

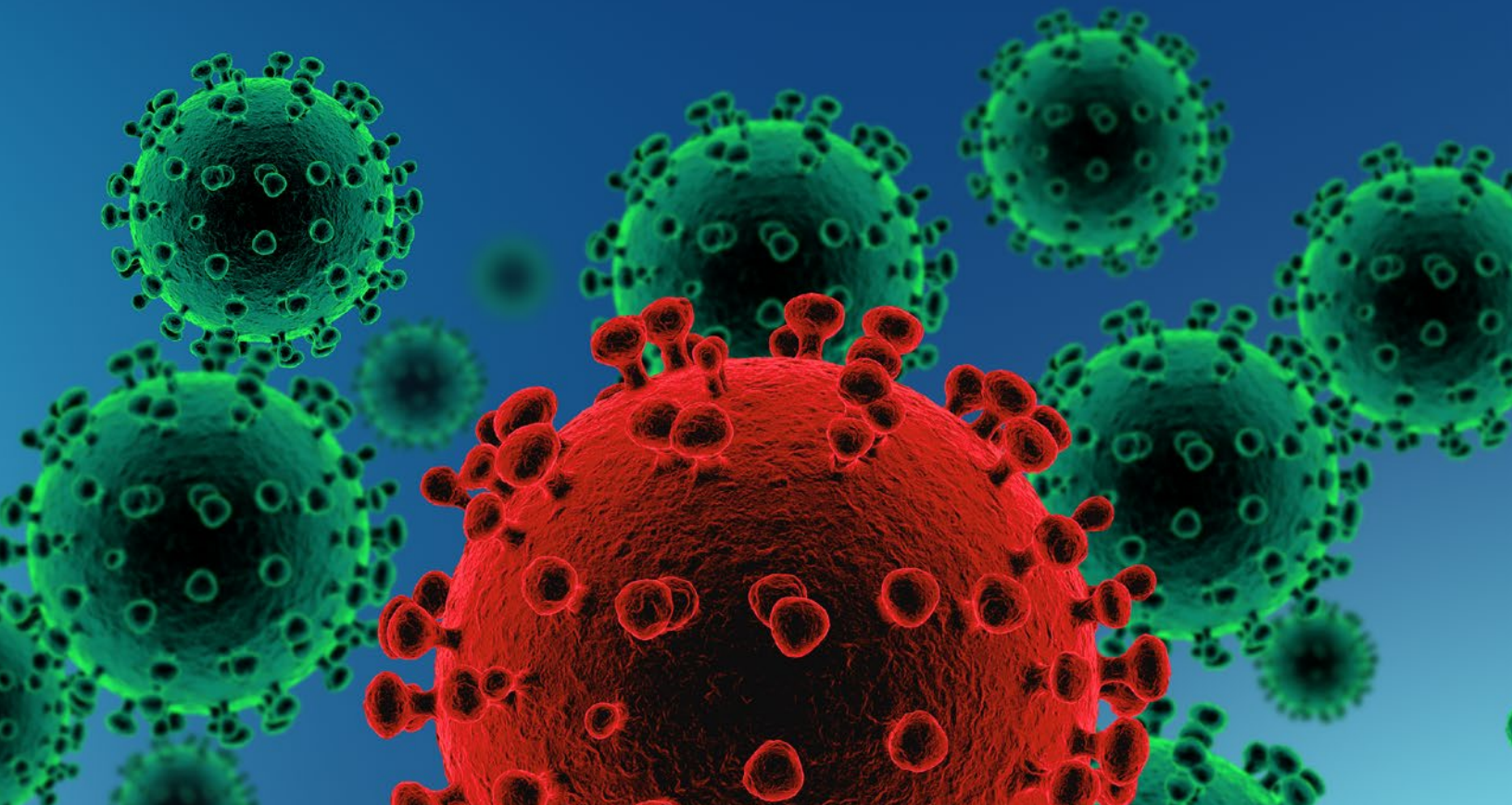


COALITION TO
STOP FLU

The 2024-2025 Influenza Season: Outcomes and Policy Recommendations

A Report of the Coalition to Stop Flu

September 2025



It's never "just the flu."

The 2024-2025 influenza (flu) season saw the highest number of deaths in children from seasonal flu in modern times. Like the last three seasons, this season was once again characterized by reduced vaccination uptake, thousands of deaths, and continued concern over the pandemic potential of H5N1, or bird flu.

Most deaths from flu are preventable. We can end deaths from seasonal and pandemic flu, and it starts with:



Prevention & Treatment

Improve messaging about the benefits of flu vaccination, especially for parents and pregnant women

Provide more tools and resources for health care providers, who remain a critical source for trusted information and vaccination services

Invest in innovative preventives, vaccines, diagnostics, and treatments



Data & Surveillance

Expand data collection to capture more precise and disaggregated data to better characterize the true burden of flu

Ensure all surveillance data collected are published in as close to real-time as possible

Make diagnostic testing a greater part of the flu strategy



The Seasonal-Pandemic Ecosystem

Identify opportunities to dissolve silos and improve interagency coordination and collaboration

Modernize the Strategic National Stockpile by supporting innovative products and approaches to stockpile management

Invest in infrastructure for routine immunization

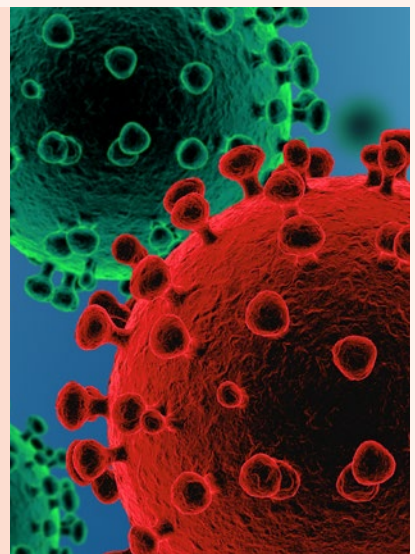
About this report

The Coalition to Stop Flu is dedicated to ending deaths from seasonal and pandemic influenza and works to advance policy solutions to improve the federal government's influenza preparedness and response efforts. This report looks back at the prior influenza season to identify successes and failures, with the goal of improving outcomes in the seasons ahead.

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The 2024-2025 Influenza Season

The 2024-2025 influenza season in the United States was the first season since 2017-2018 that was classified as one of high severity across all age groups. Nearly every category by which we can measure morbidity and mortality went up: illnesses, medical visits, and hospitalizations. Deaths remained stubbornly high. The season took a heavy toll across age groups and, tragically, resulted in the most pediatric deaths from seasonal influenza since pediatric flu deaths became reportable in 2004. Meanwhile, flu vaccination rates have fallen for the fourth consecutive season. Simply put, we are losing ground.

The influenza response was challenged by a winter respiratory season in which flu occurs alongside outbreaks of Covid-19 and respiratory syncytial virus (RSV). Managing three co-circulating diseases continues to create complications in communications, diagnosis, treatment, and other activities. Further, cases of acute respiratory infections continued to occur alongside a historic outbreak of avian flu in animals, layering an additional surveillance and diagnostic challenge on already-stretched health systems and health care workers.

By the Numbers

In 2024-2025, the nation saw a return to a highly severe flu season, the first since 2017-2018.¹ The Centers for Disease Control and Prevention (CDC) characterized this past season as one of high severity for all age groups—children, adults, and older adults.

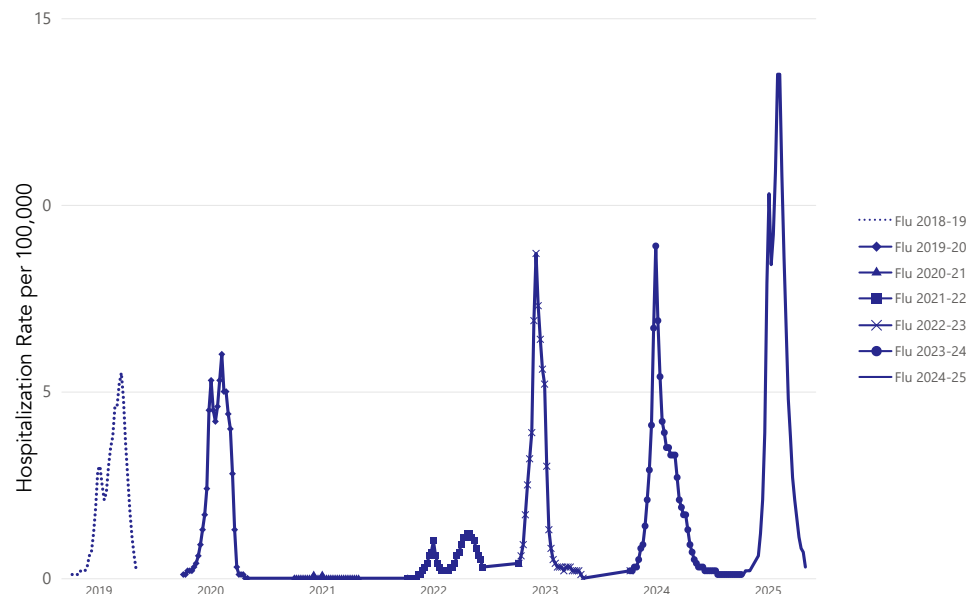
The flu hospitalization rate for the 2024-2025 season topped every other *in the last 14 years*: **128 of every 100,000 people in the United States were hospitalized** with laboratory-confirmed flu. Hospitalization rates were highest among Black persons and lowest among Asian/Pacific Islanders.

The chart on the next page provides a snapshot of how hospitalization rates for flu have skyrocketed in the years following the Covid pandemic, reaching a peak this last season. The reality of increasing flu-related hospitalization rates of Americans is unfortunately becoming part of the seasonal influenza story.

Flu mortality rates told a similar story. **Pediatric deaths from influenza reached a record 275 this season, up from 209 the prior season**, which itself was an escalation from the year before.² This represented the most pediatric deaths on record from seasonal flu, nearly reaching the record 288 children lost during the H1N1 pandemic in 2009-2010. Huge spikes in fatalities occurred in February 2025. *Ninety percent* of the children who died were not fully vaccinated, an escalation from 80% in 2023-2024.³

The maps on the next page show how this was experienced across the country.⁴ The darkest blue areas represent the regions with the highest rates of death in children from flu in 2023-2024 and 2024-2025. In just one year, numbers have risen in states across New England, the Mid-Atlantic, the upper Midwest, the Southwest, the Northwest, and the non-contiguous states of Alaska and Hawaii. If the trend continues, every region on the map will soon be dark blue.

Laboratory-confirmed hospitalizations for the last seven flu seasons

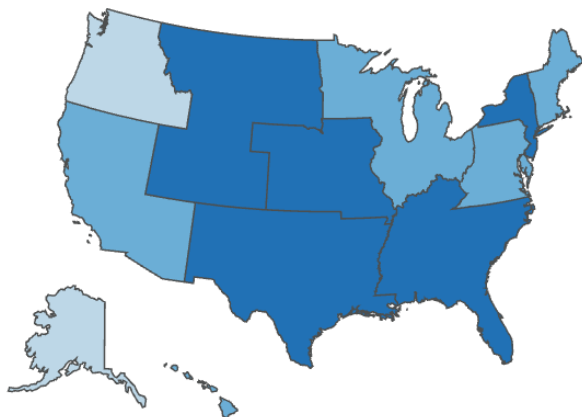


Laboratory-confirmed influenza hospitalizations since the 2018-2019 season. The drop during Covid-19 was short-lived.
Source: CDC, preliminary data, available at <https://www.cdc.gov/resp-net/dashboard/>.

Testing similarly demonstrated the severity of the 2024-2025 season. By the end of June 2025, more than **3.6 million tests had been run in clinical diagnostic laboratories**, and more than 13.4% of these were positive, up from 10% the prior year.⁵ Testing is also conducted by public health laboratories, critical to the nation's ability to track influenza rates and understand which strains are causing

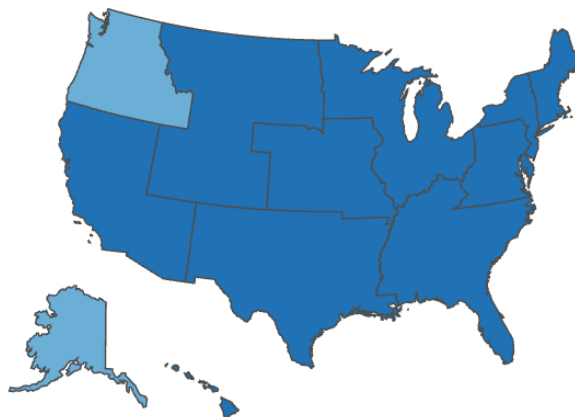
the most positives. These labs ran more than 148,000 tests, performing advanced testing to reveal the specific lineages of circulating viruses, including assessments of whether any of these were H5 avian influenza strains. Reference labs in the Association of Public Health Laboratories system provide some of this advanced genetic sequencing as well as antiviral resistance testing that helps

Pediatric death rates by region in the 2023-2024 Influenza Season



Source: CDC, available at <https://gis.cdc.gov/GRASP/Fluview/PedFluDeath.html>

Pediatric death rates by region in the 2024-2025 Influenza Season



Source: CDC, available at <https://gis.cdc.gov/GRASP/Fluview/PedFluDeath.html>

“There is no ‘acceptable loss’ when it comes to pediatric flu deaths, especially when we have the tools to prevent these tragedies. Now is the time for policymakers to strengthen our efforts to protect Americans from both seasonal and pandemic flu. The health and safety of our families and communities are at stake.”

– Serese Marotta, Deputy Chief Executive Officer, Vaccinate Your Family and President, Coalition to Stop Flu

identify mutations that may lead to more dangerous viruses.

In addition to laboratory tests, rapid diagnostic tests in clinical settings are also used to diagnose flu and help support improved clinical decision-making like the prescribing of antivirals.⁶ Data on the level of usage of these tests or their results are unavailable. Similarly, while at-home influenza tests are now broadly available for patient use, we lack data on their use and whether or how they improve care or outcomes.

While pediatric mortality from flu has been nationally notifiable to the CDC for more than twenty years, seasonal flu deaths in other age categories are not. Estimates are therefore needed. The CDC uses mathematical models based on data received through FluSurv-NET, its hospital surveillance network. Based on these models, CDC estimates that the 2024-2025 flu season resulted in at least 47 million illnesses, 21 million medical visits, 610,000 hospitalizations, and 27,000 deaths.⁷ Illness, medical visits, and

hospitalization all appear to have increased from last year based on preliminary estimates; hospitalization rose nearly 29%.⁸

These illnesses, medical visits, hospitalizations, and deaths have tremendous human cost. They also take a significant economic toll. Studies have estimated the average annual total economic burden of flu on the U.S. health care system and society at \$11.2 billion,⁹ and the CDC estimates that 17 million adult workdays are lost annually to influenza-related illnesses.¹⁰ This leads to billions more in sick days and productivity losses.¹¹

“Vaccine effectiveness,” or VE, measures how well flu vaccines work in the real world. It is often cited as an overall figure—for instance, a reported VE of 60% would mean that on average, vaccination reduced a person’s risk by 60% compared to a non-vaccinated person. The CDC conducts studies annually to assess flu vaccine effectiveness by monitoring laboratory-confirmed flu as the outcome of interest. The effectiveness of flu vaccines varies



ILLNESSES

47-82 million



MEDICAL VISITS

21-37 million



HOSPITALIZATIONS

610,000-1,300,000



DEATHS

27,000-130,000

Estimated influenza statistics for the 2024-2025 influenza season, October 1, 2024 through May 17, 2025. Data source: U.S. CDC.

“Influenza remains one of the major seasonal viral infections that infects millions of people each year and causes high morbidity and mortality in persons of all ages. Last year’s influenza season was one of the worst in over a decade in terms of infections, hospitalizations, and pediatric deaths. Influenza vaccination is the best way to protect yourself and your family against this infection and its complications.”

– Tina Q. Tan, Attending, Division of Infectious Diseases, Ann & Robert H. Lurie Children’s Hospital of Chicago; Vice-President, Infectious Diseases Society of America

with the season and the circulating virus strains. According to the CDC, flu vaccine effectiveness has ranged from 19% to 60% since 2009.¹² For the 2024-2025 season, preliminary estimates place flu vaccine effectiveness at 56%.

Perhaps even more important than preventing infection, however, is preventing outcomes like hospitalization, disability, and death. Thus, from a patient perspective, it is critical to understand how much vaccination reduces the risk of outpatient visits and hospitalization, not just infection. To do this, the CDC reviews data from multiple hospital networks. This is useful in that it broadens the reach of the datasets from just a single network, but challenges analysis because different networks can have different effectiveness levels.

Based on these data, **influenza vaccination was effective in reducing the risk of medically-attended flu across all age ranges in the United States during the 2024-**

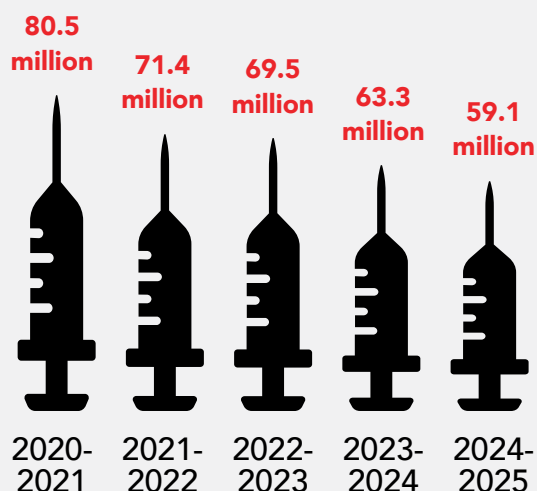
2025 season. In children and adolescents, estimates assess that vaccination reduced the risk of outpatient influenza-associated acute respiratory illness (ARI) in the United States by 32%, 59%, and 60% across three networks, respectively.¹³ The latter figures are consistent with those of the prior year.¹⁴ Critically, **vaccination reduced hospitalization risk in children and adolescents by 63% and 78%** across two networks—figures up from the prior year. In adults, VE for outpatient influenza ARI was 36% and 54% in two networks, and **VE was 41% and 55% against hospitalization in two networks.** These numbers are generally consistent with the prior year.

The more people that get vaccinated, the more likely vaccination as a strategy will be effective at a population level. Even a vaccine with modest effectiveness can have a dramatic impact on public health if uptake is high.¹⁵

“Individuals and families in our organization share their experiences with the flu as cautionary tales to help inform others. From those who have suffered severe illness or the loss of a loved one to the flu, we almost always hear the same thing—‘I didn’t realize the flu could be that serious.’ With the staggering number of flu hospitalizations and deaths, including more than 270 children this year, I hope that the message is clear: the flu is not to be taken lightly, and vaccines are our best defense.”

– Michele Slafkosky, Executive Director, Families Fighting Flu

Number of vaccines administered based on claims data for medical offices and retail pharmacies



Despite wide vaccine availability, overall **U.S. vaccination rates fell for the fourth consecutive season**. Nearly 148 million doses of vaccine were distributed this season.¹⁶ As is typical, vaccine supply was plentiful but, as in recent years, was not matched by demand and uptake, particularly among vulnerable populations like children and pregnant women.

A detailed understanding of flu vaccine uptake is challenged each season by a lack of sufficient data. One important source of information is prescription claims data. Based on prescribing data, as of April 12, 2025, more than **four million fewer flu vaccines had been administered to adults** in medical offices and retail pharmacies than the prior year.¹⁷ The drop was largely accounted for by a decline in medical office administration (down four million to 21.5 million), versus a smaller decline in pharmacies (down about 100,000 to 37.6 million). The decline was strongest in under-65 age groups.

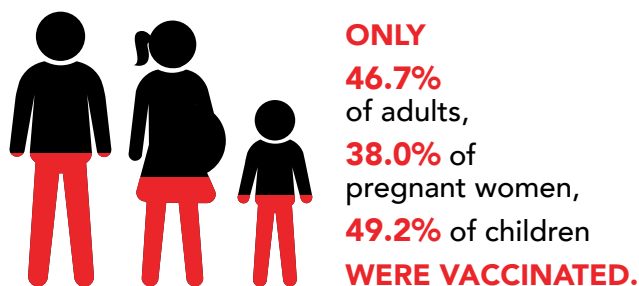
While these claims figures do not provide granularity into demographic differentials, nor

do they include vaccinations administered in other settings such as workplaces or public health clinics, they provide an important window into overall trends.

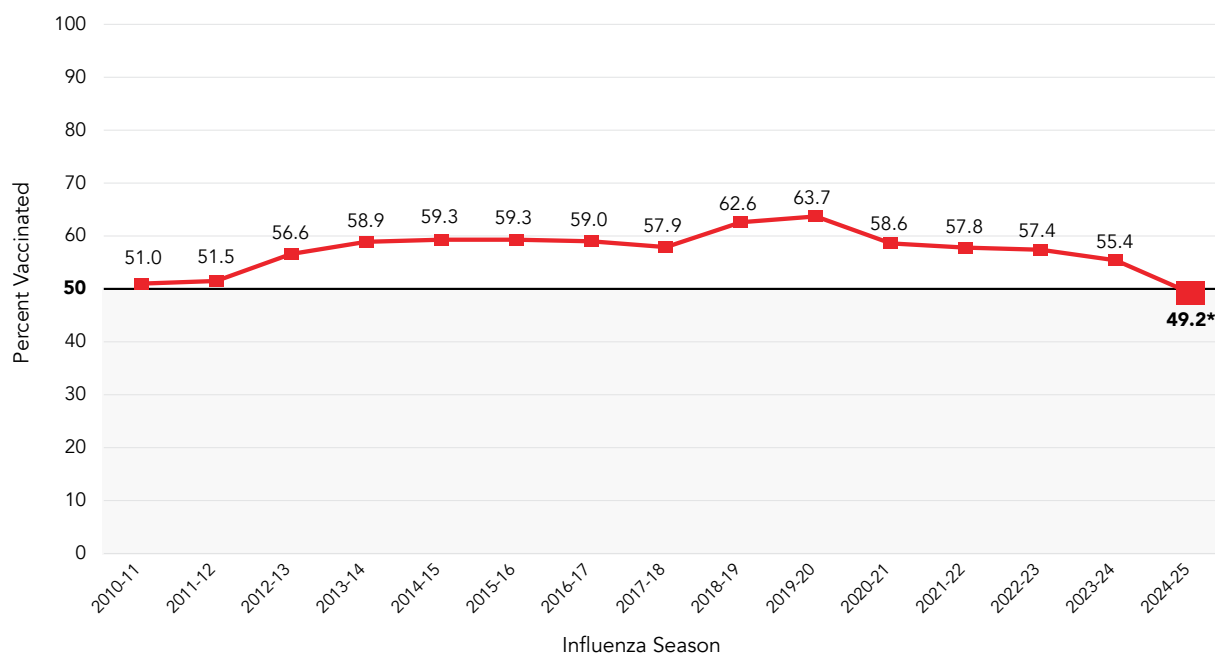
Another source of data are those captured from telephone surveys.¹⁸ Survey data identified a small but notable decrease in the adult vaccine coverage rate, placing it at 46.7%. Three states—Virginia, Wisconsin, and Idaho—accounted for the decline; one state, Mississippi, showed improved numbers. An **overall adult vaccination coverage of 46.7% is down about two percentage points from the prior year and is deeply concerning**. The gap between the Healthy People 2030 target of 70% population-wide vaccination¹⁹ and the reality of coverage is widening.

Moreover, the CDC estimates that overall **vaccination coverage among children was down to 49.2%**, a 4.2% year-over-year drop and a 13.2% drop compared to pre-Covid rates.²⁰ This marks an unfortunate milestone, with **fewer than half of U.S. children receiving the benefit of an influenza vaccination**.

Racial and ethnic disparities also reveal a continued struggle to ensure good coverage across all populations of children. Rates declined across races and ethnicities; they were lowest among White children (46.2%) and still well below targets in Black (47.8%) and Hispanic (53.1%) children.²¹ Drops in the states of Indiana (down 6%), Hawaii (down 8.5%), and especially Tennessee (down 9.6%) accounted for much of the decline.



Childhood vaccination coverage over time



Data accessed July 29, 2025; available at U.S. CDC, <https://www.cdc.gov/fluview/covage-by-season/2023-2024.html>.

*Preliminary

The **gap in flu vaccination rates between urban and rural children is stark**: children from urban areas had a coverage rate of 56.2% compared to 36.5% for children from rural areas, the latter of which was down three percentage points from last season. Further, **if you were a child living below the poverty line, you were less likely to get a vaccine than a child with greater means** (49.4% versus 53.3% coverage rate, respectively).

In another alarming trend, **vaccination during pregnancy was flat at just 38.0%**. In contrast, prior to the Covid-19 pandemic, more than half of pregnant women received a flu vaccine.²² The danger of influenza to pregnant women and newborns is well documented, resulting in increased risk of hospitalization for mothers and birth defects in developing babies.²³

A similar pattern of underuse persists for antivirals, a critical resource for both prevention and treatment of flu. Antivirals can mitigate symptoms and reduce community transmission.

Data on antiviral dispensing are not readily available publicly, but one study of antiviral administration in children published in 2024 analyzed two U.S. influenza surveillance systems for trends, comparing the 2023-2024 season to the 2017-2018 season. Among adolescents under 18 years of age with medically attended, laboratory-confirmed influenza, the number who received antivirals was down in the 2023-2024 season.²⁴ This comports with prior findings from claims data: while there is wide variability based on factors like age and geographic region, flu antivirals are underused in the pediatric population.²⁵ Claims data over prior years show a similar pattern of suboptimal usage across age ranges.²⁶ We reiterate the same conclusion we raised in last year's report: **Better understanding of the factors contributing to under-adherence to antiviral treatment guidelines is urgently needed.**

Finally, the tripledemic. The 2022-2023 and 2023-2024 seasons revealed a new pattern of incidence of illnesses of the “tripledeemic” respiratory viruses, or the overlap of seasonal influenza, Covid-19, and RSV. This trend has continued into the 2024-2025 season, with flu the most prevalent among the three by far. At its peak in February, influenza was associated with 8.4% of emergency department visits, compared to a 5.9% peak the prior year.²⁷ In other words, for every 100 people who presented to an emergency department in February 2025, at least eight of them had influenza. The persistent overlap of consequential respiratory viral disease strains emergency departments, leading to overcrowding, decreased availability of pediatric hospital intensive care beds, and prolonged patient management.²⁸

The Pandemic Threat from Avian Influenza

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Again this year, we must report on the threat of the **historic outbreak of H5N1 highly pathogenic avian influenza (HPAI)** and its continued spillover into numerous species, including humans. The virus has now been detected in poultry in **all 50 states**, with a death toll in commercial birds nearing 175 million (as of July 2025) from illness or from culling as part of the federal government’s “stamping-out” policy.²⁹ Further, HPAI has impacted more than 1,000 herds of dairy cattle across 17 states, exposing countless farmworkers.³⁰

It remains unknown whether this H5N1 outbreak will evolve into a pandemic. On July 2, the CDC deactivated its emergency response to the outbreak due to the absence of new human cases since February 2025.³¹ But even in its current state, HPAI is impacting human lives. Last year, we wrote that 14 individuals in the United States had been diagnosed with H5N1 since the start of the outbreak. The known number is now 70, including 1

death.³² It is challenging to determine the accuracy of these figures because we do not know how many cases are going unsurveilled, undiagnosed, or unreported. Those most at risk are individuals working with dairy herds, poultry farms, and culling operations; these are difficult populations to reach. And, the CDC laboratory that supports workers who rely on personal protective equipment (PPE), the National Personal Protective Technology Laboratory, suffered significant staff reductions.

Perhaps most troublingly, there have also been several human cases of HPAI with no known association with farm animals. The virus could yet evolve to become more transmissible. We do not see clear signals that the U.S. government plans to proactively address this pandemic potential, although the USDA has recently indicated some openness to poultry vaccination and two bills have been introduced in Congress to encourage it.³³ The Administration for Strategic Preparedness and Response (ASPR) does hold H5N1 vaccine assets in the U.S. National Pre-pandemic Influenza Vaccine Stockpile (NPISV) that could be used for response and has worked with industry to develop and test these vaccine candidates as well as newer options. However, the Strategic National Stockpile (SNS) has not procured fresh doses of oseltamivir (Tamiflu); most of its supply is now at least sixteen years old. And despite some critical investment on the part of the Biomedical Advanced Research and Development Authority (BARDA),³⁴ procurement of new antivirals with different mechanisms of action remains slow. Additionally, some medical countermeasure development funding for the response has also been reallocated or cancelled.

Notably, the U.S. government has no plans to offer H5N1 vaccines to at-risk groups such as farm personnel. Last fall, as part of a special program in the context of avian flu, the CDC delivered more than 100,000 doses of seasonal flu vaccine for farm workers to 12 states with

animals affected by HPAI.³⁵ The purpose was to help support local prevention of seasonal flu cases and, by extension, reduce the burden on the health care system and free up capacity to deal with a pandemic. Perhaps most importantly, this program aimed to reduce the opportunity for seasonal and H5 viruses to mix (“reassortment”) within an individual, a feared scenario that could lead to evolution of H5 viruses to make them more transmissible in humans.

Surveillance has improved after a slow start. In December, USDA established a National Milk Testing Strategy, which “facilitates comprehensive H5N1 surveillance of the Nation’s milk supply and dairy herds” and “provides a strategy to identify which States and herds within them are affected with H5N1.”³⁶ As of July 2025, 45 states were participating in the testing program. The CDC has also added H5N1 to its National Wastewater Surveillance Systems, allowing officials from CDC and USDA to investigate “hot spots” to assess whether positive results represent animal or human cases. The continuation of such efforts—which require personnel to implement and analyze—are imperative.

Despite these important actions, it feels now that a false sense of security is emerging. The outbreak shows up little in the headlines. The

Administration makes few announcements about progress or programs. Publicly available surveillance data are limited. It does not appear that the SNS, National Veterinary Stockpile (NVS), or other departmental-level caches are acquiring sufficient levels of PPE now—when it would be much less expensive than waiting for the emergency to arise.³⁷ Threat-agnostic approaches like PPE and innovative technologies like far-UVC are prevention and response tools that can address future threats—but only if we have ensured their availability.

HPAI is the poster child for the kind of threat that requires robust interagency coordination. With limited resources and authority, the White House Office of Pandemic Preparedness and Response Policy (OPPR) made an effort last year to enforce such coordination; that office is now functionally defunct, and the National Security Council’s role has been diminished. It is unclear how a complex interagency implementation to counteract such a complex problem can be accomplished absent such central planning and oversight.

Despite the current decline in cases among domestic animals and humans, H5N1 continues to circulate in wild birds. We cannot change this, and absent a significant effort to provide the virus with fewer opportunities to enter animal human populations, we continue to be at risk.

2024-2025 in Context: The Stakeholder Perspective

The Coalition to Stop Flu is dedicated to ending deaths from seasonal and pandemic influenza by raising awareness of the threat and its human impact and advancing policy solutions to improve U.S. preparedness and response. Our members represent diverse voices from many sectors, with the common goal of reducing the influenza burden and saving lives. The Coalition is cognizant of noteworthy efforts and successes every year, while also concerned with challenges both old and new that rear their heads and stymie progress.

Success Stories



The Coalition is continually heartened by the **strong and creative grassroots outreach** from its members and other organizations that are central to the cause of advancing clear messages to the public. The kind of local and tailored outreach that they do is essential. For example, Families Fighting Flu and Vaccinate Your Family have been working to not only deliver quality information through trusted messengers, but to consistently analyze metrics and approaches to ensure that those messages and resources are tailored to effectively address the unique needs of individual communities.



The nation continues to have a robust seasonal flu vaccine supply chain. The **U.S. supply of seasonal flu vaccines is strong** thanks to years of co-investment from companies and the federal government.



Private and federal investment have supported the **continued advancement of new and innovative products**. Innovative candidates in the pipeline range from new over-the-counter flu vaccines to combination flu-Covid vaccines, monoclonal antibodies, at-home diagnostic tests, and non-pharmaceutical interventions like germicidal UV light.



Federal support for surveillance tools like advanced molecular detection to sequence circulating strains of flu provided critical data to help characterize the strains of influenza in circulation and monitor potentially problematic mutations. Relatedly, CDC has been tracking influenza A, including H5N1, through **wastewater surveillance**. This is an important passive surveillance tool and can be complementary to other types of surveillance, including on-farm testing and hospital-based surveillance.



The CDC has monitored more than 17,000 individuals with potential exposure to H5N1. The CDC also published studies of veterinarian exposure³⁸ and dairy worker exposure³⁹ to H5N1 based on serological testing. Continued surveillance of at-risk individuals—even if not symptomatic—is critical to ensuring that we do not miss an important step in the virus' evolution. Further,

transparency in publishing the data from these kinds of efforts enhances everyone's understanding of H5N1 risk. The rural nature of the dairy infections and the immigrant nature of this workforce challenges full situational awareness of infection incidence. More active surveillance and more occupational studies should be undertaken to assess occupational and other exposures and risks.



Federal budgetary cuts largely spared programs at CDC and ASPR focused on seasonal and pandemic influenza.

This is a recognition of the **value and importance of this critical work defending our country against the threat of flu.**

Room for Improvement



Rates of **vaccination—our best tool to avoid flu morbidity and deaths—are down for the fourth straight**

season. Declining vaccination rates can lead to increasing rates of illness, hospitalization, disability, and death. An increasing reliance on vaccine recommendations tied to “shared clinical decision-making” is challenged by the reality that at least 5% of children and 15% of adults do not see a health care provider in a given year,⁴⁰ that these visits may be off-cycle seasonally in terms of flu vaccine availability, and that many Americans now get flu shots from retail pharmacies or other access channels outside of provider offices.



The **steep rise among deaths in children is unacceptable.** The CDC

estimates that 90% of the children who died during the 2024-2025 season were not fully vaccinated.⁴¹ While innovators are working diligently to develop even better, next-generation vaccines, the death of unvaccinated children older than six months is an outcome that can be prevented with the vaccines already at our disposal. Because many children hospitalized with flu had an underlying illness such as asthma, neurologic disease, or obesity, attention to these kinds of comorbidities can also reduce the worst influenza outcomes.

America must do a better job ensuring that every child over six months of age has access to a seasonal flu vaccine.



The **poor uptake of vaccination among pregnant women must be better understood.** The CDC

recommends influenza vaccination in pregnancy for several reasons, including because pregnant women are at higher risk from flu due to changes in their immune system, heart, and lungs, and because maternal antibodies from vaccination can protect infants during the first several months of life before they can be vaccinated. Why pregnant women are foregoing vaccination at a rate far below that of the general population is an imperative public health question.



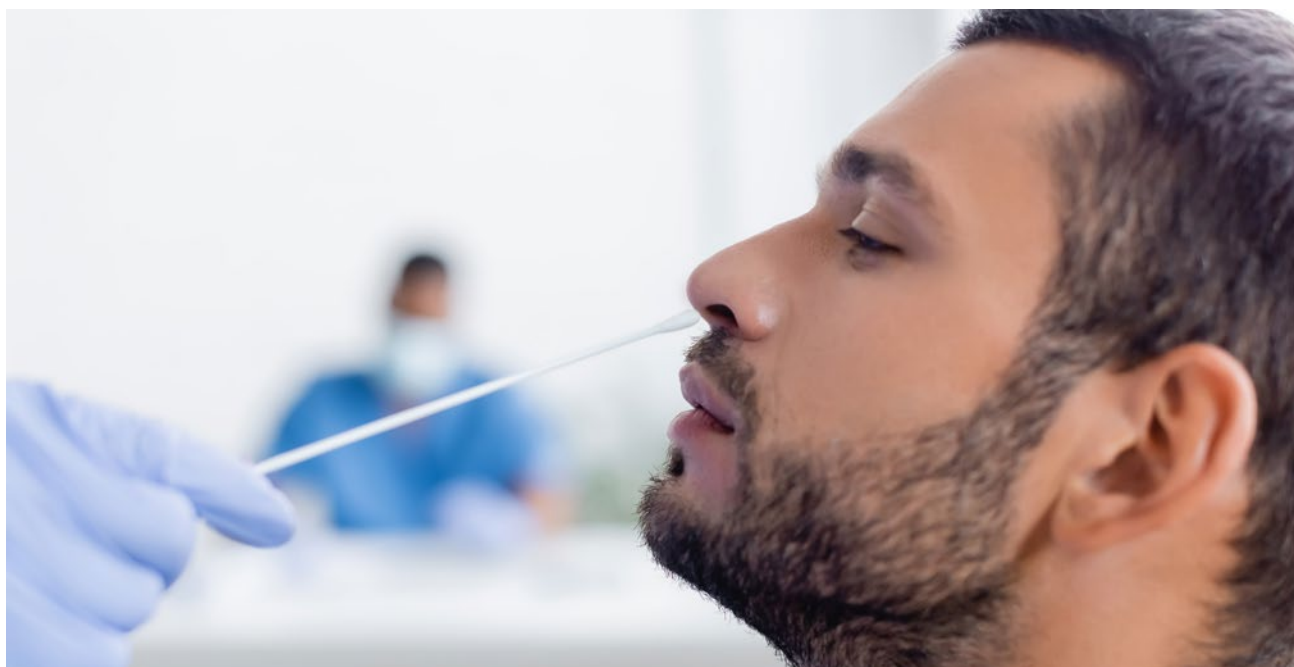
Even as the phenomenon worsens, **we still do not fully understand the drivers of vaccination decline.** This

is undoubtedly a multifaceted problem that relates to under-appreciation of the flu's worst impacts, misinformation, lack of trust in institutions, and the fatigue of the “respiratory season” and its attendant vaccination schedules. Vaccine hesitancy could quickly spill over into antiviral hesitancy if people do not understand what flu can do. All of this will lead to a great burden of disease, lives lost, and economic consequences.



It is **unlikely that the federal government will conduct its annual fall messaging campaign** on

influenza, harming efforts to reverse the



dangerous slide in vaccination rates. If states also choose to end vaccination clinics and education through their health departments, as Louisiana did in February,⁴² **individual opportunity for information, choice, and access** will become severely curtailed.

 **Upheaval in CDC leadership, including the resignation of the head of the National Center for Immunization and Respiratory Diseases, threatens the continuity of critical agency functions.** Additionally, while federal budgetary and workforce cuts have largely spared programmatic influenza personnel, cuts to administrative support personnel will make their jobs more challenging and may slow down vital activities like communications and contracting. This will be further complicated by the withdrawal from international institutions critical to global surveillance and strain selection. Further, **significant cuts to funding to state and local public health departments will detrimentally impact their ability to reach their local communities and offer education and access to vaccines and other products.** All of these variables risk making the 2025-2026 flu season even more challenging than the last.



We must continue to support uptake of existing flu vaccines and antivirals while **investing aggressively in drug candidates and modalities with improved efficacy.** Investment across an array of candidates, platforms, and alternative delivery modalities like patches is necessary. Importantly, this investment should be **technology-agnostic.** Many small companies continue to struggle to secure funding to bridge the “valley of death” and move their promising products from the lab into humans. BARDA and the National Institutes of Health (NIH) should work to diversify their emerging product portfolios to optimize use of taxpayer dollars and maximize the chance of success. BARDA could also consider the potential of artificial intelligence (AI) approaches to better predict strains and support product development.



Health care providers still lack sufficient tools to help raise vaccination rates. High demands on providers’ time—especially at the primary and family care level—layered atop vaccine hesitancy and reimbursement struggles are challenging in-clinic discussions about the

importance of annual flu vaccination and in-clinic administration of vaccines. The American Medical Association, the CDC, and groups like Immunize.org have issued guidance to support providers in having these conversations with patients, but more is needed to better understand and address these challenges.⁴³



Testing supports individualized care, awareness of the transmission of pathogens through communities, and understanding of pathogens' evolution toward greater transmissibility. However, the **role that diagnostics could play in seasonal flu remains unrealized**, both in terms of laboratory-based and at-home testing. Low uptake of antivirals is due in part to late diagnoses, at which point antivirals are less effective. This speaks to the need for increased and early access to diagnostics, particularly to be better prepared for the next pandemic. The Government Accountability Office has called on the Secretary of HHS to implement a national diagnostic testing strategy for infectious diseases with pandemic potential, citing H5N1 as a key consideration, and bipartisan bills have been introduced in Congress to the same end.⁴⁴



Insufficient gathering and posting of flu data has long been a problem. The lack of national access to disaggregated data reported at fine geographic levels continues to prohibit deep understanding of why attack rates are worse in some communities than others. But **the data access problem worsened this year**, with our members reporting a diminishing of what used to be routine information pushed out on the CDC FluView website.⁴⁵ Effective public health depends on data. Reaching **people most at risk of severe flu—which includes the many individuals with chronic co-morbidities**⁴⁶—can only be done with adequate data. Additional details like vaccination status, presence of co-morbidities, and geographic location tied to reports of illness,

hospitalization, and death can help public officials better understand and protect the most vulnerable populations.



Although vaccine coverage is down for key groups like children and pregnant women, survey data indicate that coverage among adults, including older adults, is generally holding at prior levels. While this appears to be a bright spot, a close look at available data reveals discrepancies. While survey data show that the over-65 category continues to nearly meet the Healthy People target of 70% coverage,⁴⁷ Medicare claims data identify a much lower over-65 vaccination rate—only 48.3% as of late February.⁴⁸ The **discrepancies between survey data and other sources can be large**, and more precision is needed.



We repeat our standing recommendation that **broad diversification of SNS assets and modernized asset management** to support pandemic readiness are needed to address the pandemic threat. This includes diagnostics, vaccines, treatments, and next-generation PPE. Relatedly, we urge the Administration to continually reevaluate whether to offer pandemic flu vaccinations or antivirals with prophylactic indications to at-risk populations.



The H5N1 outbreak in animals has revealed considerable **weaknesses in our ability to quickly deal with a multi-species, multi-jurisdictional outbreak of a zoonotic disease**. Cases in poultry, livestock, wild birds, and wild mammals continue. The inactivity of the OPPR raises concerns for how the continued preparedness and response activities will be adequately implemented across not just USDA and HHS, but the numerous other agencies that will be invoked should an H5N1 pandemic ensue.

What's Next?

Even a normal flu season is devastating for our country's health and economic security, and last season was far from normal. It was the worst since the disastrous 2017-2018 season, in which an estimated 52,000 Americans died.⁴⁹ The positive results of years of work appear to be breaking down. The 2024-2025 influenza season should force a national reckoning on how we can better prepare our most vulnerable citizens against a preventable threat.

We need to reset the national conversation to ensure a common understanding of **what flu is about**:

- **Flu is about impacts to individuals:** Flu causes lost time from work and school; illness ranging from moderate to severe; and the potential for brain inflammation, systemic organ dysfunction, limb amputation, and death.⁵⁰
- **Flu is about impacts to communities:** Flu burdens communities, employers, and families, especially those on fixed incomes.⁵¹ The more individuals who are vaccinated, the better protected their families, friends, and entire communities are from infection—including infants too young to be vaccinated and other individuals who are contraindicated from receiving vaccination.
- **Flu is about impacts to our economy:** Flu costs individuals, employers, and the government billions of dollars a year in direct and indirect costs,⁵² much of which is avoidable.



We have tools at our disposal that could mitigate the flu's impact, and all are underutilized. Below we repeat many of the Coalition's recommendations from last year in the hope that the sobering statistics from this most recent flu season can spur action to prevent a repeat of this year's losses.

Declining attention to prevention and preparedness is our most serious concern. The federal government has a critical role in both seasonal and pandemic preparedness and response. Despite continued budgetary support for seasonal influenza work at CDC and pandemic influenza work at ASPR, funding and workforce cuts to support functions at those agencies will impact their work. Further, as of this writing, HHS has proposed a reorganization of ASPR, which may eliminate the position of the Assistant Secretary for Preparedness and Response—a role established twenty years ago because lawmakers understood that we cannot prevent or react to public health crises in a siloed, disjointed manner. Additionally, cuts to state and local public health departments will shrink the infrastructure available for both routine and major responses. The growth in vaccine hesitancy and mistrust of public health have also profoundly impacted our preparedness for routine viruses like influenza as well as the next pandemic, whether from H5N1 or another virus.

The federal government can enact legislative and administrative changes to address influenza's profound impacts on human health, animal health, and the economy. This requires decisive action to ensure policies and programs are in place, provision of funding, and a willingness to swiftly address emergent problems. The Administration and Congress should support:

Appropriations

States do not have the resources to fund all of the activities that enable flu resilience. The Administration and Congress should invest in critical federal flu programs through targeted annual appropriations, including:

- The ASPR/BARDA Pandemic Influenza program, Strategic National Stockpile, Hospital Preparedness Program, and Industrial Base Management and Supply Chain
- CDC's Influenza Planning & Response program
- CDC's Public Health Emergency Preparedness cooperative agreement program
- CDC's Data Modernization Initiative and Advanced Molecular Detection program
- CDC's "Section 317" Immunization Program and other policies and programs that increase access to influenza vaccines for all Americans
- NIH research and development, especially for universal influenza vaccines

H5N1 Response

Planning for a widespread pandemic strain of influenza is a national security imperative. Federal policymakers should prioritize the H5N1 response given the potential threat to human health:

- The White House should staff the Office of Pandemic Preparedness and Response Policy (OPPR), which should continue its coordination role and provide regular updates to Congress and external stakeholders.
- OPPR, ASPR, and CDC should provide additional transparency to Congress and external stakeholders into the triggers that would cause reevaluation of their H5N1 risk assessments and the plans they will set in motion should an elevation in their assessments occur.
- USDA should ensure that the NVS is equipped with sufficient PPE and related resources for the farm workforce, and with medical countermeasures for livestock and poultry; poultry vaccination should be a USDA priority.
- USDA should work with state, private, and non-profit partners to increase testing and surveillance of dairy cattle, including of asymptomatic animals.
- CDC should work with state, private, and non-profit partners to enhance active surveillance of people to better capture human cases as they arise.
- ASPR should replenish and diversify the flu antiviral stockpile in the SNS.
- ASPR should consider the value of H5N1 vaccination for at-risk occupations, and CDC should ensure it readies clear public messaging about any potential H5N1 vaccination.
- BARDA should prioritize innovative investments for H5N1 medical countermeasures and ensure that companies are provided with transparency around requirements and available funding to ensure robust public-private partnerships.



Congress should also reauthorize the **Pandemic and All-Hazards Preparedness Act**. This legislation is integral to all health security efforts, including pandemic influenza.

The federal agencies working to implement flu programs should focus on:



Prevention & Treatment

Undertake more advanced **research on public attitudes toward vaccination** to better understand the specific drivers of declining vaccine uptake, especially among pregnant women and parents with respect to childhood vaccination.

Better understand pressures on providers that are serving as barriers to vaccination and work to address these challenges. Providers need more tools from government authorities and non-governmental experts to help them advocate to patients about the importance of vaccination, as well as adequate reimbursement for immunization services.

Empower and resource state and local health departments and other stakeholders to reach vulnerable Americans to educate them about the risks of flu and the importance of prevention, diagnosis, and treatment. In the absence of a federal ad campaign, the federal government should ensure that state, local, and nongovernmental partners have the necessary evidence-based information and resources, with a focus on mobilizing trusted messengers and messages tailored to regional and community levels. This includes providing access to messaging assets and data as quickly as possible.

Ramp up and diversify investment in **research and development to support innovative technologies**, focusing on technologies that reduce barriers to uptake. Emphasize influenza vaccines with broader and more durable protection, alternative routes of administration such as oral or dermal, new antivirals, and at-home testing options. The federal government should increase opportunities for public-private collaboration on early-stage products, maximizing the chances to move next-generation products to market.



Data and Surveillance

Capture and post as much flu data as possible in as close to real time as possible. Non-governmental scientists and patient groups can supplement federal analysis efforts but only if all needed data are captured and quickly made available.

Maintain and continue to build on prior work to partner with state and non-governmental partners to **enhance flu surveillance systems**, including obtaining more detailed and disaggregated data to support better epidemiological analyses.

Continue to strengthen early warning capabilities through **increased support for genetic sequencing programs** and ensure that all of the data generated are quickly released into the public domain for analysis.

Capture and publish **data on access to antivirals and supply shortfalls** to enable early identification of demand spikes and spot shortages.



The Seasonal-Pandemic Ecosystem

In addition to the specific measures described above for the current H5N1 outbreak, the following activities will support the long-term health of the seasonal-pandemic ecosystem:

Drawing on lessons learned from the H5N1 response, the Administration should **identify opportunities to dissolve silos, improve interagency coordination and collaboration, and determine where authorities are still needed** to ensure an effective government preparedness and response posture.

Increase and sustain investments in both **active and passive surveillance networks**, strengthening our ability to detect and monitor potential pandemic strains.

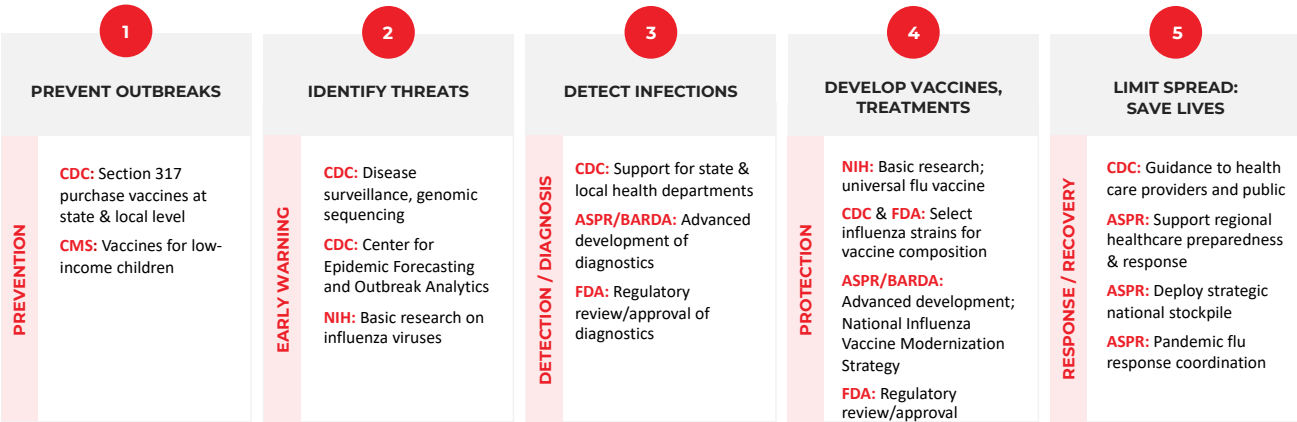
Replenish and diversify flu antivirals in the SNS, leverage vendor-managed inventory and other stockpiling techniques, and otherwise **modernize the SNS to ensure availability of diagnostics, vaccines, antivirals, and supplies such as PPE** in the event of a flu pandemic.

Support investment in **infrastructure for routine immunization**: seasonal influenza vaccination offers the nation a dry run for any pandemic response.

The country is lapsing into a new seasonal influenza reality. This reality is one that fails to take advantage of the tests, treatments, and vaccines that could eliminate serious flu illness from the annals of medicine. As we move into the next flu season and the years to come, the federal government must maintain its historical fundamental support for the seasonal and pandemic ecosystem and take every step necessary to reduce morbidity and mortality from this dangerous virus. **Annual readiness is pandemic preparedness.**

Seasonal & Pandemic Influenza Ecosystem

Federal Government Agency Roles to Prevent, Detect, Treat



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About the Coalition to Stop Flu

The Coalition to Stop Flu is a multi-sector advocacy coalition dedicated to ending deaths from seasonal and pandemic influenza. The Coalition's federal policy agenda is aimed at saving lives, saving money, and protecting public health by enhancing the U.S. influenza ecosystem, including advocating for targeted funding for priority influenza programs.

To learn more, please visit www.flucoalition.org

Coalition Members





COALITION TO
STOP FLU

The 2024-2025 Influenza Season: Outcomes and Policy Recommendations

A Report of the Coalition to Stop Flu

September 2025

