsorship and adopt a formal resolution that includes coverage reporting duties, a timeline, and an independent evaluation date.

“The evidence isn’t strong enough / serotype dynamics are uncertain.”

- Cure = Anchor to burden + effectiveness + international precedents. Pair national IPD/clinical-risk data with up-to-date effectiveness summaries and experiences from comparable EU settings.

“Public demand is weak / hesitancy will blunt uptake.”

- Cure = Keep it simple with milestone-age messaging (“At 65, get your pneumococcal vaccine”), sent by health authorities and primary-care organisations. Use invitations, proactive recalls, and co-administration in scheduled seasonal visits.

Case study: Vaccine reminders using the digital-mailbox system in Denmark

Stakeholders interviewed for this case study

Digital mailbox product owners and policy leads; immunisation-registry architects/analysts; health-authority communications teams; GP organisation leaders; regional clinic managers; municipal elder-care teams; behavioural-science researchers; older-adult user-panel leads.

Background

Every citizen in Denmark has a digital mailbox called eBoks for corresponding with the government, which includes invitations and reminders for vaccination. Hence, Denmark's digital mailbox reminder system leverages the country's longstanding e-government infrastructure to nudge adults towards timely vaccination.

The eBoks/DK Post platform was introduced in 2014 to centralise all official digital correspondence under unique Central Person Register (CPR) identifiers. From 2018 onwards, public health researchers partnered with Digitaliseringsstyrelsen and the Danish Health Authority to integrate immunization registry data with automated messaging. From 2020-2023, this programme was temporarily expanded to include pneumococcal vaccination with the goal of reaching 75% coverage in adults 65+.³¹

Multiple nationwide, registry-based randomized controlled trials show that targeted electronic reminders are a cost-effective way to increase influenza vaccination coverage rates among at-risk adults: a rare example of gold-standard evidence at population scale. Similar studies for this intervention's impact on coverage rates for pneumococcal vaccination have not been conducted, but Denmark was highly successful in raising coverage in adults 65+ from almost 0% in 2020 to 75% by 2023, with the reminder programme likely having a significant contribution to this success.³²

At a glance:



Nationwide digital post: e-Boks/DK Post effectively reaches 90% of the entire Danish population via CPR-linked secure mail.³³

³¹ SSI EPI-NEWS no37. <https://en.ssi.dk/news/epi-news/2020/no-37---2020>

³² [Pneumococcal Disease 2020-2023](#), SSI.

³³ eBoks 2024 ESG Report. https://issuu.com/e-boks/docs/e-boks_communication_on_progress_esg_report_2024?fr=sNDdIMDg2NjE2NDc



Extensively evaluated through NUDGE-FLU trials: Nudging older adults to receive an influenza vaccination increased vaccination coverage rates by a modest ~1%, with this increase sustained over time.^{34,35} However, these nudges increased influenza vaccination coverage by up to 13.9% in populations with existing chronic conditions.³⁶



Adapting messages has an impact: People who received a targeted message about the cardiovascular risks of influenza infection were more likely to obtain the vaccine. A repeated reminder 10 days after the initial message increased the impact on vaccination coverage rates.^{37,38}

³⁴ Johansen et al. 2023. <https://pubmed.ncbi.nlm.nih.gov/36889332/>

³⁵ Johansen et al. 2024. <https://pubmed.ncbi.nlm.nih.gov/39215149/>

³⁶ Johansen et al. 2024. <https://jamanetwork.com/journals/jama/fullarticle/2824956>

³⁷ Johansen et al. 2024. <https://pubmed.ncbi.nlm.nih.gov/39215149/>

³⁸ Johansen et al. 2024. <https://jamanetwork.com/journals/jama/fullarticle/2824956>

The Health Manager's Playbook for implementing digital reminders to boost adult vaccination coverage

Example scenarios where this playbook can be applied:

- Immunisation programme managers trying to increase coverage.
- Immunisation registry managers looking to streamline data collection.
- Behavioural-insight & communications teams looking to refine strategies.
- Regional operations leads & clinic managers hoping to reduce service use and disease burden.
- Municipal outreach teams working to improve vaccination equity

A set of critical considerations:



Consideration 1 – Establish guardrails (legal basis + data map)

Define the public-interest legal basis (disease prevention), the data sources that will support the programme (registry eligibility list), the messaging channels (digital mailbox/SMS/post), and the feedback loop (booking » vaccination » registry write-back » dashboards).

This can help to pre-empt unforeseen challenges. For example, Denmark's practice explicitly routes paper letters to Digital-Post-exempt citizens, which helps to foster equity.

Expert tip: Start with a weekly (or bi-weekly) eligibility batch for reminders; move to daily refresh only when and if data systems are stable enough.



Consideration 2 – Create a system that existing operations can handle

Invite by age bands (e.g., 85+, then 75–84, then 65–74 years) to work with the minimum available data and avoid booking bottlenecks. Publish a simple invitation calendar aligned with real clinic capacity (work with vaccinators to establish guidelines).



Consideration 3 – Message design moves behaviour

Consider message adaptations like using a trusted sender (health authority or GP organisation), making a single call to action (“Book now”), stating plain benefits (“reduces risk of severe pneumonia and hospital stay”), sending a 10-day reminder, and offering an opt-in phone booking service.

Denmark’s case shows that different message aspects can increase impact: pilot and evaluate several different message styles to establish the best choice for each target group.



Consideration 4 – Appointment booking and vaccine delivery should be one step away

Direct message recipients to a single landing page or phone number that offers the nearest options for vaccination (GP/clinic/contracted provider). Publish phone booking hours clearly; ensure overflow sessions (evenings/weekends) in lower-uptake and higher-traffic districts.



Consideration 5 – Measure, learn, and publish

Consistently track invitations sent/delivered, opens/clicks, bookings, 10-day conversion to vaccination, and vaccination coverage by age/region/demography. Publish a seasonal report outlining the progress of the programme – transparency sustains funding and trust.



Consideration 6 – Build-in equity by design

Identify hard-to-reach citizens and establish alternative message content and delivery channels (including translation into minority languages). Set up community or mobile booking centres (village squares/libraries) during the first 4–6 weeks of the vaccination drive. Monitor coverage gaps by neighbourhood and add mobile or extended-hours clinics where needed.

Challenges to watch out for:

Message fatigue

- Cure = Cap at one invite + one reminder. Rotate sender identity if possible.

Vaccinator overload

- Cure = Stagger reminder waves, pre-open weekend sessions, maintain a fallback system for rebooking.

Data collection lag

- Cure = Cap at one invite + one reminder. Rotate sender identity if possible.

Case study: EHMA's Call to Action for a 75% vaccination coverage target for pneumococcal vaccine for adults aged 65 and older

Background

The European Health Management Association (EHMA) has long championed stronger life course immunisation frameworks, notably through its contributions to the 2018 Council Recommendation on strengthened cooperation against vaccine preventable diseases³⁹, participation in the [EU JAV Joint Action on Vaccination](#), and partnership in the [Overcoming Obstacles to Vaccination](#) project. In continuation of these efforts, EHMA convened experts, policymakers, and patient representatives in early 2025 to assess persistent coverage shortfalls for adult pneumococcal vaccination. Recognising the rallying power of concrete targets, EHMA drafted a [Call to Action](#) - modelled on the 2009 EU influenza goal and aimed at high-level European policymakers - to establish a 75 % vaccination coverage target across the EU for adults aged 65 and older, building on existing targets at national level like in Italy and Spain.⁴⁰⁴¹

Published in July and rapidly endorsed by leading organisations including the Adult Immunization Board, European Ageing Network, Active Citizenship Network, Coalition for Life Course Immunisation, International Federation on Ageing, Vaccines 4 Life, the European Geriatric Medicine Society, Global Coalition on Aging, and the International Longevity Centre UK, this Call now serves as both advocacy and accountability tool across Member States.

At a glance:



Policy alignment: Builds on the 2009 Council Recommendation on Seasonal Influenza Vaccination⁴² and aligns with the 2024 EPSCO Council Conclusions on CVD and 2025 EPSCO Council Conclusions on 'Unlocking the Potential of Older People.'⁴³ Development aligned with the release of the EU's [Safe Hearts Plan](#), emphasizing its messages about improving monitoring and uptake for vaccination.



Launch & endorsements: Published July 2025 ([EHMA Call to Action](#)), disseminated online and at leading health conferences, and endorsed by key organisations.



Advocacy impact: EU level initiative (e.g., Europe's Beating Cancer Plan and the HPV flagship initiative) have driven national policy change and EU funded support for improved implementation. EHMA's call to action serves as a springboard to raise awareness on the existing gaps in adult pneumococcal vaccination, connecting it to current policy debates at EU level on healthy aging initiatives and the fight against NCDs, in particular the Safe Hearts Plan.

³⁹ European Union. https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=oj:JOC_2018_466_R_0001

⁴⁰ Italian Ministry of Health. 2023. <https://www.quotidianosanita.it/allegati/allegato1679488094.pdf>

⁴¹ Spain Ministry of Health. 2023. https://www.sanidad.gob.es/areas/promocionPrevencion/vacunaciones/coberturas/docs/Objetivos_vacunacion_2025.pdf

⁴² European Union. <https://eur-lex.europa.eu/eli/reco/2009/1019/oj/eng>

⁴³ Council of the EU. <https://data.consilium.europa.eu/doc/document/ST-9321-2025-INIT/en/pdf>

Practical guidance for adult vaccination advocacy leveraging EU-level initiatives

Draft SMART Goals

- Ask for a goal to be set that is: Specific (75 % target), Measurable (ECDC TESSy data), Achievable (influenza precedent, Italian example), Relevant, Time-bound (by 2030).
- To have impact, stated goals need to be eventually adopted by key international institutions like WHO, the Commission, and ECDC, which will be providing guidance to Member States in improving data collection on vaccination coverage rates for respiratory infections and registries for cardio-vascular disease risk groups.
- Back up your goals with key data on demography, disease burden, health economic analysis, and ongoing policy priorities at local level.

Seek strategic partnerships

- Engage high-leverage stakeholders for endorsement (builds credibility) and to empower dissemination. Map and open communication with experts, relevant NGOs, professional societies, patient groups, and industry actors.

Push for high-level engagement

- Submit endorsed and disseminated goals to the [EU Health Policy Platform](#) for Council Working Party discussion.
- Reach out to key contacts at DG SANTE, ECDC, WHO EURO to invite high-level discussion and incite political motivation with participation of national experts and policy-makers

Link goals to real-world implementation

- Source existing resources and develop new ones to support the eventual implementation of your stated goals, such as this EHMA Handbook which supports the EHMA Call to Action on Adult Pneumococcal Vaccination.

