

Understanding Challenges in Accessing Priority Vaccines for Seniors Living Outside Long-Term Care in British Columbia

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Executive Summary

British Columbia's vaccination rates among seniors are low, especially in rural areas and low-income communities. This is mainly due to limited transportation options and unclear vaccination policies. Seniors living in congregate settings, such as assisted living (AL) and independent living (IL), encounter greater difficulties in accessing priority vaccines. This research aimed to investigate seniors' awareness, attitudes, behaviors, and beliefs regarding the uptake of priority vaccines in British Columbia. We identified obstacles to vaccine equity and found opportunities to boost vaccination rates among seniors in congregate settings.

This research included eleven consultation sessions with government officials focused on vaccines, vaccine program leaders in assisted and independent living organizations, and older adults living in these facilities in British Columbia.

Consultation findings showed that older adults in assisted and independent living face many barriers to getting vaccines. These include physical limitations, geographic isolation, inconsistencies at the facility level, and costs, especially for vaccines that are not funded. Difficulties with obtaining consent, structural gaps in delivery, unclear roles for providers, and workforce shortages also hinder access. Generational differences, mistrust, and widespread misinformation undermine confidence, especially when clear, accessible information is not available.

Improving vaccine access for older adults includes on-site, mobile, and extended delivery options, supported by system reforms that simplify roles and reduce fragmentation. Additionally, expanding partnerships with family doctors, pharmacists, and care providers can increase vaccination rates. Continuous, targeted education is vital for building trust and fighting misinformation.

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Background

COVID-19, flu, pneumonia, RSV, shingles, tetanus, and diphtheria are the priority vaccine-preventable diseases in Canada. However, vaccination rates for these diseases, especially among seniors, remain below national targets, with fewer than 40% vaccinated for shingles and pneumococcal disease, and less than 70% for influenza—falling short of the 80% goal by 2025 (Gilmour, 2024; Manneh et al., 2022; Public Health Agency of Canada, 2025). Vaccination rates among seniors in British Columbia are even lower, particularly in rural areas and low-income communities, due to limited transportation options and confusing vaccination policies. Seniors in long-term care facilities generally have higher vaccination rates thanks to coordinated care. Those living in independent and assisted living facilities, as well as in the community, face barriers related to accessibility and cost (Office of the Seniors Advocate, 2022; CanAge, 2023; Office of the Seniors Advocate, 2024).

This research focuses on seniors living outside of long-term care facilities, specifically those residing in independent living (IL) and assisted living (AL) settings. This group of older adults has been disproportionately impacted by vaccine hesitancy and indifference due to complex experiences of exclusionary policies. Because of these inequities, we adopt an intersectionality perspective. We examine vaccine access disparities among seniors in British Columbia, with the goal of promoting equitable vaccine access.

Specifically, we explore opportunities to advocate for equitable vaccine access for residents of IL and AL facilities. To achieve this primary goal, we aim to understand seniors' awareness, attitudes, behaviours, and beliefs regarding access to priority vaccinations. We will identify current resources and programs available to promote vaccination among British Columbia seniors and pinpoint gaps. We are interested in discussing the barriers and obstacles related to vaccine equity in IL and AL settings. To provide direction, we will examine available opportunities and make recommendations to improve vaccination rates among seniors in congregate settings.

Methods

The project design adopted a cross-sectional and interpretive approach. A qualitative research paradigm was used for this study to explore the subjective experiences of seniors and the institutions that support them. Eleven consultation sessions took place at purposively selected assisted living and independent living facilities, involving vaccine leadership, implementation personnel, and policy-level professionals (see Table 1). Participants were included based on their willingness to participate and ability to communicate in English. Narratives were handled individually and grouped into categories based on relevant topics. The textual data were content analyzed and thematized according to the study's objectives using NVivo 14. The research team adopted the four basic steps for analyzing qualitative data (Ritchie et al., 2013), as outlined:

- i. The audio data was transcribed and double-translated to determine the validity of meanings (semantics and pragmatics). Response triangulation was adopted to determine that the responses align with the research focus (Lincoln & Guba, 1985). Besides, names and places in the transcripts were anonymised to protect respondents' confidentiality.
- ii. Inductive and deductive codes were ascribed to the narratives. This coding process facilitated the demarcation of major themes from emergent themes. Code groups and memos were developed and grouped for the subsequent analysis stage.
- iii. Networks were created at this stage. Code-to-code and memo-to-memo networks helped to describe the direction of the relationship between and among codes/memos.
- iv. Query tools were deployed to explore co-occurrences through the various operators and syntax structures. At this point, another level of data validation – refutational analysis (Leung, 2015) was applied to compare, contrast, and identify deviant cases that will flow into the reports' writing.

Table 1: Consultation sessions' metadata

S/N	Name	Description
A.	Leadership Consultations	
	<i>Assisted living facilities (AL)</i>	JIV (AL) MEL (AL) GAY (AL)
	<i>Independent living facilities (IL)</i>	JEN (AL-IL) GGM (IL)
B.	Vaccine Implementation Consultations	MAG (HA) MEP (HA)
C.	Vaccine Policy Consultations	DAL (POL) DSV (HA)
D.	Group Consultations	
	<i>Independent Living Older Adults</i>	ELV (IL-Comm)
	<i>Assisted Living Older Adults</i>	HOP (AL-Comm)

Findings

Findings from the consultation show that older adults in assisted and independent living facilities face multiple, overlapping barriers to vaccine access. There are also some strategies for improving access to priority vaccines in British Columbia.

Challenges of accessing priority vaccines in British Columbia

Older adults in assisted and independent living facilities encounter: (1) physical limitations, inaccessible environments, and geographic isolation that hinder their ability to get vaccinated. Individual factors, including mistrust, fear, and personal beliefs, further complicate uptake. There are facility-level inconsistencies and location-based disparities affecting access; (2) Consent and autonomy challenges arise, especially for those requiring proxies; (3) Cost is a significant barrier, particularly for vaccines not publicly funded; and (4) policy gaps create uneven access across provinces. (5) Structural delivery issues, unclear provider responsibilities, and (6) workforce shortages limit consistent rollout. (7) Generational differences also influence decision-making. Additionally, logistical constraints and (8) media misinformation undermine trust, especially where clear, accessible information is lacking.

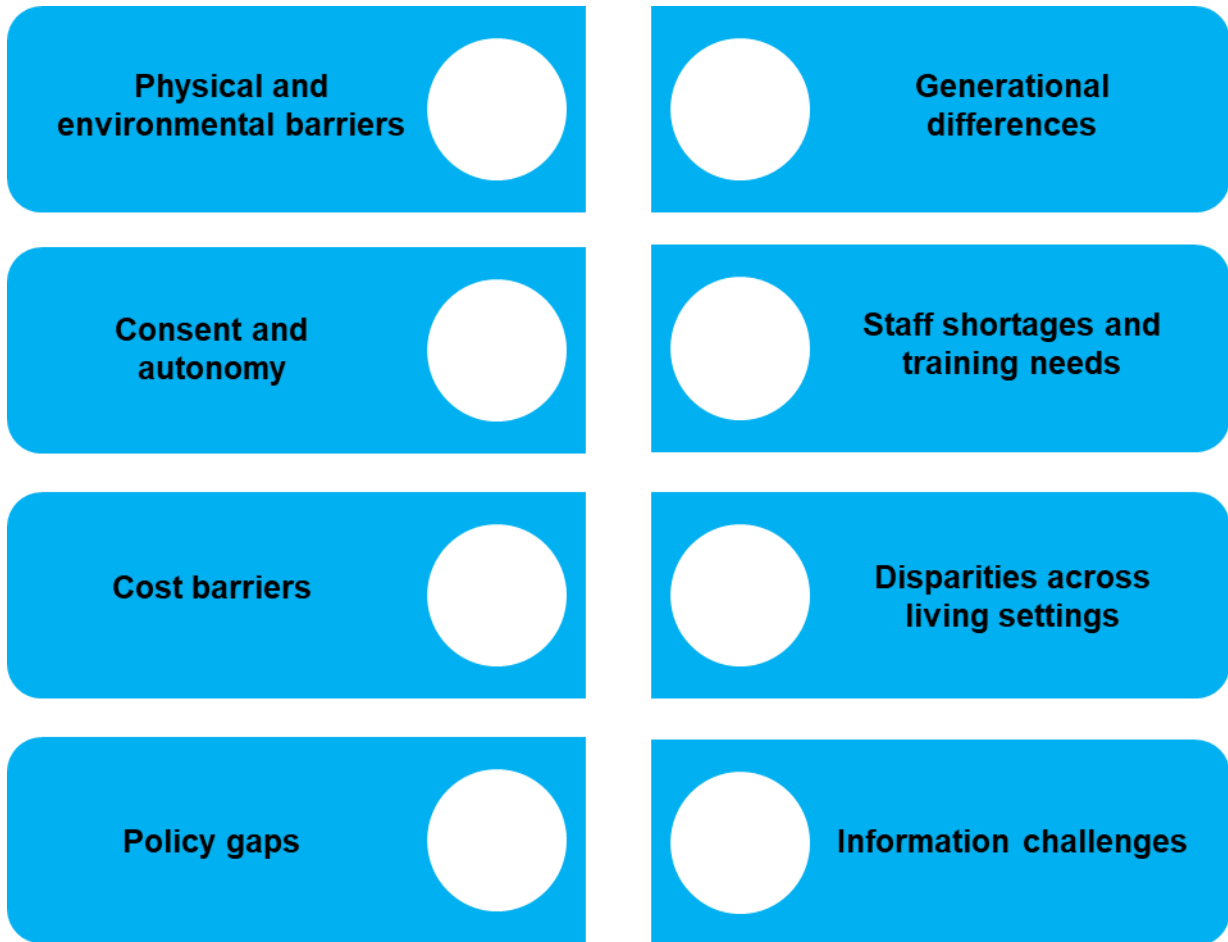


Figure 1: Challenges of accessing priority vaccines in British Columbia

1. Physical and environmental barriers

Individual-level barriers

Older adults often encounter several barriers to accessing vaccines independently, including mobility challenges, cognitive impairments, and limited transportation options. Difficulties like being unable to drive or experiencing physical health changes further hinder their ability to seek vaccination independently. Accessing vaccines within the community is especially difficult due to scarce transportation options and complicated appointment procedures.

Quotes
<i>“Our residents can’t get up those stairs without their walker... they can’t use the walker because it’ll be too narrow.” – MEL (AL)</i>
<i>“It would probably be easier just not to go for the shingles vaccination... there’s only one taxi that can accommodate somebody with a wheelchair.” – GGM (IL)</i>

Facility-level barriers

Older adults in independent living settings have access to transportation but scarcely use it. It was noted that residents rarely requested the service. Also, the older adults reported that their vaccine appointment procedures are unclear or burdensome.

Quotes
<i>“We have all of our facilities have buses and we do take people to appointments... I haven’t had that conversation with people to say they physically can’t get to see their doctor.” – GAY (AL)</i>
<i>“Barriers of... knowing where to get the vaccine, what time... do they have to book an appointment?” – MAG (HA)</i>

Location-based barrier

Rural areas face unique access barriers, including a lack of local programs and fewer external partnerships outside of the health authority.

Quotes
<i>“We don’t [have] YMCA here... there’s not a lot here...when you have rural communities that are spread out and we have less resources, it’s not always easy.” – MEL (AL)</i>

2. Consent and autonomy

Family members influence older adults' vaccine hesitancy or refusal. Assisted living residents display diverse patterns, shaped by personal beliefs, family ties, and physicians' guidance. Additionally, vaccine uptake for IL and AL residents living with cognitive impairment involves navigating the procedural complexities of assent and consent with family members. This process is inconsistent and time-consuming because family participation in the consent process is required. Furthermore, when IL and AL residents refuse vaccines, respect for autonomy and consent underpins their unequivocal refusal.

Quotes
<i>The education and the information needs to get to those adults, but also to their families, because families can really have an effect on those decisions...GAY (AL)</i>
<i>“They are consenting adults that can navigate their care... it’s conversations they should be having with their family physician.” JIV (AL)</i>
<i>We have to defer... their substitute decision maker by law and we can’t vaccinate them against that consent. MEP (HA)</i>
<i>We have a clinic... we make it available... If they take it, they do. If they don’t, they don’t. GGM (IL)</i>

3. Cost barriers

Cost remains a major obstacle for older adults in British Columbia to access priority vaccines, especially for non-publicly funded ones like Shingrix (shingles), Pneumovax (pneumonia), and RSV. These vaccines are often not fully covered by provincial health plans, leaving older adults—particularly those outside specific age groups—responsible for the entire cost. This raises questions about the cost-benefit justification, especially for residents on fixed incomes.

Quotes
<i>“There was a certain age category within a five-year span where it was covered... outside of that it wasn’t covered.” – JEN (AL-IL)</i>
<i>But again, these are the issues that the decision cannot be made at individual level...these are things that need to be assessed more thoroughly, and to see if it is a cost effective...choice to make what are the priorities? What is the epidemiology of the disease in the province, and then based on that...which one of the vaccines want to go 1st and make and offer them free of charge...do they have any cost effectiveness...is it scientifically recommended...but again, there are like different health priorities. So and we need to go, we need to spend our resources wisely... – DSV (HA)</i>

At the policy level, there is awareness that current vaccine funding structures may create inequities among seniors.

Quotes
<i>“The government should be treating all seniors the same... there may be an argument to consider income testing.” – DAL (POL)</i>
<i>“It’s expensive for people... should it be covered by a public healthcare system? I’m not sure.” – MAG (HA)</i>

Residents in IL and AL settings often have to organize and pay for vaccines themselves, which adds to their burden.

Quotes
<i>“They would have to organize... pay for it... We don’t offer shingles or RSV.” – GGM (IL)</i>
<i>“We have the paper. [Nobody] can afford it. The shingles, so we have to suffer.” – HOP (AL-COMM)</i>

Even when low-income individuals may qualify for reduced-cost vaccines, there are few requests and limited availability, partly due to system complexity and lack of awareness. Health authority staff report difficulty getting families to accept vaccines that come at an additional cost.

Quotes
<i>"We cannot change it for anyone... But I can't remember any seniors' requests like during a few months that I have been here." – DSV (HA)</i>
<i>"Any extra cost is significant for them... I rarely... will have family members accept... a vaccine that is an additional cost." – MEP (HA)</i>

4. Policy gaps

Vaccine priorities

Decisions about which vaccines are publicly funded are made at the provincial level and are influenced by epidemiological data, cost-effectiveness assessments, and provincial priorities. These decisions have a direct impact on what older adults can access, especially in congregate settings.

Quotes
<i>"Those types of decisions would have to come through the government... they're the ones who determined what types of things there's no charge for." – GAY (AL)</i>
<i>"Everything has a price tag... is it worth it to invest in increasing vaccine access in the gaps?" – MAG (HA)</i>
<i>"These are things that need to be assessed more thoroughly, and to see if it is a cost-effective choice to make... the decision needs to be made at the higher level." – DSV (HA)</i>
<i>"The government should cover more of the cost... after I retired and turned 65, that benefit is gone." – HOP (AL-COMM)</i>

Facility ownership

Some facilities benefit from coordination with health authorities, while others must arrange services independently. These coordination dynamics influence vaccine access among residents living in IL and AL, depending on the facilities' relationship with the regional health authority.

Quotes
<i>"Because we're funded by the health authority, we actually do have the health authority make arrangements to come and do the vaccines." – MEL (AL)</i>
<i>"Public health... providing us the vaccines... the pharmacy... doing the actual hands-on vaccinations." – JIV (AL)</i>
<i>"So, the only vaccine clinics that we have are the flu and COVID vaccines for them... they wouldn't have any access whatsoever." – GGM (IL)</i>

5. Generational differences

There is a generational difference between how the young-old and old-older adults think about vaccines, and these generational dynamics influence vaccine hesitancy. Younger-older adults (≤ 60 years old) are more sceptical of vaccines. Old-older adults (80+ years old)

are optimistic about vaccines due to their experiences of vaccine efficacy during the global polio outbreak.

Quotes
<i>“My 90-year-olds... ‘Doctor, if you tell me, I’m just gonna take it.’ That doesn’t hold with the 50–60-year-olds.” – MEP (HA)</i>
<i>“I mean the 80+...they looked through the years of polio and the polio vaccinations, and they saw...how things were after the polio vaccinations and the positive impact the polio vaccinations had on society.” – GGM (IL)</i>
<i>“The younger people haven’t experienced loved ones going through the iron lung for polio or the sanatoriums. Okay?.” – ELV (IL-Comm)</i>

6. Staff shortages

Staffing shortages among health authorities’ immunizers limit the ability of IL and AL facilities to provide vaccines regularly. The limited population of immunizers imposes significant access barriers when they are deployed to work in AL and IL facilities.

Quotes
<i>“If we had more vaccinators, I think we would have more access to vaccinations on site.” – JEN (AL-IL)</i>
<i>“We’re not always privy... to know if they’ve had the pneumovax or shingles vaccine.” – JIV (AL)</i>

7. Disparities across living settings

Older adults in independent and assisted living facilities face more challenges in accessing vaccines, unlike those in LTC. Many IL and AL residents must rely on personal means to access vaccines at pharmacies while navigating mobility and transportation limitations. IL and AL residents often need to self-navigate the process.

Quotes
<i>“Older adults in independent living... are left out there in the pool, you know, trying to figure things out on their own.” – DSV (HA)</i>
<i>“It doesn’t seem to be quite as easy to access vaccines if you’re not in that residential care space... the risk is the same.” – JEN (AL-IL)</i>
<i>“But then we had 100 people in independent living that were no longer getting vaccinated on site... a lot of the people that live here no longer drive.” – GGM (IL)</i>

8. Information challenges

Lack of accurate and accessible information

Many older adults and their families lack access to accurate and readily available information about available vaccines, which affects their understanding and uptake. This occurs because

residents in assisted and independent living settings do not regularly engage with media or online sources.

Quotes
<i>"They're not on the Internet... they're less likely to have that access to knowledge." – MEP (HA)</i>
<i>"They may not know that they can go outside in the community to maybe a pharmacist to get those." – MEL (AL)</i>
<i>"They do not have access to valid source of information, for example, that might be another thing. They hear different things, misinformation from others." – DSV (HA)</i>

Residents in assisted and independent living settings often only hear about flu and COVID-19 vaccines, with no clear communication on other available options like shingles, pneumococcal, or RSV.

Quotes
<i>"I think part of it's education too. I don't think people understand why it's important." – GAY (AL)</i>
<i>"There was no posters or campaigns or anything that we do... we purely say the vaccination clinic is on Thursday." – GGM (IL)</i>

Media Misinformation

The spread of misinformation—especially from U.S. sources—has increased scepticism, particularly among younger family members and some residents. Mixed media messages and fear-based narratives have further eroded public confidence.

Quotes
<i>"We're influenced by our neighbours to the south... all the misinformation...they scare us... they petrify them. She's scared to even let her children out..." – ELV (IL-COMM)</i>
<i>"The conspiracy theorists... they don't believe the data. You can't move them in my experience." – MEP (HA)</i>
<i>"There was so much negative media reporting about it... it took me a long time to decide." – HOP (AL-COMM)</i>

Strategies for improving access to priority vaccines in British Columbia

We found that vaccine equity in British Columbia depends on: (1) improving vaccine access for older adults through on-site, mobile, and extended delivery; (2) supported by system reforms that streamline roles and reduce fragmentation; and (3) expanding partnerships with family doctors, pharmacists, and care providers to boost uptake. (4) Ongoing, targeted education remains essential for building confidence and countering misinformation.

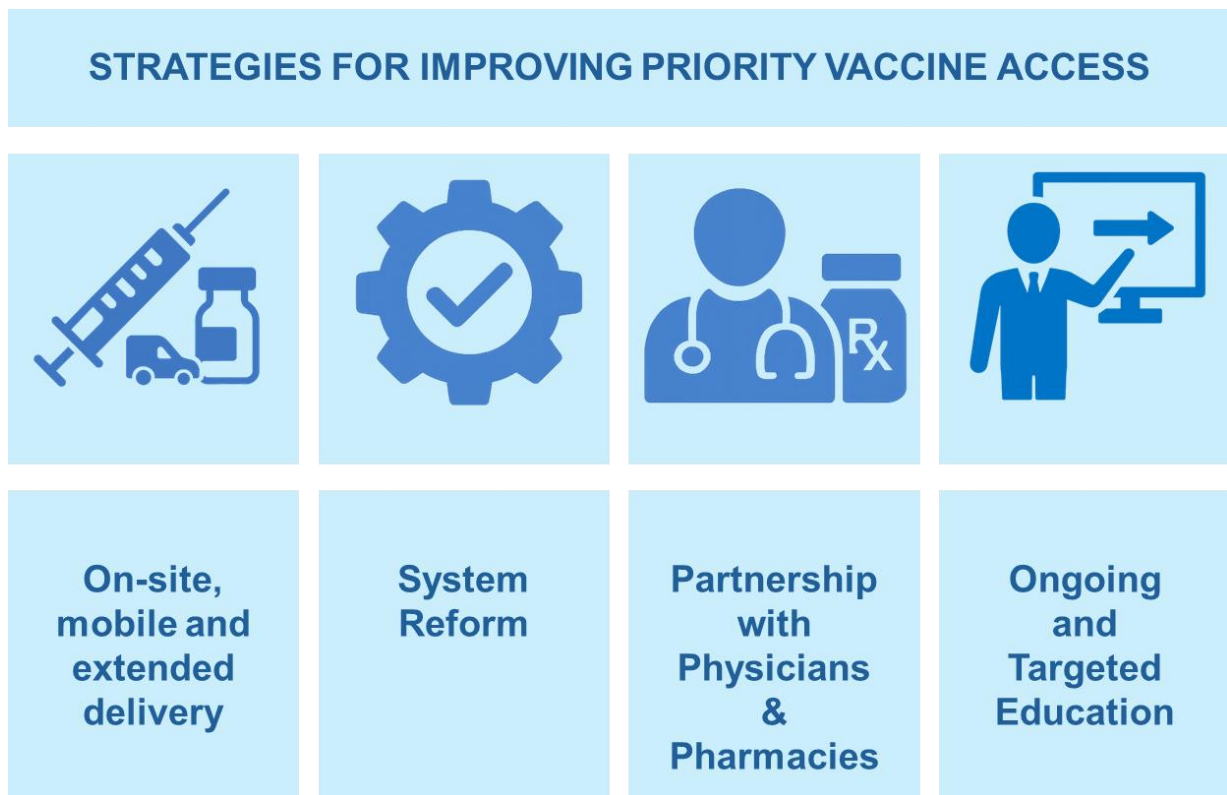


Figure 2: Strategies for improving access to priority vaccines in British Columbia

1. On-site, mobile, and extended vaccine delivery

Ease of access through onsite vaccine delivery significantly increases willingness to get vaccinated. As such, older adults in IL and AL facilities would benefit more if all vaccination services were provided directly within their residences. Having vaccination services under one roof increases the accessibility of vaccines.

Quotes
<i>“They like to have services available under one roof... going out is very challenging for them at times.” – JEN</i>
<i>“People are more likely... to receive vaccinations if they don’t have to travel outside... “We’ve had clinics here... we generally get a great response out of the 60 residents here.” – JIV (AL)</i>
<i>“This facility organizes them... the nurse came, and we just had... they gave us the shot.” – HOP (AL-COMM)</i>

“Giving our nursing team the ability to be able to offer those clinics... would be a huge assistance...maybe access to... a mobile clinic that goes from facility to facility and issues those vaccines.” – GGM (IL)

Additionally, to address these gaps, efforts include home care programs, mobile outreach, after-hours clinics, and accommodations for remote or underserved areas. There are suggestions to further improve access, including holding dedicated senior vaccine events, improving transportation support, and increasing the availability of trusted vaccine information.

Quotes
<i>“Those home care team will provide a vaccine to them at their home as part of the service that they care that they provide to them.” – SV</i>
<i>“So generally, vaccination programs...depending on the area, so they make some accommodation, so there might be some mobile clinic they are planning.” – SV</i>
<i>“Arranging and organizing events specifically for older adults... any type of like venues for their social gathering.” – SV</i>

2. System reform

Participants recommended a shift toward more equitable and proactive health systems, including calls to treat all congregate living settings—whether independent or assisted—as equally.

Quotes
<i>“There shouldn’t be a distinction between whether somebody’s in independent living or not... let’s group everybody together.” – JEN (AL-IL)</i>
<i>“The government should be treating all seniors the same...anybody who’s eligible for the vaccine should [get] them... – DAL (POL)</i>

3. Expanding partnerships with physicians and pharmacies

Partnerships with family practice and prescribing physicians offer a valuable opportunity to promote and facilitate vaccine uptake among older adults.

Quotes
<i>“There’s an opportunity there too that could be pursued... because they’re the ones who need to prescribe some of these vaccines.” – GAY (AL)</i>

Pharmacies are playing an increasingly central role in the delivery of vaccines. Strong partnerships with them allow for on-site clinics, improving convenience and uptake in both assisted and independent living settings.

Quotes

“The partnerships that are there now, in particular with pharmacies... I think that’s the key thing.” – DAL (POL)

“They help to gain access to vaccinations for us and they are also the immunizers. So they come on site.” – JEN (AL-IL)

4. Ongoing and targeted education

There is widespread agreement on the need for ongoing education efforts directed at older adults, family caregivers, and staff in assisted and independent living. Trust in personal health professionals and public health leaders remains a vital factor in overcoming hesitancy.

Quotes

“There needs to be a refresh... of information and education as to the importance of getting these vaccines...we want to see vaccination program being as important for older people as it is for younger people...one in three people will get shingles in the[ir] lifetime... we’ve said and will continue to advocate for that.” – DAL (POL)

“The more I heard about Dr. Henry... the more I realised that yes, I believe in vaccines.” – HOP (AL-COMM)

Summary and recommendations

The consultation emphasizes that older adults in assisted and independent living settings face a complex array of barriers to vaccine access, including physical limitations, cost, policy gaps, and widespread misinformation. Structural inconsistencies, unclear provider roles, and disparities across care settings add to these challenges. Addressing these issues requires coordinated efforts: expanding on-site, mobile, and extended vaccine delivery; implementing system-level reforms; and strengthening partnerships with primary care and pharmacy providers. Ongoing, targeted education will be vital to building trust and ensuring equitable vaccine uptake among older adult populations.

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