

Mandatory Influenza Vaccinations: An Example of Health Promotion Theater

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In 2009, New York became the first state to issue a policy requiring health care personnel to obtain influenza vaccinations. This law can be described as “health promotion theater,” a term introduced to describe health policies that have good intentions but carry negative outcomes. Moral panics have produced crime control policies with similar characteristics; called “crime control theater.” The proposed notion of “health promotion theater” is derived from and compared to “crime control theater.” In this article, moral panic over the H1N1 virus is introduced as the policy’s catalyst, “health promotion theater’s” components are defined, and alternative solutions are offered to more effectively achieve the policy’s ultimate intent. Finally, educating policymakers is offered as a way to avoid laws that are essentially “health promotion theater.”

INTRODUCTION

On August 13, 2009, New York became the first state to issue a policy requiring individuals working in health care settings to obtain annual influenza vaccinations. The new flu vaccine requirement was filed with the Secretary of State as amendment 3 to part 66 (Subpart 66-3) of New York’s public health law. Mandating vaccinations for health care personnel, staff, workers, and volunteers, this new law is intended to “promote the health and safety of the patients they serve and support efficient provision of services.”¹ The possible implications of this recent legislation have not yet been fully analyzed from an academic perspective. Incidentally, the outcomes likely will not be realized in the near future because, on October 16, 2009, the mandate was halted by the state’s health commissioner² due to an inadequate supply of both seasonal and H1N1 (“swine flu”) vaccines. The suspension may be fortunate, however, as it provides more time to analyze the possible effects of this policy.

New York is merely awaiting the right circumstances until the policy may go back into effect, as the mandate represents an *annual* requirement. Hence, it is a law laden with major implications that ought to be examined thoroughly before it inevitably goes back into effect. A thorough analysis may help policymakers and health care professionals assess the pros and cons of this law.

This article will first describe the new law. Next, the “moral panic” over the H1N1 virus will be introduced as the triggering catalyst behind the new law. Similar moral panics are discussed, along with the effects of policies that have resulted in response to moral panics in the past. Reactionary responses to moral panics over crime have led to policies termed *crime control theater*. The term “theater” indicates that they *appear* to be effective, but it is unlikely that they actually are. Similarly, some laws designed to address health issues have similar “theatrical” properties. The proposed notion of *health promotion theater* is thus derived from, and compared to, *crime control theater*. Using this particular legislation as an example, this article defines the components of *health*

promotion theater. Numerous predictions are then expressed about the potential problems associated with the new law, which indicate that this new public health law is likely *health promotion theater*. Some alternative solutions are offered to more effectively ensure the vaccination of health care personnel. Finally, educating policymakers is recommended; and this article will suggest that this may be achieved by researchers and experts in all fields initiating partnerships and working alongside policymakers to prevent the implementation of policies that are likely *health promotion theater*.

SUBPART 66-3 IN DETAIL

New York's new public health law, Subpart 66-3, went into effect on August 13, 2009, and required individuals who work in health care settings to be vaccinated for both seasonal flu and the H1N1 influenza A strain virus (commonly referred to as "swine flu") by November 30, 2009.³ This law is the first of its kind, as there is no similar state-wide policy mandating the vaccination of working adult populations. The Department of Health gave the following rationale in the amendment's "Emergency Adoption Justification" section:

Influenza disease is a leading cause of morbidity and mortality among hospitalized patients and those admitted to other types of health care facilities. This fact, plus the new threat posed to health and safety by the novel H1N1 influenza A strain that is circulating in New York State, puts a need for emergency regulations requiring that all health care personnel be immunized against influenza annually.⁴

Vaccination and immunization are used interchangeably throughout the amendment in reference to seeking shots. However, for the purposes of this paper, vaccination will be the word used consistently. The term health care personnel refers to anyone (whether paid staff or volunteer) who has direct contact with patients in health care facilities such as hospitals, treatment centers or homes.

The law places the financial burdens associated with the vaccinations on each individual health facility. A rough cost and benefit analysis is presented by the state positing that the institutional costs of complying with the mandate "should be modest" and "more than offset by cost savings to the facility."⁵ It is estimated that the cost of vaccinating each health care personnel will be minimal, compared to the monetary savings gained from lower levels of absenteeism and fewer workdays disrupted by sick employees working below their maximum potential. In addition, the spread of influenza among patients will decrease, thereby improving the quality of health care and patient outcomes. The state posits that vaccinating its staff will decrease both direct and indirect costs to health care facilities in the long run.

However, the legislative action is not currently in effect. On October 16, 2009, just two months after the law's passage, the requirement was temporarily suspended because of a vaccine shortage caused by the sudden spread of the H1N1 virus. The assumed "emergency" situation posed by the H1N1 virus not only caused a vaccine shortage, but also happens to be responsible for the swift passing of this public health

law. In the following section, moral panic over the H1N1 virus is credited with bringing about this piece of legislation.

MORAL PANIC

Moral panic, in response to the recent H1N1 outbreak, is a viable explanation for the quick adoption of New York's recent public health law. The law directly addresses the moral dilemma of responsibility and advocacy concerning national health and wellbeing. Who will act on behalf of citizens at risk? It is deemed the moral obligation of health care providers and policymakers to promote the wellbeing of their society. Thus, it may be unacceptable and even unethical for them to idly stand by at such a critical time. H1N1 has been deemed a unique health threat that is more dangerous than other seasonal strands. As such, H1N1 creates a number of dilemmas for policymakers and health care workers. First, it seems "wrong" to stand by and do nothing; thus, those in authority must do whatever is "right" and necessary to stop the spread of the virus. Second, many people would think it obvious that health care providers would be eager to do their part by getting vaccinated. Health care professionals could be said to have a heightened responsibility to help prevent a health epidemic. Thus, laws such as the New York law are enacted to ensure that health care providers make the morally responsible choice: to seek vaccination.

As discussed next, recent alarm over the spread of the H1N1 virus fits the criteria for a moral panic, and that concern led to the adoption of this law. The phenomenon of moral panic occurs when:

A condition, episode, person or group of persons emerges to become defined as a threat to societal values and interest; its nature is presented in a stylized and stereotypical fashion by the mass media; the moral barricades are manned by editors, bishops, politicians and other right-thinking people; socially accredited experts pronounce their diagnoses and solutions...⁶

Moral panics need not be responses to novel occurrences; they can be manifested as new constructions of re-emerging incidents in the past,⁷ as the case with the H1N1 virus. Examples of moral panics throughout history include: freeway violence, road rage, satanic cult panics, cyberporn, school violence, child abuse in day cares, and child abduction. All of these examples share five essential elements that qualify them as moral panics. These elements are: concern, hostility, consensus, disproportionality, and volatility.⁸ All five of these elements can be observed within the context of the recent H1N1 pandemic.

The first indicator of a moral panic is widespread public concern about the consequences of the target behavior or condition.⁹ Generally, concern is measured via opinion polls, media attention, action groups, or proposed legislation. This indicator of moral panic is often observed in heightened levels of public concern. Reactions to the recent H1N1 pandemic fit this description. President Obama's reference to the H1N1 pandemic as a "cause for concern" was repeated numerous times by various news stations. Similarly, newspapers have printed headlines such as "Flu Fears Spur Global

Triage" (*Wall Street Journal*); "Nation Braces for Worst as New Strain Emerges" (*USA Today*); "U.S. Steps Up Alert as More Swine Flu Is Found" (*Washington Post*); and "Hog Wild" (*New York Post*).¹⁰ Further, the Center for Disease Control and Prevention (CDC) has placed a special "H1N1 'Swine Flu'" link on their homepage with up-to-date postings.¹¹ This concern is exacerbated by worry that health care personnel might not voluntarily get vaccinated. New York's law is an attempt to force health care personnel to make the ethical choice to get vaccinated. It is evident that there is a high level of concern about H1N1 among citizens and authorities.

The second necessary component of a moral panic is an increase in the level of hostile attitudes toward the target. This target must be publicly perceived as harmful and threatening to shared values, interests, or even the existence of a society.¹² Any virus with the potential to claim lives can be considered threatening, thus triggering hostile attitudes. The hostility of citizens toward the H1N1 virus, in particular, was heightened, as evident in online journals and news reports.¹³ The CDC reported that, "flu-related hospitalizations and deaths are increasing ... and are higher than expected."¹⁴ Pregnant women also happened to be among the most vulnerable to it. Given this vulnerability, hostility has especially been expressed through online blogs by mothers attempting to protect their children from H1N1 infections.¹⁵ There is also hostility toward health care personnel who refuse to get vaccinated. One blogger notes that "an infected health care worker comes in contact with people who are at greatly increased risk...they may endanger [the patient] by their choice not to get vaccinated. If they won't be vaccinated, they shouldn't be allowed to come to work in a health care setting."¹⁶ MSNBC commentator Arthur Caplan wrote an article entitled, "Health Workers Must Get Flu Shot or Quit."¹⁷ It is evident from the various online postings that H1N1 virus—and health care workers who refuse to be vaccinated – have certainly elicited hostility among U.S. citizens.

Consensus is the third element necessary for a behavior, occurrence, condition, or event to qualify as a moral panic. A measure of societal agreement about the reality, seriousness, and threat of the matter is necessary. However, it is not required that the widespread sentiment necessarily be expressed by the majority of the populace.¹⁸ Public consensus about its unacceptability must also be accompanied by the belief that something ought to be done to address the problem.¹⁹ In the case of the recent H1N1 outbreak, these criteria are likely met. The C.S. Mott Children's Hospital National Poll on Children's Health revealed that 87 percent of the public supports laws that require health care personnel to be vaccinated.²⁰ According to Gallup polls, 42 percent of women under the age of 50 reported feeling worried about the H1N1 pandemic.²¹ Men have consistently shown less concern than women; however, men over 50 with children are twice as likely to be worried about the H1N1 virus as men over 50 without children.²² This makes sense, as pregnant women, children, and those who are in frequent contact with children are more susceptible to the virus. This data demonstrates there is a stronger consensus among populations who are at high risk. There is also a similar consensus among authorities. The U.S. and several other governments recommended limiting travel, the World Health Organization raised its pandemic alert to the second highest level possible, Phase 5, and the CDC has referred to H1N1 as an epidemic of concern likely to worsen with time.²³ Thus, there is fairly clear consensus that the flu is a serious threat, and that health care workers need to be vaccinated.

The fourth moral panic criterion, disproportionality, means that the level of panic is out of proportion to the nature of the threat.²⁴ Indeed, the amount of alarm over the H1N1 virus is greater than the actual threat. Between April 2009 and April 2010, the estimated range of deaths due to H1N1 was somewhere between 8,870 and 18,300.²⁵ Although any number of deaths is a cause for concern, this number is quite low when compared to the Center for Disease Control's estimated 36,000 flu-related U.S. deaths per year.²⁶ Further, many of the H1N1-related deaths cannot be exclusively attributed to the virus. As with most flu related deaths, the cause is likely a combination of preexisting conditions, such as pregnancy, diabetes, asthma, heart or kidney disease, as well as a weakened immune systems or old age, *along* with the H1N1 virus.²⁷ In fact, about 70 percent of those hospitalized with H1N1 had medical conditions which placed them in a "high risk" category for flu-related complications.²⁸ Although panic is high among citizens, only 38 percent of health care personnel indicated planning to seek vaccination against the H1N1 virus,²⁹ which reflects a possible disproportionality. If such a high proportion of health professionals who come into contact with the virus in their jobs consider the vaccine unnecessary, this may indicate that health care personnel feel that the public's perception of the threat is disproportional to the actual threat. Nonetheless, this particular virus has received an overwhelming amount of media attention and unwarranted concern.

The fifth and final indicator of moral panic is volatility, which is a sudden eruption of alarm over something that could have been latent for a period of time, or has reappeared time and time again.³⁰ This alarm eventually dissipates and leaves the moral fabric of society relatively unchanged. The 2009 H1N1 pandemic fits this description fairly well. It is, in fact, a reappearing virus. The "swine flu" virus dates back to 1918. Since then, strains and subtypes of this flu have reappeared throughout the twentieth century.³¹ Over the years, it has come and gone causing short-lived alarm. Thus, this particular strand will also likely disappear without any unique implications to society as a whole. Similarly, statewide and facility-wide vaccination recommendations for health care workers have fluctuated over the years, often in proportion with the level of alarm over circulating viruses.

Having compared the five elements of moral panic to the current state of the 2009 H1N1 virus, it is appropriate to label this pandemic as a moral panic. There is a heightened level of concern, hostility, and consensus pertaining to the virus (and to health care workers' refusal to get the vaccine) that is quite disproportionate to the reality of its implications; hence the volatility of its emergence, and its predicted retreat. Moral panic associated with these attributes could explain the legal response that New York took in passing this legislation. Although the law itself is unprecedented, the way in which it arose is not a new phenomenon. The formulation of this recent public health law is similar to the adoption of Amber Alert, Megan's law, Jessica's law, and other such laws birthed out of moral panic called *crime control theater*.

CRIME CONTROL THEATER

Many in the academic community are hesitant to recognize Amber Alert, Megan's law, Jessica's law, and similar legislations as successful. Such laws have been referred to as "*crime control theater*,"³² which is "a public response or set of responses to crime which

generate the appearance, but not the fact, of crime control.”³³ Given that they only appear to be effective, they are labeled as “theater.”

These sorts of laws tend to be widely supported by the public as a way of addressing the particular crime. Often, such laws are attractive because they appeal to mythic narratives, such as saving children from harm. However, they are unlikely to achieve their intended goals because they are very simple solutions to complex crimes. Further, such laws may even have harmful effects and can take attention away from more frequent problems that are more easily addressed. Laws that qualify as *crime control theater* generally have four components: a reactionary response to moral panic, unquestioned acceptance and promotion, appeal to mythic narratives, and empirical failure.³⁴

Crime control theater was initially developed by Griffin and Miller, using Amber Alert as an example.³⁵ After a child is abducted, an Alert is issued (e.g., by posting the description of the child, abductor, and/or car on road-side signs) in order to get information to the public in time for community members to see the child and report the sighting to authorities, who can then rescue the child. There is evidence that the assumptions underlying the Alert system are flawed.³⁶ First, statistics demonstrate that children who are killed by their abductors usually are killed within three hours of the abduction.³⁷ Other research shows most Alerts are issued much later than three hours, suggesting that Alerts are typically not issued in time to rescue the child.³⁸ Second, psychological research on memory suggests that the likelihood of an individual seeing, remembering, and retrieving the Alert information at the key time (e.g., when the individual sees the abducted child) is slim.³⁹ One study specifically investigating memory for Alerts found that only 8.3 percent of participants in a study were able to remember Amber Alert information.⁴⁰ This problem is exacerbated when Alerts are not issued with enough information to allow the community to recognize the child.⁴¹ Third, there is concern (although little evidence of yet) that the Alert system may lead to copycat crimes, or may lead an offender to kill a child sooner than intended (out of fear of getting caught).⁴² These issues, and various others, explain why many in the academic community are wary about the effectiveness of Amber Alerts, even though the public embraces the system.⁴³

Although the four elements of *crime control theater* have previously only been used to describe criminal laws, they are also applicable to New York’s vaccination law. This indicates that a new term is needed; this article offers the term *health promotion theater* to explain theatrical laws that attempt to address health promotion issues such as New York’s vaccination law.

HEALTH PROMOTION THEATER

Health promotion theater can be defined as a social or policy response (or set of responses) adopted to address a moral panic over a health threat. The response generates the appearance of effectively promoting good health, but fails to actually do so. It is a socially constructed or politically formulated solution to a socially constructed health problem that happens to be more complex than the proposed solution can possibly address. Even so, the public feels a need to “do something” to address this problem; thus the policy chosen is quickly and widely accepted with little question.

Despite good intentions, such laws are not always successful. Thus, the key word “theater” implies the appearance or illusion of promoting health, but without substantive evidence of actually achieving that goal. These characteristics are represented by four main components that qualify a policy as *health promotion theater*.

First, a *health promotion theater* policy is a reactionary response to moral panic. The reactionary nature of New York’s recent public health law is evident in the dedication of a section in Subpart 66-3 titled “Emergency Adoption Justification.”⁴⁴ The decision to adopt the law in 2009 rather than in any other year is no coincidence; it is highly attributable to the moral panic caused by the H1N1 virus, as described above. In response to a fear that some health care personnel would not voluntarily get vaccinated, the state took steps to ensure they do the “right thing.”

Unquestioned acceptance and promotion of the law is the second component of *health promotion theater*. As with any policy, it is difficult to find absolute consensus among citizens, politicians, laypeople, professionals, and scientists. Therefore, it is necessary to distinguish *which* populations are accepting and promoting the law. This component of *health promotion theater* refers to acceptance among citizens and promotion by policymakers. It is important to point out that nurses, physicians, and health care personnel were *not* among those who demanded any sort of statewide solution to influenza; a law which, ironically, singlehandedly impacts them directly. The public widely supports such laws, as the C.S. Mott Children’s Hospital National Poll on Children’s Health discussed above demonstrates.⁴⁵ While 87 percent of the nationwide sample supported the law, the State Hospital Review and Planning Council quickly drafted and adopted the “emergency” mandate, which indicates that it was relatively unquestioned. The few critics have been medical professionals, not policymakers.

An appeal to mythic narratives is the third component of *health promotion theater*. There is, perhaps, no mythical feat greater than that of saving a life. In the case of this law, the objective is saving the lives of thousands of citizens who could potentially catch the H1N1 or seasonal influenza virus and perish. The most likely victims are children, pregnant women, and the elderly—groups that tend to garner high levels of sympathy. The viruses are the antagonist, the publicly perceived harmful and destructive force that must be stopped. Failure on behalf of health care personnel to get the vaccine further provokes the public to take action to stop a possible “pandemic.” The H1N1 virus, in particular, has raised high levels of antagonism, given the CDC’s report that, “flu-related hospitalizations and deaths are increasing ... and are higher than expected.”⁴⁶ This emergency calls for a protagonist, a hero, to prevent possible devastation. Consequently, the New York Department of Health boldly accepted the challenge. This all-too-real scenario could very well pass as the plot for a best-selling mythical narrative or the script for a motion picture. It is an epic struggle that appeals to people’s sense of self-preservation and need to protect the helpless.

Empirical failure is the fourth and final component of *health promotion theater*. Contrary to the state’s estimates, there are several reasons why the costs of this public health law will likely outweigh its benefits. Although the governing body did a cost/benefit analysis, it was limited to monetary costs and benefits. There are other concerns to weigh as well, and these are the focus of this analysis—overlooked factors which lead to the adoption of policies deeming the *health promotion theater* label.

Before delving into the problems, it is necessary to consider the law's purpose: to promote the health of patients and to decrease the spread of influenza in health care facilities. The effectiveness of influenza vaccinations, however, is a controversial matter. Not everyone is convinced that flu shots are the best way to avoid the virus, or that seeking vaccinations is a worthwhile effort. In fact, only about 40 percent of adults seek influenza vaccinations each year.⁴⁷ Ironically, that rate is not any different for those in the health profession, as roughly only 40 percent of health care personnel obtain yearly flu vaccinations.⁴⁸ There is no comprehensive explanation for why a majority of people neglect getting vaccinated. Explanations range from a lack of vaccine effectiveness, a lack perceived safety, and/or a lack of incentive or reward for getting vaccinated.

Concerning vaccine efficacy, the effectiveness of flu vaccines never reaches 100 percent (and fluctuates depending on how well-matched the circulating viruses are to the accompanying vaccines).⁴⁹ Furthermore, flu vaccines happen to be the *least* effective for populations *most* vulnerable to the flu, the elderly, and children. Additionally, some people are wary of vaccines due to safety concerns. In the case of the H1N1, there is heightened alarm over safety due to a class action suit brought against the FDA for hastily approving four H1N1 vaccines without determining their safety or efficacy.⁵⁰ That may explain why 30 percent of the population is not confident about the whether the new H1N1 vaccine is actually safe.⁵¹ In fact, about 62 percent of 30 to 64 year olds and 53 percent of senior citizens decided to skip vaccination for the 2009 season.⁵² On the other hand, a simpler explanation for overall low vaccination rates among citizens as well as health care personnel may be that there are no tangible rewards or benefits associated with taking the effort to seek yearly vaccinations. Outside of personal conviction, there is no motivator or incentive compelling individuals to get vaccinated.

There are evident deficiencies in the perceived efficacy, safety, and motivation for seeking vaccinations, to which H1N1 is no exception. For the purpose of this account, however, it will be assumed that annual vaccinations are a generally helpful preventive measure against catching influenza. With that said, even *if* the vaccines themselves are 100 percent effective, this law's success in meeting its intended purpose is *still not guaranteed*. This is because failure is not strictly defined by the absence of achieving a particular result, but involves examining the disproportionality between the costs and benefits (both monetary and non-monetary). Undoubtedly, the law will prevent *some* people from catching the flu, but it carries unnecessary burdens for the state and unintended consequences for individual health facilities. The anticipated benefits are not likely to outweigh the burdens and unintended consequences.

The manpower required to oversee the mandate is a costly and unnecessary burden. Under New York's policy, each facility is required to enforce the vaccination of its personnel, assign punitive consequences to those who do not comply, and report back to the state regularly. This translates to thousands of people being paid to supervise and enforce a law that is likely to worsen the culture of the work atmosphere. When personnel do not comply in a timely manner, punitive actions will not be well received, and will diminish the cohesiveness of the work environment. A worst case scenario of firing noncompliant employees and training new persons will be time-consuming and costly. The compliant, and thus remaining, employees will likely be upset and may show their frustration in ways that distract them from performing their duties.

Noncompliance or reluctant compliance among health care personnel will also inevitably be an issue, as the majority of health care workers regularly choose not to obtain vaccinations.⁵³ There is no similar state-wide vaccination mandate to compare this to. However, there have been voluntary programs aimed at increasing influenza vaccination rates among health care personnel, and even those have yielded poor vaccination levels.⁵⁴ Generally, vaccination rates among health care personnel do not extend beyond 40 percent.⁵⁵ This suggests that the solution ought to be anything *but* mandating vaccination. The likely effects of requiring health care personnel to get vaccinated will jeopardize the personnel's perceived freedom of choice and personal control over their health.

Although the law makes provisions for those whose religious beliefs are in opposition to receiving vaccinations, or whose prescription medicine intake is incompatible with the vaccine, this only creates more problems in the workplace. The provision, while well-intended, requires the disclosure of intimate and personal information. It is not only likely, but understandable, that certain personnel may not feel comfortable sharing confidential information, such as religious affiliations or medication they are taking, with their superiors.

The amount of effort, manpower, and monetary commitment required by the law's enforcement, its unintended consequences, and the unavoidable change in the culture of the workplaces affected by the law are likely to outweigh the potential benefits. In other words, it is appropriate to predict the failure of this law on account of the lack in positive changes it will render. Through this new law, the state shows favoritism by seemingly valuing the interests of some citizens over others. It sends the message that protecting its patients from the flu at health facilities is more important than the personal health choices and privacy of its health care personnel at those facilities. Even assuming health care personnel compliance *is* established, it will be reluctant, and at a cost. Deviance can be expected in terms of receiving the vaccination due to diminished appraisals of legitimacy of the state and those institutions cooperating with the policy. This law simply cannot produce enough positive consequences to outweigh the effort and side effects required to sustain it.

In sum, these four components render New York's recent public health law as *health promotion theater*, an illusory solution to a socially constructed health problem. The law is correctly labeled by its authors as an "emergency regulation," because it is a reactionary response to the moral panic created by the H1N1 virus. Devoid of any precedence, it sprang up with overwhelming public support and acceptance, and policymakers pushed forth until its adoption. It undoubtedly appeals to various mythical narratives, such as life, good health, survival, self-preservation, and saving lives. Lastly, its overall success is unforeseeable. It will likely fail on account of unexpected consequences; such as noncompliance, high monetary costs associated with the manpower necessary to sustain it, and the negative effect it may produce on the work cultures where implemented.

ALTERNATIVE SOLUTIONS

Given the above mentioned issues with the new law, a false illusion of health care promotion is created. As with any social issue that leads to *health promotion theater*,

there are no easy solutions. However, if New York officials are adamant about vaccinations being the solution to the influenza problem, they ought to consider alternative ways of achieving their ultimate goal of vaccinating health care personnel. New York, as well as other states considering following suit, ought to consider implementing these more effective alternatives that do not result in high monetary costs, unnecessary manpower, and negative changes in the work culture. To our knowledge, the alternatives suggested below are not currently practiced in any health setting for the purpose of increasing vaccination rates. However, they have succeeded in motivating behavior change in other settings, as reported by each of the respective references.

Making vaccinations optional and offering rewards for those health care personnel who receive vaccinations could boost vaccination rates without the negative effects described above. Such voluntary recruitment attempts are certainly not a novel idea, and many have been utilized by officials in the past without significant effect.⁵⁶ However, the method suggested here is based on two of the six most powerful principles of influence: reciprocity and consistency.⁵⁷ Tendencies toward reciprocity, the first principle, are observed across all societies. Reciprocity is the normative gesture of repaying what one has received, be that a reciprocal exchange of gifts, favors, or invites. The reciprocity principle does not only refer to tangible items. Consistency is the second principle, introduced as the notion that public commitments predict future action. Even minor verbal agreements positively influence the likelihood of following through on intentions. These two principles can be merged in such a way as to significantly boost health care personnel vaccination rates.

Traditionally, when offering rewards to people, individuals are asked to *first* meet a requirement (i.e., getting the vaccine) *in order to* get a promised reward. Building off of reciprocity research,⁵⁸ however, it is worth trying the opposite; *first* giving individuals a reward or gift and then anticipating their reciprocity (seeking vaccinations). To buffer the vaccination success rate, health facilities should also utilize the second principle of influence, consistency. This principle can be employed simply by asking for commitments, especially public commitments or promises, prior to distribution of the reward/gift stating that the individual *does* plan on following through with his/her vaccination (as a sort of oath to reciprocating the gift). As this will take place in a public setting, the personnel will be held accountable to each other in following through on their commitment. Thus, no oversight is necessary (as people will be socially motivated and held accountable by those whom they care to preserve their reputation in front of).

This method is quite simple. An announcement could be made during a staff meeting about the importance of vaccination, asking the group to seek the shots. The announcement would be followed by asking for an informal public agreement/confirmation succeeded by the distribution of a small in-advance thank you gift to those present. Although there is a gift involved, the focus is on fulfilling the commitment and the gift's reciprocity. Yet, there are no "one-size-fits-all" rewards that will equally motivate all health care personnel to take the effort of seeking vaccinations. Thus, luring personnel with the promise of delivering a gift *upon* their vaccination is a less appealing and less effective method, as it is contingent on the gift's value to each individual. Utilizing this principle, however, the focus is not on the reward,

but on enforcing the socially accepted norms of reciprocation and consistency (to which there is generally a stronger pull towards than there may be to an arbitrary gift). With that said, it matters very *little* what the actual rewards are. Each facility could come up with its own reward ideas. The rewards could be low-cost items such as holiday items, movie tickets, gift cards, or items donated by a company. Such prizes would be less costly than the manpower required by the law to ensure that each staff member is up-to-date on his or her annual vaccinations. Additionally, as opposed to feeling forced to seek vaccination, employees would feel rewarded for doing so.

Health related incentives would be another appropriate means of encouraging health care personnel to seek vaccinations. These incentives could include offering lower insurance co-pays or deductibles for those health care personnel who choose to get vaccinated. Granted, this solution would also require some manpower, but the anticipated satisfaction and positive attitudes among health care personnel in response to these incentives would far outweigh the energy required to sustain such a program. Given that more than three out of four people report being dissatisfied with the cost of health care,⁵⁹ this type of incentive has never been more appropriate than now. Given these attitudes, it is likely that health care related incentives would motivate many to seek vaccinations.

Lastly, an entirely free way to promote influenza vaccinations would be to provide seemingly small *group* enticements that are tailored to be meaningful to each individual health care institution. Sometimes motivators targeted at the individual may not be as effective as creating a competitive group atmosphere where *groups*, rather than *individuals*, are challenged with a task. Research on social identity theory shows that intergroup behavior is motivated by an effort between groups at promoting and protecting their positive distinctiveness from other groups, which ultimately leads to secure a positive social identity.⁶⁰ This phenomenon occurs because group membership leads to an evaluation of individuals' selves through their social identity, and that often translates to heightened self evaluations as a result of the group experience. This principle can be applied to boost vaccination rates.

Groups need not be artificially created, as various groups (e.g., different specializations, shifts, floors, sections, and units) already exist at health facilities. Upon drawing a criterion that divides the facility into any given number of groups or teams, the goal must be stated (the highest percentage of group member vaccinations). Then there needs to be an established prize for the winning group/team that ought to be meaningfully tailored by each facility. For example, if employee parking happens to be a hassle, whichever group obtains the highest vaccination rate could be assigned closer parking spaces for a limited time. Other rewards could include relaxed dress codes, longer lunch breaks, or donations to the group's choice of charities. These options constitute a low-effort, fun, and enjoyable means of promoting higher vaccination rates *alongside* of building team morale and social validation among the health care personnel.

All of these proposed rewards, incentives, and enticements would achieve the law's goal of increasing the number of vaccinated personnel, *without* negatively impacting the work atmosphere or diminishing the perceived choice over their personal health. Rather, these suggested alternatives would build group solidarity alongside of

health awareness, ultimately leading to more satisfied employees and better-served patients.

AVOIDING HEALTH CARE PROMOTION THEATER

The suggestions above can help promote flu vaccinations within facilities. However, the broader issue is the general prevention of laws that are mere *health promotion theater*. In other words, the question at hand is, “How can we prevent health care policies that only *appear* to tackle an issue, but do little to actually solve it?” The primary way to do this is by educating policymakers, as they are the ones who ultimately create mandates and laws. It is unreasonable to expect politicians to be experts in all fields. Therefore, the responsibility of disseminating applicable knowledge and new research falls on experts in all disciplines. Cynical researchers and experts in all fields ought to not only speak up, but should contact their policymakers. When an issue or “moral panic” arises, academics and experts in that discipline should write letters, initiate dialogue, and publish their research through venues accessible to the target politicians. This may mean launching interdisciplinary dialogue and networking outside of comfort zones. Experts on a hot-topic issue that is on the brink of causing social alarm ought to be proactive in contacting, and even trying to meet officials for the purpose of disseminating their knowledge. For many in academia, this translates to a shift from policy critiquing to active involvement in policy formulation. All of this ought to be done in a timely matter, *during* rather than after policy formulation, as hindsight criticism does little to impact policy.

Public policy centers can also help by sponsoring seminars which provide neutral, unbiased research for policymakers. This could be modeled after ‘family impact seminars,’ which have successfully educated policymakers about a wide range of issues in various states.⁶¹ Experts from around the country would gather and present their research in order to help policy makers make the best possible decisions. While policy making bodies likely do some sort of cost/benefit analysis for most mandates and laws, such seminars will provide an unbiased, broad, and multi-disciplinary array of monetary, as well as intangible research-based costs and benefits. Likewise, it would be appropriate for public policy centers, research institutes, or special interest groups to create public service announcements about potentially alarming issues that may be blown out of proportion by the public, triggering hasty legislation. For example, had a union or association of nurses or physicians sought out a way to thwart the inflation of public concern about H1N1, Subpart 66-3 may not have been implemented. Educating the public along with policymakers is the ideal way to craft policy.

Unless experts speak up in time, *health promotion theater*-like policies will continue emerging out of reactionary responses, and premature actions will be utilized to address pertinent issues. Legislation ought to be based on facts and research, not emotion. Weighing the costs and benefits ought to take place with qualified experts involved. Ideally, policymakers ought to be the ones calling in the experts and initiating the necessary partnerships; however, this does not always happen, especially in emergency situations. Therefore, the broader message that this article seeks to advance is the importance of researchers and experts broadcasting their knowledge through different publication venues, open seminars, public service announcements, and

primarily though seeking out connections with influential policymakers, as opposed to waiting for an invitation to do so.

CONCLUSION

There is no doubt that illness is a major concern, and that steps should be taken to avoid illnesses or viruses becoming epidemics. Even so, when policymakers hastily enact responses as a result of moral panic, they risk passing policies that are mere *health promotion theater*; that is, policies that have the appearance of addressing a health issue, but actually may be unsuccessful, or even have negative consequences. Thus, while policymakers should consult experts, the experts likewise ought to seek out policymakers and offer their knowledge and research to help fully evaluate the pros and cons of proposed policies, and ultimately work together toward avoiding the enactment of *health promotion theater*.

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