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VACCINES FOR CHILDREN PROGRAM

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

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COMMUNICATIONS

VACCINES FOR CHILDREN PROGRAM

THURSDAY, MAY 4, 1995

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:30 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Bob Packwood (chairman of the committee) presiding.

Also present: Senators Simpson, Moynihan, Breaux, and Moseley-Braun.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The Committee will come to order please.

This is the only hearing we have scheduled on the issue of the Government's vaccine program, which was enacted only a short time ago.

It is an entitlement program. Unfortunately, its projected costs are now 3½ times what we projected less than a year ago. This seems to be the history of most entitlement programs.

Second, the evidence seems to be that the cost of vaccine does not seem to be the problem with children not getting vaccinated. There may be other problems, but that does not seem to be a problem, or even the principal problem.

And, three, I think we have to question whether or not the program is needed at all. It may be; it may not be. The GAO has done an extraordinarily good report. And Mr. Chan is here today to testify about it.

With that, we will start this hearing to examine the real barriers as to why all children cannot get fully immunized. And I will say again that it does not appear to be the cost of the vaccine itself.

Our first panel consists of Kwai-Cheung Chan, who is the Director of Program Evaluation in Physical Sciences for the General Accounting Office, and Dr. David Satcher, who is the Director for the Centers for Disease Control and Prevention in Atlanta. He has just returned from Geneva, was it Doctor?

Dr. SATCHER. Right.

The CHAIRMAN. He has just attended a World Health Assembly. I hope you did not get in late last night.

Dr. SATCHER. No.

The CHAIRMAN. All right.

Mr. Chan, do you want to start?

Mr. CHAN. Yes.

STATEMENT OF KWAI-CHEUNG CHAN, DIRECTOR OF PROGRAM EVALUATION IN PHYSICAL SYSTEMS AREAS, DIVISION OF PROGRAM EVALUATION AND METHODOLOGY, ACCOMPANIED BY DR. SUSHIL SHARMA, ASSISTANT DIRECTOR, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

It is a pleasure to be here today to share with you the preliminary results of our ongoing work on the vaccine for children program. As you requested, I will present information on barriers to immunization, including our assessment regarding the role of vaccine cost as a barrier for parents in immunizing their children.

VFC is an entitlement program to provide free vaccine to children 18 and younger who are eligible for Medicaid, are uninsured or underinsured, as well as Native Americans or Alaskan Natives. The administration has stipulated that an increase in the cost of vaccine was a major factor in low rates of vaccination. By providing free vaccine to this population, VFC was intended to remove vaccine cost as a barrier. The goal is to raise immunization rates for 2-year-olds to 90 percent for most antigens by 1996.

To determine these barriers, we talked with health officials and reviewed pertinent literature. We also reviewed four major studies sponsored by CDC, and convened an expert panel of the investigators of these studies.

These studies are to diagnose and identify reasons for low immunization rates among high-risk racial and ethnic minority inner-city preschoolers in Baltimore, Los Angeles, Philadelphia and Rochester, New York, where the needs are.

What did we find? We found many barriers to timely immunization. These include parents' lack of awareness of their children's vaccination schedule, inadequate resources in the clinics—such as insufficient clinic staff, inconvenient clinic hours and inaccessible clinic locations—clinic policies that deter vaccination by requiring appointments or refusing to see walk-in patients, and various factors that cause providers to miss opportunities to immunize children at regular visits. In other words, we did not find sufficient evidence to conclude that vaccine cost has been a major barrier to children's immunization.

The findings from CDC's diagnostic studies indicate that most under-immunized children have access to free vaccine through Medicaid or public health clinics, and that they had visited their providers an average of 6 to 8 times during the year. During these visits, the children could have received their scheduled immunizations, but providers failed to vaccinate them, and opportunities are missed.

There are several factors associated with missed opportunities. These included factors such as failure to use simultaneous vaccinations or accelerated immunization schedules for children who are behind schedule, lack of access to records to a child's immunization status, and lack of organizational support. The missed opportunities occur very frequently during both sick- and well-child care visits.

These studies found that if we eliminate all missed opportunities, they would account for a third to half of the increase needed to reach the 90-percent goal for 1996. However, this alone would not

raise the immunization rate to the targeted 90-percent level for all vaccines. This is shown in the report on table 1.

The results of CDC's diagnostic studies indicate that while no single factor or category of factors accounts for under-vaccination, access to health care among under-immunized children is not generally a problem.

The studies suggest that achieving and sustaining a high coverage level will require a variety of interventions aimed at changing the practices of providers that result in missed opportunities.

CDC identified six types of evidence to support the notion that vaccine cost is a barrier.

One, increases in vaccine cost over the past decade.

Two, surveys of health care providers inquiring about the frequency with which they had referred patients to public health providers for immunization, their reasons for doing so, and their opinions regarding a universal vaccine purchase program.

Three, reports from health departments of increased referrals for private providers.

Four, surveys of parents visiting public health clinics regarding their reasons for using the clinics.

Five, policy studies addressing the relationship between health insurance coverage, health care utilization and immunization.

And, finally, comparisons of immunization rates between States with and without universal vaccine distribution programs.

Unlike the diagnostic studies, which examined populations at high risk of under-immunization, the additional research cited by CDC had a narrow scope. It focused on factors such as providers' referral patterns. We found that, for the purpose of assessing the role of vaccine cost in under-immunization, this research suffers from three major conceptual and methodological problems.

First, these studies failed to distinguish vaccine cost from other fees associated with immunization.

Second, these studies did not determine that the measures were valid indicators of eventual failure to receive immunization.

Finally, these studies rely on opinion data collected in surveys, rather than through analysis of the immunization status of children.

For example, CDC officials acknowledged that providers' fees in the private sector would be about $40 per office visit and about $15 per dose for the vaccine, representing potentially about 60 percent of the total cost of full immunization, but much of the evidence they cited failed to distinguish between the cost of vaccine, which is addressed by VFC, and office visits, which are not addressed by VFC.

To summarize, the studies we examined, and the other sources of information available to us, lacked sufficient evidence for us to conclude that the major factor addressed by VFC—that is vaccine cost—has been a significant barrier to immunization.

It appears that efforts to address a variety of other barriers may be equally or more important in improving immunization levels.

We have discussed our findings and conclusions with responsible CDC officials. They are in general agreement with our finding that there is not sufficient evidence to conclude that vaccine cost is among the most significant barriers to immunization.

Mr. Chairman, this concludes my remarks.

The CHAIRMAN. Mr. Chan, thank you.

Mr. CHAN. Yes.

The CHAIRMAN. Dr. Satcher, you are a Ph.D., in addition to an M.D., are you not?

Dr. SATCHER. Yes I am.

The CHAIRMAN. What is your Ph.D. in?

Dr. SATCHER. It is in cell biology, cytogenetics.

The CHAIRMAN. Thank you.

The last statement that Mr. Chan made, that CDC "is in general agreement with our finding that there is not sufficient evidence to conclude that vaccine cost is among the most significant barriers to immunization." Do you agree with that?

Dr. SATCHER. We believe that vaccine cost is a major barrier to immunization.

The CHAIRMAN. You do not agree with his last statement, the last sentence?

Dr. SATCHER. No.

The CHAIRMAN. Go right ahead.

[The prepared statement of Mr. Chan appears in the appendix.]

STATEMENT OF DAVID SATCHER, M.D., Ph.D., DIRECTOR, ACCOMPANIED BY WALTER A. ORENSTEIN, M.D., DIRECTOR, NATIONAL IMMUNIZATION PROGRAM, CENTERS FOR DISEASE CONTROL AND PREVENTION, ATLANTA, GA

Dr. SATCHER. Thank you, Mr. Chairman.

As you pointed out, I am David Satcher, Director of the Centers for Disease Control and Prevention. I have with me today Dr. Walter Orenstein, who directs the CDC national immunization program.

I want to thank you for the opportunity to appear before this Committee to discuss childhood immunization.

As you mentioned, I have just returned from Geneva, where I was participating with the U.S. delegation to the World Health Assembly.

I do think it is interesting that, as you probably know, the World Health Organization has listed immunization of children throughout the world as a major priority, has concluded that immunizations represent a cost-effective investment, and has targeted the year 2000 for the complete eradication of polio from the world. This is a commitment to immunization as an investment in children of the future.

The VFC program began 7 months ago. Since that time we have made significant progress. The program is operating in all States. Our purchase contracts were signed with the manufacturers to provide the vaccines for eligible children at discounted CDC contract prices for all the vaccines routinely recommended.

State health departments are rapidly enrolling public providers. They have enrolled over 8,000. Private providers are also being enrolled and, to date, over 22,000 private provider sites, many of them containing numerous physicians. And the enrollment continues.

The vaccine ordering system is working well. Since October, over 13 million doses of vaccines have been shipped through the program.

I think the good news is that we are making progress toward our goal of immunizing 90 percent of the nation's children against vaccine-preventable diseases.

Our most recent immunization coverage information, which is from the first quarter of 1994, indicates a record high level of immunization coverage for 2-year-old children.

However, it is important to point out that we still have a significant problem in that over 30 percent of the children in this country are not being adequately immunized by the age of 2.

In some inner-city communities, more than 50 percent of children are not being immunized by the age of 2. So we are talking about in excess of 2 million children under the age of 2 who are not fully immunized, as we would like to have them. And that is the goal of our program.

I do want to say that our program is comprehensive. The vaccine for children is only one part of it. The other parts of the program address the infrastructure. They address parent and provider responsibility. They address tracking systems. They address research to continue to improve the vaccine and use of the vaccine.

There are three reasons why we think the vaccines for children program is important. Number one, it allows eligible children to obtain immunizations at their medical home. It provides greater access to vaccines because every time a private provider enrolls, there is a significant improvement in access to vaccine. And it forges a public/private partnership to get more children immunized.

But I do want to stress that we believe that any time a child is referred from his or her primary provider to a public clinic in order to get immunization, we have disrupted the continuity of care. We have interrupted the medical home of the child. And I know of no one in the health professions that would disagree that it is important for children to have continuity of care and a medical home. When those things are disrupted, it is in fact a significant barrier to immunization.

There have been a lot of successes in the program, in terms of the enrollment, in terms of the reduction in cost. CDC contract price is now available to the Medicaid population at about one-half of what the price was for Medicaid before. So it is $130 as opposed to $270 for the series. So that is a significant reduction in cost.

The major private physician associations and tens of thousands of private physicians support the VFC program. Total Federal and State vaccine expenditures will in fact not be much more when VFC is fully operational than they were before, because of the reduction in contract costs.

Most State health departments strongly support the VFC program, and value its benefit to individual children and communities as a whole.

And I will stress again that about 50 percent of the immunizations in this country are now done in the public sector, and the other 50 percent in the private sector. For most States, therefore, it is important to have full participation of the private sector.

The VFC program has strengthened and institutionalized the public/private partnership.

There have been problems with the program, and I will mention two of them. In the area of accountability, we have been concerned that we balance accountability with participation. If we required physicians to report on every immunization transaction, that would include 14 million pieces of paper submitted per year. We do not want this kind of accountability and administrative burden on the participants in this program, so we are working very closely with the States to try to avoid that.

We are also monitoring orders, and requiring the submission of three annually required forms in terms of reporting.

Vaccines are being delivered to physicians in some States. CDC was not able to develop its national distribution center because of concerns that Congress had about that. And we have had difficulty in negotiating with individual manufacturers' delivery systems.

However, 49 States are delivering vaccines to public clinics, and 35 are delivering vaccines to private providers. Ten of the remaining 14 will be delivering vaccines by the end of this fiscal year, which means that 45 States will be delivering vaccines to private providers.

There are many other barriers to immunization, other than the vaccine cost, and we are trying to deal with all of those barriers.

We have major outreach programs to educate parents and providers. We have research going on in terms of tracking systems that will help parents and providers to know where their children are on the schedule. We continue to try to improve the system.

But I do want to stress that we believe that the cost of vaccine is a barrier, primarily because the cost disrupts the continuity of care in the primary care physician's office. It causes parents and children to leave their medical homes and go to public clinics. In many cases, they never make it to the public clinics.

So we believe that if we are going to have a comprehensive system, we have to deal with the cost of vaccine.

Thank you.

[The prepared statement of Dr. Satcher appears in the appendix.]

The CHAIRMAN. Doctor, I am looking at this chart from CDC, which shows America's immunization success. For DTP, you have 90 percent, polio 90 percent, measles, mumps and rubella 86 percent. If this is accurate, we are doing very well.

Dr. SATCHER. Well, I can give you the accurate figures as of the first quarter of 1994.

The CHAIRMAN. The last one I have here is 1993.

Dr. SATCHER. All right. DTP 3, 87 percent. DTP——

The CHAIRMAN. Wait a minute. Say that again.

Dr. SATCHER. DTP 3, which is the third dose of DTP, 87 percent. DTP 4, 67 percent, which means that one million——

The CHAIRMAN. Excuse me. Can you stick to your chart?

Dr. SATCHER. I am reading from our chart. And our chart has been published in the Morbidity and Mortality Weekly.

The CHAIRMAN. Well, just do me a favor.

Dr. SATCHER. Sure.

The CHAIRMAN. This is your chart. It says 1993 DTP, diphtheria, tetanus, pertussis, 90 percent in 1993. Are we higher than that now?

Dr. SATCHER. No, that is not our chart. That is not an official CDC report.

The CHAIRMAN. It is not? It says "Source: CDC" at the bottom of it.

Dr. ORENSTEIN. I think there is at least one error on that chart, that I am aware of, on polio vaccination.

The CHAIRMAN. Is this your chart?

Dr. ORENSTEIN. It is not our chart, no.

The CHAIRMAN. Now hold on just a minute.

Dr. SATCHER. In fact, polio vaccination is 76 percent.

The CHAIRMAN. But this is from CDC.

Dr. ORENSTEIN. Well, it is not our chart. On page 4 of our testimony, we have the actual numbers. And we also have in that testimony the numbers of unprotected children. For example, for DTP 3, which I think is what you were referring to, the level in the first quarter was 87 percent, which translates to about 800,000 children 19 to 35 months of age, who were not protected.

The CHAIRMAN. Hold on just a minute. I want them to sort this out.

Dr. SATCHER. Mr. Chairman, we publish regular reports on the vaccine status of children in the country. So they are available.

The CHAIRMAN. All right. You are claiming that this chart, with the CDC source at the bottom, is not your chart?

Dr. SATCHER. Well, also, I am saying something else. It says DTP, 3 or more doses. Our report goes with the goal, which is DTP 4.

The CHAIRMAN. That is fine. All I want to know is are you claiming this is not your chart?

Dr. SATCHER. This chart here is not our chart. It is someone's interpretation.

The CHAIRMAN. All right.

Dr. SATCHER. And there is a major error in terms of polio vaccine. The figure should be 76 percent in 1993. This chart has 90 percent.

The CHAIRMAN. All right.

Dr. SATCHER. But, Mr. Chairman, I think the most important thing is that we publish regular reports.

The CHAIRMAN. That is fine.

Dr. SATCHER. They are available.

The CHAIRMAN. No, no. That is fine. If I have been given bum information on this chart and its source, that is fine. I am not trying to hold you to this chart if it is not yours.

Dr. SATCHER. Right.

The CHAIRMAN. I just looked at the source and thought it was yours.

Let me go to this dispute that you and Mr. Chan seem to have. He says that he has checked with CDC, and they seem to agree with him that cost is not a major barrier.

Mr. Chan, can you tell me who you talked with, or how CDC came to this conclusion, or you think they came to this conclusion? Dr. Sharma?

Dr. SHARMA. Yes. We talked yesterday to Roger Bernier, and Martin Landry.

The CHAIRMAN. Who is he?

Dr. SATCHER. He works for Dr. Orenstein.

The CHAIRMAN. All right.

Dr. ORENSTEIN. He is the Associate Director for Science.

Dr. SHARMA. And, essentially, our agreement was that we are in agreement that, based on the evidence of diagnostic studies, there was not sufficient evidence to conclude that cost was a significant barrier. These studies did not show that. All these children who were under-vaccinated had access to free health care.

The CHAIRMAN. Now this is Doctor who? Doctor, can you come up to the table please.

The CHAIRMAN. Is he here?

Dr. ORENSTEIN. No, he is not here. Dr. Bernier is the Associate Director for Science within the National Immunization Program.

The CHAIRMAN. Would he be authorized to speak to Dr. Sharma about this subject, and make that statement?

Dr. ORENSTEIN. He is authorized to speak with Dr. Sharma, and is an expert in his own right in immunizations. We have another person who was on that conversation who feels that there was not that same agreement.

Dr. SATCHER. What Dr. Sharma just said though, Mr. Chairman, is not the same as what is written in his report. I want to make that point. What he said was, when you look at the four studies, it was not possible to disaggregate the different causes. He did not say that CDC concluded that cost was not a major factor. I think those are two different things. And I think we ought to make that very clear.

So I do not think Dr. Bernier said what is in this report. I think what he said was that he agreed, if you look at the four studies, it is difficult in those four studies to disaggregate the different components.

Dr. SHARMA. Our conclusions are based on these four studies. We are not going beyond the evidence that we had examined from the four diagnostic studies, and the evidence that you had provided to us in support that cost is a significant barrier.

The CHAIRMAN. Mr. Chan?

Mr. CHAN. I was in the latter part of the conversation, and I feel comfortable with what we said. The strongest evidence that was presented to us by CDC in that conversation was the referral rates that physicians had made. And these were opinion surveys whereby they are in fact stating that, yes, I refer my patients to public clinics because I believe that they cannot afford the vaccination, including the visits.

And what we were asking for was in what way does VFC, which addressed the vaccine cost only, affect the barrier? And the answer is extraordinarily difficult to separate these components.

As you stated in your opening statement, Mr. Chairman, you wanted to focus on the vaccine cost as the major barrier.

The CHAIRMAN. Yes, that is what the hearing is trying to focus on, and I am not trying to get into the other issues.

Mr. CHAN. That is what we are saying. From the data on visits, you find that it is $40 per visit, of which $15 is for vaccine cost.

And what we are trying to figure out is, by having a program that takes out the vaccine cost alone, how does that address the question of whether cost is a barrier?

And what happened is that they said the real issue then is that the referral can potentially cause delay, and they possibly do not end up getting vaccinations. And, as Dr. Satcher said in his statement, you do not have the continuity.

Our question in the conversation was, to what degree do we have the evidence that this delay is a problem, versus they did not ultimately get the vaccination?

In the VFC program, the intent is not stating that the children will not get vaccinated, but rather that they need to be vaccinated by age 2. So that potential delay could be tomorrow, the day after, or what not. We accept that fact that there is some linkage to that.

The question is then, would that be significant in terms of the outcome of the immunization rate? And the answer was, well, we do not know.

So we all agree that it is potentially one of the many factors, including the missed opportunities I talked about in my statement. But the real question is what is really the outcome? And we found that the research lacks that linkage between the referral rate to the outcome of vaccination, and the referral rate in terms of vaccine cost.

And that is how we agreed that, yes, it could be one of the factors, but we could not piece it out. So that is where we ended up.

The CHAIRMAN. Dr. Satcher, do you want to comment?

Dr. SATCHER. Mr. Chairman, in our study published in the Journal of Pediatrics in September of 1994, 93 percent of physicians interviewed in North Carolina, pediatricians and family physicians, said that cost was the major factor for their referring patients to public health clinics.

The CHAIRMAN. The cost of the vaccine?

Dr. SATCHER. The cost of the vaccine is the major barrier. Physicians have said that they will accept—and we have documented information—as little as $10 to $15 for administering the vaccine in order to keep their patients. And physicians all over the country are saying that.

They will provide the vaccine for children at no profit if they do not have to pay for the vaccine. There is no question about the fact that there are many physicians throughout this country who have taken advantage of the Vaccine for Children program in order to keep their patients in their practice, and to assure continuity of care.

There is no question about that. We can argue about the research design and the disaggregation of factors, but the fact of the matter is that the people who take care of patients on the front lines in this country—and the organizations that represent them, the American Academy of Pediatrics, the American Medical Association, The American Academy of Family Physicians—have made it very clear that the cost of vaccine is a factor, and that the Vaccine for Children program will in fact improve continuity of care of their patients in their practice.

The CHAIRMAN. Let me ask you. Those figures you were giving me on percent of children vaccinated as of 1994, were up to age 2? Or was that up to age 5?

Dr. SATCHER. The goal is up to age 2. But when we look at children, we look at them from 19 months to——

Dr. ORENSTEIN. It is 19 to 35 months, a median age of about 27 months.

The CHAIRMAN. All right. And by the time children start kindergarten, I assume those percentages are somewhat higher.

Dr. SATCHER. Definitely. Yes.

The CHAIRMAN. Now, if cost is the problem, how do so many of them get vaccinated by the time they start kindergarten?

Dr. SATCHER. Well, let me say this again. Cost is an important problem in the vaccination of children. So many of them get vaccinated by the time they go to school. For one thing, we have a law in this country which says that they have be immunized by the time they start school. I want to make this point very clear. Our concern is what can happen to children between the ages of 2 and 5, before they get ready to go to school.

The CHAIRMAN. But how do they afford it at age 5 if they cannot afford it at age 2?

Dr. SATCHER. I do not know if I can answer that question about why a parent, in making decisions about how to spend limited income, whether it is for food or clothes, or what have you, decides that if they want their children to get an education, they are going to pay for the vaccine at age 5. But at age 2, they are going to make other decisions.

Now we can talk about that. But I think the fact of the matter is that the cost of vaccine is affecting children not being adequately immunized by the age of 2.

We agree with this throughout the world, by the way. The United States supports a comprehensive program for immunizing children throughout the world. It has been very successful, so much so that 80 percent of children in the world are not being immunized by the age of 2.

We do not necessarily agree with it for inner-city children in this country. Therefore, we say that cost is not a factor, when the parents say it is, the providers say cost is in fact a factor in their not being immunized.

The CHAIRMAN. All right. Secretary Shalala, when she testified before the Budget Committee this February, said that 67 percent of the children are immunized. What did she mean?

Dr. SATCHER. Well, if you look at our report, this is the exact figure we just gave you. She means fully immunized, with all 9 vaccinations.

The CHAIRMAN. Including the two new vaccines that came out only in the last few years?

Dr. SATCHER. Yes. If you look at the total of vaccines that we are now using, and you look at the number of children that are fully immunized. We are primarily talking about DTP, OPV and MMR.

When we did this report, those new vaccines were so new, hepatitis B for example, that I think only about 20 percent of the children had been immunized. And we understood that.

Also, haemophilus influenza which, by the way, is preventing the overwhelming number of meningitis cases that we have in this country from that organism, was also new. But we are now up to 71 percent with haemophilus influenza.

The CHAIRMAN. But here is the unfairness of using statistics. We say we are approaching the 90-percent vaccination rate, and we are talking about the 7 vaccines. Then we bring two new ones on, and you suddenly drop the percentage down to 50 or 60 percent, but it is apples and oranges. I understand the difference.

Dr. SATCHER. Mr. Chairman, we did not use the new vaccines in the 67 percent figure. The 67 percent figure represents 4 DTP, 3 OPV and MMR.

The CHAIRMAN. Well then, what is the 90-percent figure you are just citing?

Dr. SATCHER. Well, the 90-percent figure was for DTP 3.

The CHAIRMAN. That is all?

Dr. ORENSTEIN. We have an interim goal for 1996 of 90 percent for DTP 3. Our goal for the year 2000 is the full series. And we have a chart, and maybe the chart will be helpful. This is in our testimony. The chart may help explain what our latest data are on immunization coverage. And you can see from those data that, for DTP 4, which is strongly recommended by all the advisory committees of experts on immunization, it is 67 percent. It was low before.

The CHAIRMAN. What is the 4, as opposed to the 3 plus?

Dr. ORENSTEIN. A child should normally get 3 doses of DTP in the first year of life, at 2, 4 and 6 months of age, and a fourth dose somewhere between 12 and 18 months of age.

The CHAIRMAN. And you are saying you have reached 87 percent on the first three, and then it falls off on the fourth dose?

Dr. ORENSTEIN. Exactly.

The CHAIRMAN. Why is that?

Dr. ORENSTEIN. There are problems in children returning, particularly during the second year of life.

The CHAIRMAN. This surely cannot be money. If they have managed to get three shots in the first 6 months, it cannot be money.

Dr. ORENSTEIN. The issue here is making vaccines available in as many places as possible.

The CHAIRMAN. But where do they get the first three shots?

Dr. ORENSTEIN. They may get them at well-child visits, and not come back. They may have to wait weeks to months to get appointments, and not come back. And they may be going to their doctor for one thing but, because they cannot get immunization at their doctor, they may not be going to the public clinics.

The CHAIRMAN. But none of that relates to the cost of the vaccine.

Dr. ORENSTEIN. The cost of the vaccine at their doctor's office is an issue. There are data, looking at immunization coverage by insurance status—for example, in Minnesota—that have shown that uninsured children had about a 3 to 4 month delay in getting their third dose of DTP. This is a population-based study.

The CHAIRMAN. All right. Let me come back to your chart again. You have DTP 3, 87 percent. And that is within 6 months of birth?

Dr. ORENSTEIN. No. That is within between 19 and 35 months of age.

Dr. SATCHER. No. He is asking about where those came from.

Dr. ORENSTEIN. It is recommended within the first year of life. It is very likely that if you asked me how many of the children got these immunizations when we really want them to, the percentage would be much lower. Pertussis is particularly a severe disease early on. When we measure by 27 months, we are in a sense measuring late already. We really want these doses at 2, 4 and 6 months. The actually level of age appropriate coverage is probably much lower than 87 percent.

The CHAIRMAN. All right. We have reached the DTP 3 plus at 87 percent somehow, assuming your measurements are accurate. And if cost is a barrier, we have gotten at least 87 percent with cost as a barrier. Is that correct?

Dr. ORENSTEIN. We have gotten to 87 percent with cost as a barrier that is helped in part to be solved through Medicaid funding, which has been buying vaccines at roughly $270 for a full series, compared to $130 for a full series.

So there has been a substantial change in the way our public sector funds have been used to provide vaccines with this program. Two hundred seventy dollars is being paid for those Medicaid children.

Dr. SATCHER. There is no question about the fact that all over the country the gap between that visit for the third DTP and the next visit is a problem. It has been a problem.

The CHAIRMAN. Why is it a problem? If they get there for three different shots, what is the problem in getting there for the fourth one?

Dr. SATCHER. For one thing, those visits are regular visits after birth, and then there is a gap between the third——

The CHAIRMAN. Well, Dr. Orenstein said they go up to 35 months. That is not just after birth.

Dr. SATCHER. No. I think Dr. Orenstein was also talking about the period during which we evaluate. But he is also saying that the fourth visit is more difficult.

The CHAIRMAN. Why?

Dr. SATCHER. Well, I think it has to do with the age of the baby.

The CHAIRMAN. More difficult for what, for the parent to bring the baby in?

Dr. SATCHER. For bringing the baby——

The CHAIRMAN. It is no problem for the first three, but it is on the fourth? But why?

Dr. SATCHER. It is. It was a problem on the first three.

The CHAIRMAN. But you have gotten up to 87 percent on the first three. You have pretty much surmounted this problem.

Dr. SATCHER. And we want to get there on the fourth one.

The CHAIRMAN. I understand that. But I want to know what the problem is on the fourth one.

Dr. SATCHER. Well we think that there are five kinds of problems, one of which is the cost of the vaccine.

The CHAIRMAN. But why is that not a problem on the first three?

Dr. SATCHER. We did not say it was not a problem on the first three. But we have managed to get to this level on the first three.

The CHAIRMAN. And you have gotten to 90 percent on measles, mumps and rubella.

Dr. SATCHER. That is one visit. Now I hope you understand. We are talking about one versus four versus three visits, and it does in fact make a difference.

Dr. ORENSTEIN. We are trying to remove missed opportunities, in that every time a child goes to places and is referred, then you lose an opportunity. It is a lot easier to get three versus four in.

I think the problem we are having is not simply measurement that 19 to 35 months of age. The problem is that we really want these vaccines administered at exactly the ages that they are recommended. And I think we have data in Minnesota suggesting that there is in fact a delay when somebody has to make a second visit. That is, they go to their doctor, and then they have to go from their doctor to a health department clinic. They are not going to show up there the same day. They are going to wait. And the data from Minnesota suggests that there is a 3- to 4-month delay.

The CHAIRMAN. What does a dose of DTP cost in the private sector?

Dr. ORENSTEIN. DTP is about $8 I believe.

The CHAIRMAN. Eight dollars?

Dr. ORENSTEIN. Yes.

The CHAIRMAN. So we get them for three doses, and we figure that it is $8 for the vaccine, $8 for administering it?

Dr. ORENSTEIN. I may be wrong on the DTP.

The CHAIRMAN. Well, it is under $10 I think. Now you are telling me that even to get the DTP 4 is under $10, and cost is the factor between 87 percent and 67 percent.

Dr. ORENSTEIN. It is that they do not get one vaccine at the same time. Many times we are trying to get multiple vaccines administered simultaneously. So at that same visit, we want MMR, which costs $25, polio vaccine, which costs about $10, DTP, which adds another $8 of $10, whatever it is. And we want haemophilus vaccine, which adds even more.

So when we think about cost, it is not like parents are going to come in for each vaccine separately. They are potentially going to be hit with a very heavy bill at that time.

The other issue about the VFC on cost is that providers that enroll in the VFC must agree not to waive their administration fees, if a parent that they normally serve cannot afford the administration fee. So the VFC program has attempted to reduce another potential part of the cost barrier.

The CHAIRMAN. How do we account for States like Georgia and Mississippi, which have raised their percentage rates immensely before the VFC program was ever in effect? If cost is the problem, how do they succeed at this?

Dr. SATCHER. I can speak to Mississippi. Georgia is a different issue because we have worked very closely with Georgia. CDC has this information project that started in Georgia, which has worked very closely with clinics.

I believe you are going to hear from Mississippi later, and I think Dr. Thompson will tell you that 85 percent of the vaccines in Mississippi are given in the public clinics. Fifteen percent are given by private providers. Throughout the country, the figure is 50 percent in the public sector and 50 percent in the private sector.

So if you take a State that gives 85 percent of its vaccines in the public sector because it has so few private providers, or for whatever reason, then I think it is a different kind of challenge than trying to take a situation where up to 50 percent of the vaccines were given in the private sector, and allow children equity of access to vaccines with their private provider.

The CHAIRMAN. Well, let me conclude with this. Mr. Chan, let me go to you.

Mr. CHAN. Sure.

The CHAIRMAN. You are pretty much convinced, based upon your studies which, in turn, are based on CDC studies that you have reviewed, that the cost of vaccine is not a major barrier. Is that correct?

Mr. CHAN. That is correct.

The CHAIRMAN. There may be other causes—administration or the problems of getting children to come to a clinic, or a dozen other problems—but the cost of the vaccine itself is not a major problem.

Mr. CHAN. I think a lot of the reasons we stated in our testimony, as well as what Dr. Orenstein just said in his response to your questions, explain those issues.

Let me try to say why we believe that, and for what reason we take these four studies. One is that we find that the vaccination across the country, 1993 and 1994, suggests that vaccination is at a very high rate, higher than ever before.

If you are trying to solve a problem, that problem lies with a minority of the group, we look for the problem where it lies. We do not look for the overall, or try to figure out why 87 percent delayed, and all that sort of thing. Rather, we look to where the problem lies.

For that reason, the diagnostic study of the measle epidemic of 1989 to 1991 suggested that we should look at where the pockets are, and where the outbreaks are. In those diagnostic studies, by looking specifically at who was vaccinated and who was not, which is also supported by what Dr. Satcher said, that in the inner city the vaccination rates were very low. The first question is why is that?

Well, the first thing you find is that most of them qualify for free vaccines to begin with. So cost, in itself, has been controlled for. So, for that reason, the evidence still suggests that when you remove cost as a barrier for the majority of those recipients, we still find a very low vaccination rate.

So we look at those studies and ask what are the other causes, even if you remove that as a barrier?

The CHAIRMAN. All right.

Mr. CHAN. Rather than asking all the physicians across the State if cost is a barrier, if it is, they still achieved a pretty high level of vaccination. And that is why we are trying to link outcome to the problem you are trying to solve. And there lies our logic behind this conclusion.

Dr. SATCHER. Mr. Chairman.

The CHAIRMAN. Thank you. Go ahead, doctor.

Dr. SATCHER. I know you want to end this part, but I just wanted to respond to the comment regarding the increase in the cost. Ac-

cording to our figures, the increase for 1995 over 1994 was 11 percent.

I am trying to figure out where that figure came from because, according to our figures, there has been a significant decrease in the cost of this vaccine through Medicaid, because of the VFC program. We tried to make that point. And I am not sure that we made it that, because of this VFC program, Medicaid, HCFA, can now purchase vaccine through the CDC contract. That means about one-half the cost.

When you add all those things up, we have significantly increased vaccine available, with a cost increase of only 11 percent. I just want to make that clear.

The other point I want to make, and I will end with this, I have spent a lot of my life working in cities, starting in Watts. There are a lot of uninsured people in Watts who go to private physicians, and in New York City. They would like to get their vaccines at their private physicians. So to say that there is not a problem in the inner city is not accurate, when we have so many uninsured people who go to private physicians for their care and get referred to public clinics. We have to continue to struggle with that if we are going to solve the problem.

The CHAIRMAN. Doctor, thank you.

And I want to apologize to the other two Senators here. I have overstayed my time.

Senator Moseley-Braun?

Senator MOSELEY-BRAUN. Thank you very much, Mr. Chairman.

I know we have all this information and data regarding the costs of the program and the specifics of how the program is administered, but I think I would like to take a step back for a moment and talk about why we immunize at all. What is the purpose? Why are we here, and what are we talking about?

As I understand it, immunization is used to combat measles, mumps, rubella, diphtheria, polio, tetanus, pertussis, hepatitis B—I am not a doctor—haemophilus influenza—that I know—hepatitis A, and varicella, which is known by the world as chickenpox.

Now I guess when we talk about the costs, one of the problems when we talk about scoring or anything else, is that it is always so much more difficult to itemize cost savings. That is, if you prevent a harm, how much have you saved versus trying to make up for that harm after the fact? That is a problem that is endemic to our attempts to rationalize all of our budgetary efforts.

But, in this regard, I would hope that CDC, or some of the witnesses perhaps, would have some figures with regard to expenditures by the CDC or, alternatively, by the U.S. Government overall, to combat outbreaks of these various diseases where the absence of immunization has given rise to an epidemic.

When I was growing up, polio outbreaks could devastate whole communities, and there are people still bearing the scars of what happened because they had not been immunized against polio.

Dr. Satcher, could you, either in the general or in specific, talk about the costs that have been borne by the Federal Treasury in connection with outbreaks of these diseases, in the absence of appropriate and comprehensive immunization efforts?

Dr. SATCHER. I would be happy to. Before you arrived, Senator Packwood and I were discussing my trip to Geneva. Among other things, in looking at the goal of eradicating polio by the year 2000, the World Health Organization estimates that we will save $3 billion a year worldwide, once we have eradicated polio. In the United States alone, we will save more than $230 million a year for this one disease.

Now let me take you to something else. The most recent major outbreak in this country was the outbreak of measles between 1989 and 1991. There were 55,000 cases of measles in this country, a disease that is preventable by immunization. But because the immunization levels were so low, among other things, there were 55,000 cases, 11,000 hospitalizations, almost 100 children died. The cost was in excess of $150 million—in other words, an average of more than $3,000 per case.

So we are contrasting that with providing vaccines for the amount of $270 for the whole series of vaccines. We spent $3,000 per case for the 55,000 people, if you average it out.

Now if I may back up further, and talk about our cost effectiveness studies at CDC, our studies show that for every dollar we spend for DTP, we save at least $21. For MMR, it is probably closer to $30. For polio, we save more than $6. So there is a consistent pattern when you look at what we do, when you look at our studies, or whether you look at what has happened when we have had outbreaks.

By the way, you mentioned pertussis, that word you were struggling with. It is really whooping cough.

Senator MOSELEY-BRAUN. Oh, all right.

Dr. SATCHER. I almost died with it when I was 2 years old. We should not have any more in this country. Last year we had about 6,000 cases.

Senator MOSELEY-BRAUN. Sixty thousand?

Dr. SATCHER. Six thousand.

Senator MOSELEY-BRAUN. Six thousand.

Dr. SATCHER. So we still have a lot of pertussis in this country, a disease that should be completely gone.

So there are a lot of indications that the investment we are making in immunization is one of the best investments that any nation could ever make. The World Health Organization agrees with that. We agree with it when we are supporting the World Health Organization. And we have gone all over the world to implement immunization programs, removing cost as a barrier.

And I want to make one final point again. The issue here is access. We believe that children should receive their immunizations in the offices of their primary care providers. They should not have to be sent to the public health clinics. When they are sent, it creates another burden for the parents, and some people do not understand that burden. There are people in Watts who had to catch three different buses to get to the public health clinics. So we are not talking about going to the public health clinic. The burden of getting there is not as easy as some people think.

Senator MOSELEY-BRAUN. Would some of the other witnesses like to respond to the prophylactic value of immunizations?

Dr. ORENSTEIN. I could talk about some of the recent cost/benefit analyses that have been done. But some of these analyses have shown, for example, that every dollar spent for polio vaccines saves society about $6. Every dollar spent for DTP saves about $29. And every dollar spent for MMR saves about $21. The newly-licensed chickenpox vaccine has been estimated to save about $5.40 for every dollar spent.

Senator MOSELEY-BRAUN. Could you get that information to the Committee in writing? Could you provide us with the costs spent in previous outbreaks, factored out in terms of present value, if that is appropriate, Mr. Chairman.

Dr. ORENSTEIN. Sure.

[The information appears in the appendix.]

Senator MOSELEY-BRAUN. Now, if I may, one last question. There was an article recently in one of the Washington newspapers that mentioned that in some border areas near Mexico, only 40 percent of the children on the United States side are immunized while, on the Mexican side of the border, 90 percent of the children are immunized. Is that accurate, and why?

I cannot understand how it is, with the economy of Mexico certainly not being comparable to ours, that we have border areas with only a 40 percent immunization rate, and that country right across the border has a 90-percent immunization rate. They are afraid of us having a disease outbreak on our side of the border that might influence their communities.

Dr. SATCHER. Senator Moseley-Braun, I think that is consistent with WHO's report that 80 percent of the children in the world have now reached WHO's goal for immunization by the age of 2.

We have recently had visits to the U.S.-Mexican border from El Paso down to Brownsville, looking at the problems along that border. And it is true that the attitude toward immunization in Mexico, and in other developing countries, is that this is such an important investment that they have actually stopped wars for a day in order to immunize children. They invest in the vaccines, and they are determined that everybody should be immunized.

There is one very positive example of a city on this side of the border and a city on the other side cooperating, and that is El Paso and Juarez. They decided that they were one community. And they got together and said we are going to immunize everybody. In that one case, both El Paso and Juarez are about 80 percent for immunization. But along the rest of the border, access is a major problem for people on our side of the border. There are problems with access to private physicians, access to clinics where you do not have to wait for 2 or 3 months to get an appointment.

When I was there, I met with farm workers in Harlingen and Brownsville who said that they had waited more than 3 months to get an appointment to the public clinic that was supposed to take care of them.

Senator MOSELEY-BRAUN. Thank you very much.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman. I thank the panel.

I think at a time when we in the Congress—in the last Congress, and I guess in this Congress too—have been trying to emphasize preventive care and primary care, it seems to me that one of the

most important ingredients in primary care and preventive care is, of course, vaccinations.

It seems to me that that chart indicates that we still have about 2 million children under the age of 2 years old in this country that are not being vaccinated. In my opinion, this is the best way to provide for preventive care in this country.

I was looking at your testimony, Dr. Chan. I take it that you are not saying that cost is not a factor.

Mr. CHAN. That is correct.

Senator BREAUX. Is that correct?

Mr. CHAN. Yes, that is correct.

Senator BREAUX. So your testimony is not that cost is not a factor. You said in your testimony that the studies you looked at lacked sufficient evidence to conclude that cost has been a significant barrier to receiving vaccinations. But there are a lot of things out there that cause people not to become vaccinated.

Dr. ORENSTEIN. Yes.

Senator BREAUX. I think when we talk about cost, Mr. Chairman and my colleagues, the real cost we ought to be talking about is not whether cost prevents people from being vaccinated, but whether these vaccinations in fact save us all money however they are delivered.

The numbers that I was really impressed with, Dr. Orenstein, are your numbers that, for every dollar you invest in a DTP vaccination, you are saving $29. For every dollar you invest in a measles vaccination, you are saving $21.

Dr. ORENSTEIN. Yes.

Senator BREAUX. For every dollar that we invest in a polio vaccination, we are saving $6. I think the last one was, for every dollar we invest in vaccinating against chicken pox, we save $5.40.

So if you want to talk about cost, to me that is the real cost. For every child that this program gets vaccinated, that would not be vaccinated otherwise, we save a tremendous amount of money to the American taxpayer. Does anybody disagree with that?

Mr. CHAN. No. Not at all. In our statement, we try to underscore the importance of vaccination and the critical role it plays in preventive health care. I think we also said that the vaccine is the most cost-effective health intervention known.

Senator BREAUX. Let me ask this question then. Do we have any idea of how many children would not be vaccinated in this country if it were not for this program?

Mr. CHAN. Excuse me.

Senator BREAUX. Does anybody have any idea of how many children in this country would not be vaccinated in the absence of this program being in effect?

Mr. CHAN. Well, the best thing to do is to look at the rising trend in immunization rates from 1993 to now, and where we are. As Dr. Satcher said, the VFC is going through its implementation phase, and they are still trying to bring providers in and address what the intended goal is.

Senator BREAUX. Well, is it not a fair assessment to determine how many we did vaccinate under this program?

The CHAIRMAN. I wonder if that is not almost impossible. It has been in effect for only 7 months.

Dr. SATCHER. You are right. It is very early.

Senator BREAUX. What is the projected number?

Dr. SATCHER. That is what I was going to speak to. Several States have made projections as to the impact that the VFC program will have. This is from California which, by the way, states that it is saving $40 million because of the VFC program, Mr. Chairman. The State of California is saving $40 million because of the different costs between Medicaid and the VFC.

In Delaware, they estimate that the VFC will push coverage 10 to 15 percentage points higher. In other words, Delaware estimates that it will get that coverage up to the desired levels, 10 to 15 percent higher. And this is based on things they have done in terms of studies of people who are not getting it.

But it is too early for us to say definitely what is happening. So we just have to go by the estimates.

In Oregon, by the way, we are told that the impact of repealing the VFC would be catastrophic. There are thousands of children being immunized through VFC who would not be eligible for State-supplied vaccines by any other method.

And we have these statements in States throughout the country. The interesting thing is that both the State departments of health and the private providers are agreement on the importance of VFC. It is not just the private sector. It is not just the States. It is both saying that the VFC is important.

Senator BREAUX. In our own State of Louisiana, I received a letter from the Department of Health and Hospitals. They say that, with the CDC vaccine grant funds reduced sharply, and an unclear future with Medicaid, it is clear that we cannot provide vaccines to the uninsured population in Louisiana without the VFC program.

At a time when Congress is focusing so much on benefit/cost studies for everything, it seems very clear that if you attached a purely statistical benefit/cost study to this program, and the numbers you said we save for every child that is vaccinated in this country, and the number of children who would not be vaccinated in the absence of this program, it seems very clear to me that this is a very good deal for the American taxpayer from a bottom-line dollar standpoint. This is not to mention the suffering and misery that we are eliminating as a result of children being able to receive vaccinations.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Moynihan?

Senator MOYNIHAN. I have no questions, Mr. Chairman, save to say that I am glad you had this hearing. During the course of the 1993 budget reconciliation legislation, we had to raise $500 billion in budget deficit reduction by cutting programs and raising taxes. And it fell almost entirely to this Committee.

Simultaneously we were insistently told by administration officials that the most important thing we had to do was create the new entitlement program of vaccines for children. And we were not in any way disposed to resist this idea, save that for someone such as a New Yorker, it was an odd proposition. We have had free vaccination for a century.

When I was Chairman of this Committee, Mr. Rostenkowski and I discussed this. I asked him if they had not had the same in Chicago for a century, and he said sure. It was not entirely clear why a Federal entitlement had to be created out of what had been a municipal provision from the 19th century, when they first effected vaccines. Well, I guess smallpox was the first effective vaccine.

I gather that the GAO is not persuaded that the cost is the problem. I gather that GAO does not find that to be the case. The missed opportunity is the problem, but it is not a function of cost.

Mr. CHAN. Well, we did identify many many other reasons why people are not getting immunized as they should be. And I think what we said is that cost is but one factor of many. It is not a major factor, when we look at the research done.

Senator MOYNIHAN. I would just hope that we break out of the pattern of simple explanations for complex social problems. I see Dr. Sharma agrees. It is perhaps too easy to say that the problem is cost, when the problem is social function.

Dr. SATCHER. Senator Moynihan, could I speak to that?

Senator MOYNIHAN. Sir.

Dr. SATCHER. I think it is a very important point you are making. And we have sort of missed one point that you are raising. And that is that the childhood immunization initiative has five components. It so happens that this hearing is about one of them. The others are, first, to improve the infrastructure of local and State health departments so that they can better deliver the vaccines.

Another issue is the education and motivation of parents and providers. We have gone all over the country with outreach programs, trying to improve access, using education, using motivation, organizing community groups.

A third area is the development of tracking systems so that if a child is behind on vaccines, the parents can be notified. Or if a physician sees a patient, and does not know where that patient is on the immunization schedule, that there is a tracking system that allows that physician to know. We are investing in that.

And the last one is research. We continue to do research to improve the vaccine and the packaging of it. So those are the other four, other than the cost issues. We believe, as you pointed out, that it is a complex problem. It is just that this is the only one that has been challenged.

Senator MOYNIHAN. Is it not the case, I would ask Mr. Chan, by the time children enter school, almost all of them have had their vaccinations? Is that not right?

Mr. CHAN. That is correct.

Senator MOYNIHAN. There may be a lag there, but we do vaccinate our children.

Dr. SATCHER. Right.

Mr. CHAN. That is correct.

Dr. SATCHER. But it would be too late for many of them.

Senator MOYNIHAN. You can get something at age 3.

Dr. SATCHER. You sure can.

Senator MOYNIHAN. You are not over it.

Dr. SATCHER. Right. It can prevent you from ever getting to school.

Senator MOYNIHAN. Sure.

Dr. SATCHER. But you are right. It is true that by the time a child goes to school, 95 percent are vaccinated.

Senator MOYNIHAN. Ninety-five percent. Well, that is about what anything is in the United States. [Laughter.]

Thank you, Mr. Chairman. Thank you, doctors.

The CHAIRMAN. Senator Simpson.

Senator SIMPSON. Mr. Chairman, and Senator Moynihan, I have listened to some of this. And I have watched through the years as we all believe that it is so important to do this, we have done it with our own children. It is critical.

I was a young man when polio went through the community of Cody, Wyoming and just savaged people we knew and loved, our friends, 13, 14 and 16 years old. And the iron lung that went with it, and all of those things which were horrifying. And now to think that that disease is not only checked, but nearly eliminated.

I heard this years ago, and I do not know that it is still true, that a reason that there is not much activity with immunization, especially in the inner city, is because people equate needles with something other than positive. In other words, needles are to convey controlled substances, dope.

So if you take your child to get immunized, it is going to require a needle. And some people just say they are not going to do that. I know that sounds stupefying, but is that still out there in some way as part of it?

As our Chairman and Ranking Member say, we have people who are immunized when they come to these early school situations. You have discussed how you do it in the inner city. But is this part of it at all?

Dr. SATCHER. Well, I think the parents who do not want their children to be immunized represent a very small percentage of the problem. And those parents exist in inner cities, in suburbia. But there are very few. Some of them have objections on religious grounds. Others have objections because they do not trust anything provided by the Government. A lot of them do not trust the medical establishment. From all of our cities, that would represent a very small percentage of this problem.

I have been involved in extensive surveys in innercities in this country, asking parents regarding their attitude toward medical care. Immunizations are consistently ranked near the top of what they want out of a health care system.

Walt, do you want to add anything?

Dr. ORENSTEIN. I have worked at a community health center part-time, and it is my impression that that is not a major issue. Sometimes parents do not want multiple needles. One of the things we have is more vaccines that we can give children, and more diseases we can protect them against. So there can be multiple needles at the same time, but not a fear that the needle itself is a problem.

Senator SIMPSON. At one time, that was a problem, was it not, in years past?

Dr. SATCHER. I would not go so far as to say that it is not ever a problem. I think you will find parents, you will find adults, who do not want shots, even though they are life saving. They are that

afraid of needles. But I think that is so rare that it is not viewed as a major part of this problem.

Senator SIMPSON. I remember in the Army there was a little exercise. They said, now look, you see poison gas, you take this thing off your belt and you stick it in the calf of your leg and squeeze it, and that will save you. And this guy said, I am not going to put that thing in my leg. It was a self-administered needle which, if used, would save your life. And a lot of people said they would not do that to themselves for anything in the world. And they would take the gas, I guess. A lot of people do that.

Senator MOYNIHAN. In the Navy, it was well known that, for persons who misbehaved, they had square needles. [Laughter.]

Dr. ORENSTEIN. I might add that we have far better immunization levels in children with needles than we have adults with needles. We have a far more difficult time getting adults immunized than children.

Senator SIMPSON. Well it shows you the difference between the infantry and the Navy. We had round needles, not square.

Well, enough of that. But I am pleased that the plan to have the GSA warehouse activity here did not materialize. They were at one time going to have a distribution system with the GSA. And that was abandoned when we thought the GSA's experience in that warehousing would not be the best.

Senator MOYNIHAN AND I HAVE BEEN WORKING WITH THE GSA FOR MANY YEARS. You would not want them administering your immunization. That is my experience. [Laughter.]

So I have nothing further. I thank you for this, and I apologize for not being present the entire time.

Mr. CHAN. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Moseley-Braun, any others?

Senator MOSELEY-BRAUN. No further questions, Mr. Chairman.

Senator MOYNIHAN. I have nothing more, Mr. Chairman. Thank you.

The CHAIRMAN. Gentlemen, thank you very much for coming. We appreciate it.

And we now have our next panel. That is Dr. Lloyd Novick, who is the First Deputy Commissioner of the New York State Department of Health; Dr. Irwin Redlener, the President of the Children's Health Fund in New York; Dr. F. E. Thompson, the State Health Officer from the State of Mississippi; and Dr. David Wood, the Assistant Director, Division of Primary Care Pediatrics at Cedars-Sinai Medical Center in Los Angeles.

Gentlemen, welcome. I might say, Pat, that Dr. Wood just told me that he is soon to go to Woodburn, Oregon, where he is going to be head of the Salud Health Clinic, which is a very successful clinic in an area where we have a high migrant population.

Senator MOYNIHAN. Congratulations.

The CHAIRMAN. Doctor, we will look forward to your coming to Oregon.

Dr. WOOD. Thank you.

The CHAIRMAN. Dr. Novick, do you want to start?

STATEMENT OF LLOYD F. NOVICK, M.D., FIRST DEPUTY COMMISSIONER, NEW YORK STATE DEPARTMENT OF HEALTH, ALBANY, NY

Dr. NOVICK. Good morning. My name is Lloyd Novick, and I am the First Deputy Commissioner of the New York State Department of Health. I am here today on behalf of Dr. Barbara DeBueno, Commissioner of Health, who also serves on the Advisory Committee on Immunization Practices of the United States Public Health Service.

I am pleased to have the opportunity today to present to the Committee New York's experience with the Vaccines for Children program, referred to as VFC.

Since its inception a little more than 6 months ago, VFC has become an important link in the chain of our efforts in New York to improve the vaccination status of our children and, ultimately, to prevent unnecessary illness and death in these, our most vulnerable citizens.

We at the State level have designed a unique system which successfully serves children in New York. In our State, we have devised a vaccine distribution system which allows children to be vaccinated by their own pediatrician or family doctor, preserving continuity of care.

States should have the opportunity to design their own programs. And the Federal Government should continue to support State programs that have demonstrated track records of success. States can benefit from both Federal assistance and flexibility in the design and implementation of programs of this type. I strongly recommend to you this morning that you continue to provide support for the immunization program to achieve our goal to eliminate vaccine-preventable disease in this country.

In recent years, we have had substantial experience with New York children suffering because vaccine-preventable diseases were not actually prevented.

In 1990 and 1991, we had the largest measles outbreak in recent memory, with almost 5,000 confirmed cases and 24 deaths.

In 1993 and 1994, we have had the highest rates of pertussis, or whooping cough, in over a decade.

The root of this problem is poor vaccination levels in the preschool children under 5 years of age. In New York we have only recently achieved the level of 58 percent of 2-year-olds up to date for the basic series of vaccines.

We take a very aggressive approach to childhood vaccination in New York. We adopted a routine two-dose measles vaccination first, before the rest of the nation. We were among the first States to require screening of pregnant women for hepatitis B and treatment of at-risk newborn babies. And we were the first to require routine hepatitis B immunization for entering into school.

The focus of our efforts is to use the concept of a medical home for each child. That is, a health care provider who the family can know and trust, and who is able to provide vaccinations and other preventive health services.

A vaccine program is an important link in our efforts to build a partnership for immunization between public health and the medical care community in New York.

This partnership is vital in New York because over two-thirds of our children receive their routine medical care in the private and voluntary sector, and not in public health department clinics.

This is in sharp contrast to the situations our colleagues face in Mississippi, and some other States which you have already heard about, where the vast majority of vaccinations are given in public health clinics.

No amount of effort directed at public health clinics in New York will solve our immunization problems, because that is not where most children are vaccinated.

Despite the problems you may have read about—and those problems have already been referred to in this hearing—with the Federal VFC warehouse, New York's VFC program began on time last October, and has grown rapidly into a major success.

We have enrolled over 2,800 physicians and 478 health facilities, including 95 of major Medicaid fee-for-service providers. We have shipped over 2.8 million doses of vaccine. We have begun a campaign of informing parents of the program, highlighted by a television spot by the Harlem Globetrotters.

We have had good cooperation from physicians. A recent satisfaction survey of 55 physician practices showed good acceptance of the program.

Will immunization levels improve as a result of VFC? Again, I believe the answer is yes. Although, as others have commented, the impact of VFC is difficult to separate from that of all of our other efforts.

There are a number of ways in which we can measure the impact of VFC in New York. We see VFC as more than a vaccine distribution program. We are using it to educate providers. We are developing computerized immunization registries, and we will coordinate these registries with VFC.

Finally, and most significantly, we have preliminary evidence that referrals for vaccine to public health clinics have declined dramatically. Data on vaccine usage from the first 37 counties in which the data is available indicate an average of 30 percent drop in vaccine administered in county health departments for December, 1994 through February, 1995, compared with the same period in 1994.

If this trend continues and is seen in other counties, it will provide significant evidence suggesting that VFC has reduced referrals to public health department clinics, thus increasing immunization efficiency.

I want to conclude by reiterating our support for Federal immunization assistance in New York, for the work of this Committee in striving to find the best alternatives to provide immunizations to children. The program is up and running in New York, and is working well. It is an important link to improving our commitment to immunization for the sake of our children's health.

Thank you. I would be glad to answer any questions.

The CHAIRMAN. Doctor, thank you.

And now we will take Dr. Redlener.

[The prepared statement of Dr. Novick appears in the appendix.]

STATEMENT OF IRWIN E. REDLENER, M.D., PRESIDENT, CHILDREN'S HEALTH FUND, NEW YORK, NY

Dr. REDLENER. Thank you, Senator Packwood and Senator Moynihan. I very much appreciate the opportunity to be here before you.

When my testimony was made available yesterday, I got irate calls from many friends, from every conceivable political orientation and perspective on this. So I either did something very right or something terribly wrong here. Here is my perspective on the VFC program:

First of all, by way of background, I should say that I have spent 25 years dealing with medically underserved child populations throughout the United States, with the exception of a 7-year hiatus when I was in private practice in a suburban area in upstate New York. I am currently Associate Professor of Pediatrics at the Montefiore Medical Center at the Albert Einstein College of Medicine in New York.

Most relevantly here, I am President of the Children's Health Fund, an organization that uses both public and private resources to establish medical programs for extraordinarily underserved children. In fact, our program in New York, called the New York Children's Health Project, is the largest existing health care program for homeless children in the nation. And, in addition, we have replicated what was done in New York in eight other sites around the country, including rural West Virginia, Mississippi, Dallas, Newark, South Central Los Angeles, South Florida, and in Anacostia here in Washington.

So the experiences I am going to relate to you, and my perspective on the Vaccine for Children Program, comes from a fairly long and extensive exposure to, and working with, children who are as needy as one could possibly get from the point of view of access to medical care.

We have done some 200,000 health encounters with such children over the last few years. These kids that we are dealing with are sick. They are extraordinarily disadvantaged. They are suffering terribly, and they are not immunized. On their first visit to the New York Children's Health Project, we are finding that 90 percent of all of our children are either not up to date, or cannot document any immunizations.

I just want to reiterate that. Nine out of 10 are not up to date when we see them for the first time. This is a terrible indictment of the quality of access to health care in New York City. And we are dealing with what I consider to be the tip of a huge iceberg.

The CHAIRMAN. Are they not up to date because of the cost of the vaccine?

Dr. REDLENER. It is not because of the cost that they are not up to date. They are not up to date because of a failure of availability of health care resources to take care of them in proper ways.

And I want to just say a word about that. The kind of health care that we are interested in for children is a comprehensive, continuity-based, organized system where the health provider becomes the "medical home" that you have heard referred to before. It is the only context in which children should be immunized.

For some children, those who are in a medical home environment and who have problems meeting the cost of care, and for many low-income working poor families, cost may be a factor.

The patients that I am seeing, however, which are the very underserved and extremely disadvantaged, highest-risk populations, it is not so much cost at all, but it is a tremendous inability to provide resources, i.e., infrastructure, doctors and clinics for those children. My estimates are that there are a good 300,000 children in New York City alone who do not have what I would consider to be appropriate health care. And that is just in New York City.

Yes, they get access to emergency rooms or drop-in clinics, or even an immunization program here and there, or a lead screening program. But in terms of access to the kind of quality health care and comprehensive health care that we are talking about, that is where I find the problem to lie, the children who are most intractably unimmunized.

And I think this issue is not about whether vaccines work, or whether they are cost-effective. They are enormously cost-effective, and they work like crazy. The problem is how do we get kids vaccinated who are not vaccinated?

As you have heard earlier today, this is a multi-prong problem with lots of issues to deal with, one of which is cost. But a huge amount of it is not cost. It has to do with whether the kids have access to health care or not.

I am desperately afraid though that you will interpret my comments as somehow meaning that we need to take down a program that is trying to increase the immunization levels in this country. And I think that in a day when we are worried about budget deficits and State versus Federal control of public programs, and possible changes in Medicaid structure, we have to safeguard against any erosion of programs for children, especially poor children. And particularly, the Vaccine for Children Program has got to be protected.

On the other hand, it has got to be drastically changed if it is going to fulfill its fundamental mission. We have to safeguard against some of the problems that have arisen, that we could not have known about before, that we do know about now. Unintended negative consequences of the Vaccine for Children program have caused certain funds to be expended where they should not be expended, and left areas where we should be targeting funds completely or insufficiently covered.

And I want to say specifically what those concerns are. My written testimony has already been submitted to you. But I just want to tell you what I think are the big concerns that I have from the point of view of very underserved children vis-a-vis the Vaccine for Children program.

The biggest problem is that the program, as currently structured, does not sufficiently confront the factors that are most responsible for under-immunization in the populations that are at most risk of being under-immunized. And that is the access to a comprehensive medical home.

The second thing is that the program does not sufficiently monitor who is benefiting from the public program, and it provides a mechanism which I strongly disagree with. It provides a mecha-

nism for States to use public funds, any public funds, to support low-cost or no-cost vaccines for insured people or economically thriving families. I think in a day and age when we have 15 million children in this country who do not have access to health care, to spend our public dollars on those situations is wrong. There should be a refocus of those funds on getting children access to health care.

And, third, I find that private doctors may take advantage of this public program. but still refuse to care of any child who is on Medicaid or any child who is poor.

In preparation for this hearing, we called 17 consecutive pediatricians' offices in New York City, simply with my secretary saying, "I am on Medicaid. Would you take care of my baby who needs shots. I understand there is some program to give shots to children." Sixteen out of 17 refused to speak to her, would not give her an appointment, and would not even discuss the possibility of having Medicaid people come into their offices.

I do not think that doctors who take advantage of a public sector program should be allowed to get away with not seeing poor children or medically underserved children.

And a fourth point is that what we have created here is an inadvertent windfall for insurance companies. Insurance companies who cover families with health insurance should be required to include immunization and vaccine cost coverage in their family health insurance plans. That currently is not the case, and I think we are unfortunately allowing that problem to slip away from us.

The biggest concern here is that the Vaccine for Children program absolutely should be sustained. In fact, I think the amount of money we put into it should be doubled, because we are just scratching the surface of the challenge. And I have a lot of problems with much of the data you have heard already today.

But the focus should be shifted from so much concentration on purchase to dealing more with the barriers that inhibit and prevent people from getting the health care that they need.

I think it would be an easy thing to do under the umbrella of the Vaccine for Children program, and that is where I think our efforts need to be concentrated.

I think that children, unfortunately, are being pitted against one another. We should not be pitting the children of working poor families who do not have insurance, who do need help in the cost of vaccines, against those children who I take care of who are extremely disadvantaged and do not have access to any health care provider.

That is what this kind of debate is forcing us to do. I think both groups of children need to be taken care of. And I think it is really in the interest of the nation, and certainly in the interest of these families and children, that we understand that the biggest barrier to immunizing America's children has to do with lack of access to care. It has to do with our ability and willingness to fix it.

The CHAIRMAN. Doctor, I am going to have to ask you to wind down.

Dr. REDLENER. I am winding, I am wound already. [Laughter.]

All right, I am totally wound. But I think we should fix the program, and target it to the children who most need it.

I thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Redlener appears in the appendix.]

The CHAIRMAN. And Dr. Thompson, the State Health Officer for the State of Mississippi.

STATEMENT OF F.E. THOMPSON, JR., M.D., STATE HEALTH OFFICER, MISSISSIPPI STATE DEPARTMENT OF HEALTH, JACKSON, MS

Dr. THOMPSON. Thank you, Mr. Chairman and Senator Moynihan.

I am Dr. Ed Thompson. I direct the State Health Department in Mississippi. If I do not do anything else today, I am going to disabuse everybody here of the notion that Southerners talk slow. [Laughter.]

Mississippi's children have immunization levels well above the national average. Details of our program are provided in my written testimony.

From the perspective of a successful immunization program, I would like to address some issues surrounding the Vaccine for Children program. I want to make it clear that we are talking about the Vaccine for Children program, not about immunizing children. Immunizing children is unquestionably one of the most important goals this country has. The issue is whether the Vaccine for Children program is the best way to go about it or not.

First, the barriers. The cost and availability of vaccine has simply not been a major barrier, even before the VFC, largely due to section 317 of the Public Health Service Act and the ability of States to buy vaccine through national contracts at reduced prices.

I can elaborate on this later, but we are one of the poorest States, and we have some of the highest immunization levels. We have just not found cost to be the problem.

The real barriers include the complexity of the vaccine schedule, failure to track children's immunizations, lack of access to clinics and staff, and missed opportunities to immunize many children who were already seen.

By addressing these real barriers, and developing activities to get vaccine out of bottles and into children, one of our public health districts raised completion levels for 2-year-olds from 58 percent to 80 percent in 1 year.

The two most important barriers are actions not taken—failure to track children's immunizations and missed opportunities. Immunization tracking systems or registries can enable us to send reminders to parents and recall children for immunization if they fall behind.

Last year, 16 percent of Mississippi's children lacked a single visit to complete the primary series by age 2. A tracking and recall system could have put us over the national goal.

The other major area of emphasis is to avoid missed opportunities to immunize children. At one of our largest health department clinics, only 50 percent of children being seen in that clinic had completed their basic series by 19 months of age. But if all opportu-

nities to immunize had been taken, the percentage would have been 67 percent.

A policy of stick them while you have got them is critical to raising our Nation's immunization rates.

With regard to implementation of the VFC, the main problems encountered in Mississippi have been the unexpected responsibility of the health department for distributing the VFC vaccine and the lack of private provider participation. We sent out 1,300 enrollment kits to providers. So far, only 77 private providers have signed up.

The main success has been that, as noted before, in some States Medicaid matching funds previously used to pay for vaccines now covered by VFC have been made available for other uses.

As to the effect of the VFC on immunization levels, even as originally proposed, the VFC would have had little if any impact on raising our immunization levels. However, as originally proposed, the VFC was at worst wasteful, spending a huge amount of money for a minimal impact on immunization levels.

As it now exists, at least in some States, the VFC itself stands to become a major barrier to improving immunization levels, and is very likely to lower them.

The reason for this is the restriction of the VFC vaccine use to federally-qualified health centers, or FQHC's for underinsured children, those who have health insurance which does not cover vaccines. In Mississippi, that is 53 percent of our children.

Many of those children have a private doctor, but that doctor cannot give them VFC vaccine. If they come to the health department, which has clinics in every county in the State, we cannot give them VFC vaccine. Under the program as it now stands, their doctor or the health department must send them to an FQHC or give them non-VFC vaccine.

The vaccine for health department clinics has long been purchased with funds provided through the CDC under section 317 of the Public Health Service Act. With the advent of VFC, section 317 funds for health departments have been reduced on the theory that VFC will replace them.

In 1994, Mississippi received $3.9 million in 317 funds. For 1995, our allocation was $1.7 million. Meanwhile, we have $3 million for VFC, but we cannot use that vaccine for many of the children who come to us. And they do come to us. They come from the WIC program, they come for well-child care, they come for immunizations because our clinics are convenient.

Under the VFC, as it now stands, we will be faced with turning these youngsters away. Rather than reducing missed opportunities, the VFC will create and multiply them.

I would like to make recommendations for three critical actions that the Congress can take.

One is to restore funding of the 317 program to its pre-VFC levels.

Second, if the VFC is left in place, any changes made to it should preserve the ability of States to purchase vaccine at Federal contract prices using State funds, at least for use in health department clinics. These two actions will at least insure that existing, working immunization programs are not adversely impacted.

Finally, and most importantly, I recommend that this Committee and the Congress consider the wisdom of the VFC as a whole, in addition to examining the mechanics of its implementation.

If the VFC is left in place, I strongly urge this Committee to recommend that the restriction of the use of VFC vaccines for underinsured children to FQHC's be removed. If it cannot be removed, at least extend the ability to give VFC vaccines to underinsured children to health departments. Otherwise, the VFC, a well-intentioned program, will do more harm than good.

Senator MOYNIHAN. Wow. [Laughter.]

The CHAIRMAN. Not only did you prove your premise, but you have a future as a tobacco auctioneer, doctor. [Laughter.]

Dr. Wood, can you equal that?

Dr. WOOD. I do not think so. Maybe somewhere in between Dr. Redlener and Dr. Thompson.

[The prepared statement of Dr. Thompson appears in the appendix.]

STATEMENT OF DAVID L. WOOD, M.D., ASSISTANT DIRECTOR, DIVISION OF PRIMARY CARE PEDIATRICS, CEDARS-SINAI MEDICAL CENTER, LOS ANGELES, CA

Dr. WOOD. Thank you for inviting me to come. In addition to being a pediatrician in Los Angeles, and a practitioner in the inner-city of Los Angeles, I am also the principal investigator for the Los Angeles diagnostic study that you have been hearing about, one of the four diagnostic studies.

So I have been looking at this problem for 3 or 4 years pretty intensively. And I would like to make two points.

One is that there continues to be a problem. I think that point has been adequately made by many people. Especially in the inner city, we found rates as low as 25 percent that were fully immunized. And I hear a lot of confusion about what is fully immunized? But the rates are very low in some pockets in the inner city, and that is where epidemics can start.

The second point I would like to make is to examine the impact of the VFC. Speaking from the State that has two-thirds of their vaccines delivered by the private sector, I believe it is a different issue for us in California than it is in Mississippi.

And I think the biggest problems with under-immunization are serious issues in the quality of care, missed opportunities that have been mentioned, and the child health financing system that we have. And I would like to address that by looking at four areas of the child health financing system.

One is Medicaid fee-for-service and EPSDT; Medicaid managed care, which is growing; private fee-for-service and private managed care; and then the uninsured.

Each sector has different incentives and disincentives for delivering vaccinations. And I would like to address how VFC could be effective or ineffective in each of those areas.

First of all, Medicaid fee-for-service and EPSDT. We found that about 25 percent of children in the United States are covered by this program. And we found some of the lowest levels in the inner-city were children covered by Medicaid. In California there has

been a study which showed that only one-third of children on Medicaid received preventive services.

Now why is this? They have insurance. The reason is that it is underfunded. Medicaid is horribly underfunded. It only reimburses providers about half of the usual, customary and reasonable fees for that service for each visit that a private doctor delivers under Medicaid for well-child care and immunizations. And that is the way immunizations are delivered, in the context of a full exam and the immunizations. They lose $40 to $60 from the UCR.

As a result, I think a lot of providers are dissuaded from doing comprehensive physical exams and immunizations in the inner city under Medicaid programs. It is a lot easier for a doctor to see a kid for a quick ear check or check his nose for a cold. The parents go away happy with a prescription for an antibiotic. This is easier than to talk to that parent for another 10 or 15 minutes and refer that patient to your nurse, who has to spend 10 or 15 minutes doing the immunizations.

That takes a lot of your staff time. And you do not get reimbursed for it. So I want to make it clear that physicians in Medicaid do not get adequately reimbursed. We are asking them to provide a service, for which they cannot support their practice. And many practices in this country are still small businesses.

What VFC does under Medicaid it gives those doctors the vaccine free. Currently they have to pay for them out of pocket at $150 a vial for DTP. Many doctors say to me, you know, when I used to buy DTP, it was $10 or $15 a vial. Now I have to pay thousands of dollars for vaccines up front and, hopefully, 3 or 4 months later, get reimbursed from Medicaid. And many times their claims are capriciously denied.

EPSDT is the same thing. EPSDT only serves about a third of kids that are eligible for it in the inner city. And the reason is that they cannot get providers to participate in this program. The main reason is not the patients; it is the reimbursement rate.

I think the major benefit of VFC in Medicaid is that you are saving doctors the up front cost of buying vaccines, giving it to them free. In California, we estimated $40 million savings in the Medicaid program. They are taking $10 million of that—I wish they would take more—and putting it into raising Medicaid fees.

It costs a doctor's office between $10 and $15 for administration of a vaccine, taking into account the nurse's time, the syringe, etc. In California, we have been reimbursing physicians $4.52 for that. In some States it is less than $2. They lose money doing it. With VFC, at least it gets raised to $7.50.

So under VFC, they not only do not have to put out money for the vaccine, they also get more for administering the vaccine. So it is a financial incentive to the provider. And I think the providers are the key issue here. I watched you Senators trying to list what these immunizations are for. Parents cannot do it either. They do not understand what these diseases are. They cannot list what they are. They are just letters on a page to them. The parents depend on their doctors to say "your child needs this shot today." And if they go in for a cold, and the child is not very ill, and they need a shot, and the doctor does not say anything, well the parents assume the child did not need it.

I have asked so many patients why they did not get immunized. They say, well, I went to the doctor, and he did not say anything. So patients really depend on the system.

Under Medicaid managed care, it is a fairly similar thing. We are having a revolution in Medicaid managed care. This year, California is going to put 2.5 million Medicaid recipients into managed care. In managed care, the less you do, the more you make, unlike fee-for-service, where the more you do, the more you make. And there is a real tendency for underservice. And, in the first years of life, well-child care is a significant proportion of that capitation rate.

Because the cap rates in Medicaid were based on the already underfunded Medicaid fee-for-service expenditures, Medicaid managed care is really underfunded. And we have seen the effects of that in California.

In Los Angeles, only 30 percent of kids in Medicaid managed care were up to date in our study. And we have seen many abuses of Medicaid managed care.

What we can do for that? one, increase the capitation rate for Medicaid managed care, so they can have enough money. HCFA actually criticized California by saying that the State must reinburse managed care plans at a level to affectively do a decent job.

The second thing we can do is monitor the plans, and request that they report immunization rates within their plans. One of the disincentives plans have is that the Medicaid population turns over so frequently. If they do not immunize them today, 6 months from now the child will be in a different plan. They will not be held accountable or benefit from that shot.

So I would encourage us to look at increasing the eligibility time for Medicaid managed care as well. The savings from VFC can actually be used in Medicaid managed care to monitor plans. Again, the States have to use those savings. The State savings can also be used to increase the capitation rates for plans that are doing a good job. Give them an incentive to perform, and I think we will see our Medicaid managed care plans doing a lot better job in the inner city.

The last thing I would like to talk about is one brief comment on the fully-insured populations. I agree with Dr. Redlener that the VFC handles the insured populations that do not have immunization coverage in a very poor way. Requiring them to go to federally-qualified health centers is completely inadequate, and will not really do anything for the 60 percent of our kids who have insurance, about half of which do not have vaccines covered.

So I think a much better, although maybe politically more difficult, solution is to amend ERISA and allow States to mandate all insurances to cover this essential service.

The last point is the uninsured. This program will help the uninsured. Again, the poor uninsured qualify for EPSDT. And this program helps bring in funds to EPSDT, and helps incentivize providers to participate in EPSDT. The key to getting vaccines, especially to poor kids and inner-city kids, is getting the providers to participate, and making the service at least a break even deal for the providers.

Missed opportunities is absolutely a key issue here. Cost of the vaccine is not the only issue. I think providers have to do a better job of screening kids, giving shots. CDC has taken leadership here to develop standards; they are being disseminated. And now we in the professions have to take these standards up and make sure they are implemented. I think that will help dramatically.

Thank you very much.

The CHAIRMAN. Pat, we are not going to have a better panel of people who have been in the trenches than this panel.

Senator MOYNIHAN. Oh, no. That is why you got them.

The CHAIRMAN. I really have only one question of all of you. This hearing is really trying to find out if the problem of vaccination is the cost of the vaccine.

And what I hear from all of you, in one form or another, is that this is not the principal problem. It may be delivery, it may be a variety of things. But the cost of the vaccine is not the problem.

And, of course, that is what the GAO study indicated. Only CDC seemed to disagree with that.

But if I could just start with you, Dr. Wood, and go across. I do not mean this in any sense to badmouth if the program can be made to work. But if the cost of the vaccine is not the problem, then we are focusing at least this particular program in the wrong direction.

Dr. Wood? And then we will go right across the panel.

Dr. WOOD. I think cost to whom is the question. Is it cost to the parents?

The CHAIRMAN. Cost of the vaccine.

Dr. WOOD. Well, I mean the cost in general. There is cost to parents. Is the cost of the vaccine to the parents a problem? But there is also the cost to the providers.

Under Medicaid, parents see no cost because they are not allowed to be charged anything. So cost is not the problem under Medicaid, or in poorer populations that qualify for EPSDT. The problem is getting the providers to give the service. And the providers tell us that cost is a problem. They have to lay out money for the vaccine. They do not get reimbursed. Every time they give a shot to a child, they are losing money. That is the way they feel. You know, cost is often a very irrational debate.

The CHAIRMAN. But you are missing my point. I understand that they have to put out money, and they do not get reimbursed, and that is a delivery problem. But is the cost of the vaccine itself a problem?

Dr. WOOD. It adds to that problem, yes. It adds to their reluctance to give vaccine, to be as aggressive about giving vaccines as we need providers to be. And again, the providers make the decision to vaccinate. Even in our study of very poor inner-city kids, they went to the doctor's office 6 to 8 times, like the GAO said, usually for minor illness.

Now in that setting, if a doctor is really motivated, we could ask the patient about their vaccination and give them. But if you are losing money every time, it is hard to get docs, especially the small businesses, to do this.

The CHAIRMAN. It sounds to me like they would lose money if they got the vaccine for nothing.

Dr. WOOD. They lose less.

The CHAIRMAN. All right.

Dr. WOOD. But if they get the vaccine for free, and they get a little more on the reimbursement administrative fee from EPSDT and Medicaid, they lose less. So they are more motivated. The cost to parents is really more an issue of the middle class and non-poor. When they go to their doctor, they have to pay the $140 in one wallop because they are paying the physical exam fee, the administration fee, and the cost of the vaccine. And out of that $140, $40 or $45 is the vaccine cost.

So you are right. It is not the whole problem at all. But I know many of my friends who are middle class went and lined up at the health department, or tried to work some way to get it because it is quite expensive.

The CHAIRMAN. Dr. Thompson?

Dr. THOMPSON. I think it depends on whether we are worried about cost as a barrier to immunization, or cost as an irritant and an aggravation, and something some of us hate to pay, but we go ahead and pay it.

Cost as a barrier had already been eliminated prior to the VFC. One key to that was a fair amount of Federally-provided vaccine through the 317 program. And that was one of the main reasons that cost was no longer a barrier.

Cost is a barrier if there is not adequate Federal support for the purchase of some vaccine. As long as we keep the 317 program strong, put it back where it was before, then cost would not be a barrier. Without the VFC, we would probably not see much difference in immunization levels.

What we will do with the VFC vaccine is use it to vaccinate children who are already being vaccinated, but now they will not have to pay for the vaccine.

The CHAIRMAN. Dr. Redlener.

Dr. REDLENER. I feel like we are the proverbial visually handicapped individual trying to describe an elephant because we are looking at different angles of it. The question you are asking is answerable in different ways. If I am in private practice, and I have somebody coming to me who is working full time, making very low wages, and working for an employer who does not provide health insurance, cost is a major problem for that family.

Cost is not a problem in any way, shape or form for my patients, however, because it is other kinds of access barriers that are the principal problem for these very highly needy and highly vulnerable children.

The CHAIRMAN. Dr. Novick.

Dr. NOVICK. Cost is a problem in New York State. There are other problems, but cost is one of the problems. We surveyed pediatricians and family practitioners throughout New York State in 1993 and found, really to our surprise, that 50 percent of the pediatricians at that time referred at least some of their patients to other sources of care like the public health clinics. When we asked them why, over 80 percent of them said financial hardship.

So, on the basis of that, we would say it was a factor. Availability is a factor, and then all the infrastructure problems are a factor.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Well, just to pursue that, what the Chairman is basically asking is that if you were going to construct a program to address issues of immunization, would you begin by having the Federal Government use its money to buy vaccine and give it away? Of would you have us use the money to get vaccine into children?

And, Dr. Novick, I can recall 40 years ago when I was in the Governor's office in Albany. Dr. Hilabo was the Commissioner then.

Dr. NOVICK. Yes. Right.

Senator MOYNIHAN. And there were very few issues we did not talk about. But the issue of immunization never came up.

Dr. NOVICK. Right.

Senator MOYNIHAN. And it would have come up if it was a problem. You say in your testimony that, "In New York State, we have only recently achieved the level of 58 percent of 2-year-olds up to date for the basic series."

What would that ratio have been in 1950?

Dr. NOVICK. Well, it is hard to say. I would guess it probably would have been in the area of the high 40's or about 50 percent. I base that on the fact that we were surprised 5 years ago, when we had the measles epidemic, we looked at New York City and the ratio was about 50 percent, but it was only slightly higher than that upstate. There were less immunizations——

Senator MOYNIHAN. We have had free immunizations in New York City for a century, have we not?

Dr. NOVICK. Yes. We have had free immunization. And at one time, the State health department and the New York City health department had enough vaccine so that they could make it available in the private sector.

Because of the increasing costs of vaccine, until the VFC program came along, we had restricted availability of vaccine.

Senator MOYNIHAN. Well, of course, you have additional vaccines now.

Dr. NOVICK. Yes, we have additional vaccines.

Senator MOYNIHAN. Could you get this Committee a data series as best you have, going back a century?

Dr. NOVICK. Yes, I can. We have the same interest you do in the history of that.

Senator MOYNIHAN. That is right.

Dr. NOVICK. New York, to its credit, really started immunization in terms of diphtheria immunization with the New York City health department. I think it was in about 1910.

Senator MOYNIHAN. When it became available in 1910.

Dr. NOVICK. Yes. But, in answer to your question, you need both the infrastructure and the availability of vaccine. As other people have testified, we have less than a satisfactory child health system in terms of continuity. Until we have such, having available vaccine helps us. When we do get a satisfactory system, I think the importance of solely providing vaccine will become less critical.

Senator MOYNIHAN. But there has been a change in social structure. Fifty-two percent of the children born in Brooklyn, Kings County, were on Medicaid as of 2 years ago.

The simple fact is that—and I do not ask you to agree, Mr. Chairman—one of the unanticipated consequences of 50 years of

social policy is that we have produced an enormous class of dependent persons who in other times would be described as paupers. They have no resources. They own nothing. They may in fact get good health care. They get good health care in Montefiore, which has been there in South Bronx for a century.

But I was there 3 weeks ago at the groundbreaking for the new outpatient center. When we open it, it is going to be magnificent, the best medicine in the world, but available to an increasingly destitute population. Is that not the case? Is that not where your problem is? I ask Dr. Redlener.

Dr. REDLENER. There is a tremendous disparity of health care access and quality among our populations in our country.

The question about immunization in New York City, we are only immunizing up to 50 percent or so, across all populations, in New York City right now at age 2.

In the absence of free vaccine through the health department programs that have become a model for the nation, we probably would be dealing with only 10 or 15 percent being immunized.

So cost has had an effect. The provision of free vaccine has had an effect. But it is nowhere near the answer to the question.

Senator MOYNIHAN. I think social structure has had an effect too.

Dr. REDLENER. Quite a lot.

Senator MOYNIHAN. Thank you, Mr. Chairman. Thank you, doctors.

The CHAIRMAN. Gentlemen, thank you very much.

We are adjourned.

[Whereupon, at 11:22 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF KWAI-CHEUNG CHAN

Mr. Chairman and Members of the Committee: It is a pleasure to be here to share with you the preliminary results of our ongoing work on the Vaccine For Children (VFC) program. As you requested, I will present information on barriers to immunization, including our assessment of available evidence regarding the role of vaccine cost as a barrier for parents in immunizing their children.

First, however, I would like to underscore the importance of vaccines and the critical role that they play in protecting children from potentially serious diseases. Vaccines are the most cost-effective health intervention known.

Section 13631 of the Omnibus Budget Reconciliation Act of 1993 created VFC as an entitlement program to provide free vaccine to children 18 and younger who are eligible for Medicaid, Native American or Alaskan natives, uninsured, or underinsured (that is, whose insurance does not cover childhood vaccinations). The administration had stipulated that an increase in the cost of vaccine was a major factor in low rates of vaccination and proposed VFC to purchase and distribute vaccine supplies "to make sure that children do not become sick or die from vaccine preventable diseases."[1] By providing free vaccines, VFC was intended to remove vaccine cost as a barrier to childhood immunization. VFC is a part of the Childhood Immunization Initiative (CII), the goal of which is to raise immunization rates for 2-year-old children to 90 percent for most antigens. By law, VFC is to provide the states with vaccines. The schedule established by the Public Health Service's Advisory Committee on Immunization Practices includes vaccines for measles, mumps, rubella, diphtheria, polio, tetanus, pertussis, hepatitis B, and hemophilus influenza. It is expected that the recently approved hepatitis A and varicella (chicken pox) vaccines will be added.

To assess barriers to immunization and the particular significance of vaccine cost as a barrier, we talked with CDC officials and reviewed pertinent literature and agency documents, including various types of information CDC cited to address vaccine cost as a cause of delayed immunization. In addition, we reviewed four major studies sponsored by CDC in the wake of recent measles epidemics to "diagnose" and identify reasons for low immunization rates among high-risk racial and ethnic minority inner-city preschoolers in Baltimore, Los Angeles, Philadelphia, and Rochester (New York). We reviewed CDC's four studies to assess the factors associated with underimmunization. Further, we convened an expert panel of the principal investigators of these studies to help determine the extent to which the cost of vaccine for parents affects their children's vaccination status.

In our review of the available data and our discussions with the expert panel, we did not find sufficient evidence to conclude that vaccine cost has been a major barrier to children's immunization. The literature does identify many barriers, including parents' lack of awareness of their children's vaccination schedule, inadequate resources (for example, insufficient clinic staff, insufficient or inconvenient clinic hours, and inaccessible clinic locations), clinic policies that deter vaccination by requiring appointments or refusing to see walk-in patients, and various factors that cause providers to miss opportunities to immunize children at regular visits. We found that although a variety of socioeconomic and demographic variables are associated with undervaccination among inner-city children, these relationships appear

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[1] Centers for Disease Control and Prevention, National Immunization Program, *The Childhood Immunization Initiative* (Atlanta: April 1994), p. 1.

to function not through cost but, rather, through other factors associated with poverty, such as family size and maternal education.

The findings from CDC's diagnostic studies indicate that most underimmunized children have access to free vaccine through Medicaid or public health clinics (that is, through private or public providers) and that they had visited their providers an average of six to eight times during a given year. During these visits, these children could have received their scheduled immunizations, but providers failed to vaccinate them. These occasions are commonly known as "missed opportunities." Specifically, a missed opportunity is defined as a health care visit during which a child eligible for vaccination on the day of the visit and with no valid contraindication for vaccination fails to receive the needed vaccine.

CDC's studies identified several factors that are associated with missed opportunities. These primarily include provider and clinic-related factors and policies, such as failure to use simultaneous vaccinations or accelerated immunization schedules for children who are behind schedule, lack of access to records of a child's immunization status, and lack of organizational support. The missed opportunities observed in the diagnostic studies occurred during both sick- and well-child care visits. In fact, incorrect beliefs regarding contraindications for immunization are a particularly important contributor to missed opportunities. For example, CDC's diagnostic study in Baltimore reported that missed opportunities occurred at approximately 25 to 30 percent of preventive visits but at more than 75 percent of sick-child visits and that a health care provider was more likely not to vaccinate a child during a sick-child visit.[2] Table 1 shows immunization levels observed among children 24 months old in each of CDC's four diagnostic studies and potential levels that the investigators believed could be achieved by eliminating missed opportunities.

Table 1: Percentage of Actual and Potential Vaccination Coverage Among 24-Month-Old Children by Individual Vaccine Doses and Site, 1991–92[1]

City	Vaccine[2]/dose	Actual	Potential	Difference
Baltimore	DTP/DT/3	85%	93%	8%
	DTP/DT/4	58	74	16
	Polio/3	65	81	16
	MMR/1	80	89	9
Los Angeles	DTP/DT/3	54	62	8
	DTP/DT/4	26	34	8
	Polio/3	34	50	16
	MMR/1	39	48	9
Philadelphia	DTP/DT/3	82	85	3
	DTP/DT/4	57	67	10
	Polio/3	68	79	11
	MMR/1	87	94	7
Rochester	DTP/DT/3	94	99	5
	DTP/DT/4	75	96	21
	Polio/3	80	95	15
	MMR/1	90	96	6

[1] Assumes all missed opportunities to vaccinate had been eliminated.
[2] DTP/DT = diphtheria and tetanus toxoids and pertussis vaccine/diphtheria and tetanus toxoids. MMR = measles-mumps-rubella vaccine.

Source: *Morbidity and Mortality Weekly Report*, 43:39 (October 7, 1994), 711.

The diagnostic studies' findings regarding missed opportunities were consistent across the four studies, even though they used different methodologies. The studies concurred that 2-year-olds missed opportunities very frequently during visits to health care providers: 82 percent of children studied in Rochester missed one or more opportunities, 75 percent in Baltimore, 69 percent in Los Angeles, and 64 percent in Philadelphia. Assuming baseline coverage of 60 percent, these research projects found that eliminating all missed opportunities would alone account for a third to a half of the increase needed to reach the 90-percent goal for 1996. However, as table 1 shows, eliminating missed opportunities alone would not raise immunization rates to the targeted 90-percent levels in all cases.

The results of CDC's four diagnostic studies indicate that while no single factor or category of factors accounts for undervaccination, access to health care among

[2] Baltimore investigators found that diagnoses commonly recorded at sick-child visits in which an opportunity to immunize was missed without valid contraindication included gastroenteritis, otitis media, skin infection, and upper respiratory infection.

underimmunized children is not generally a problem. The diagnostic studies suggest that achieving and sustaining a high coverage level will require a variety of interventions aimed at changing the practices of providers that result in missed opportunities. Specifically, the findings do not provide sufficient evidence to conclude that providing free vaccines through VFC will boost coverage for most underimmunized children, for whom vaccines are already free.

In addition to the four CDC studies, we examined other studies and information cited by CDC as addressing the role of vaccine cost in delayed immunization. CDC identified six types of evidence to support the notion that vaccine cost is a barrier:

1. increases in vaccine cost over the past decade;[3]
2. surveys of health care providers inquiring about the frequency with which they had referred patients to public health providers for immunization, their reasons for doing so, and their opinions regarding a universal vaccine purchase program;
3. reports from health departments of increased referrals from private providers;
4. surveys of parents visiting public health clinics regarding their reasons for using the clinics;
5. policy studies addressing the relationship between health insurance coverage, health care utilization, and immunization; and
6. comparisons of immunization rates between states with and without universal vaccine distribution programs.

Unlike the diagnostic studies, which examined populations at high risk of underimmunization to assess the relationship between immunization status and a variety of potential barriers, the additional research cited by CDC tended toward a more narrow investigation of particular factors, such as providers' referral patterns. We found that, for the purpose of assessing the role of vaccine cost in underimmunization, this research suffers from several conceptual and methodological problems, such as failure to distinguish vaccine costs from other fees associated with immunization, inability to determine that the factors actually measured (such as provider referrals to public health clinics) were valid indicators of eventual failure to receive immunization, and reliance on opinion data collected in surveys rather than through analysis of the immunization status of representative samples of children. For example, CDC officials acknowledged that providers' fees in the private sector would be about $40 per office visit and about $15 per dose, representing potentially about 60 percent of the total cost of full immunization, but much of the evidence they cited failed to distinguish between the cost of vaccine, which is addressed by VFC, and these fees, which are not. Comparisons of immunization rates between states operating universal distribution programs and other states do not permit accounting for the various other factors that may affect rates in these states.[4]

To summarize, the studies we examined and the other sources of information available to us lacked sufficient evidence to conclude that the major factor addressed by VFC, vaccine cost, has been a significant barrier to immunization. It appears that efforts to address a variety of other barriers may be equally or more important in improving immunization levels. We have discussed our findings and conclusions with responsible CDC officials. They are in general agreement with our finding that there is not sufficient evidence to conclude that vaccine cost is among the most significant barriers to immunization.

Mr. Chairman, this concludes my remarks. I would be happy to answer any questions that you or members of the Committee may have.

PREPARED STATEMENT OF SENATOR ORRIN G. HATCH

Thank you Mr. Chairman.

Let me just say briefly that I hope today's hearing will afford the committee an opportunity to explore fully all aspects of the Vaccines for Children Program. As we all know, there have been some problems with this program and they have been serious enough, in my view, to have undermined the important public health initiative this program serves to implement.

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[3] See our July 21, 1993, correspondence to the Honorable John Dingell and July 27, 1993, correspondence to the Honorable Dale Bumpers, noting problems in linking price changes to low coverage.

[4] U.S. General Accounting Office, *Childhood Immunization: Opportunities to Improve Immunization Rates at Lower Cost*, GAO/HRD–93–41 (Washington, D.C.: March 1993).

I do not think we should be here today looking for someone to blame, but rather identify and understand the problems so that we can move ahead. Today's hearing will serve to accomplish that goal both for this committee and, I should add, for the Centers for Disease Control and Prevention, and the Department of Health and Human Services.

I strongly believe in the importance of childhood immunization to protect our youngest citizens against a host of diseases, many of which lead to death.

Let me add, Mr. Chairman, under the Vaccines for Children Program the state of Utah is currently working on a state distribution plan. In fact, within the next several weeks the Utah State Department of Health expects to enter into a contract with a successful bidder to begin distribution of vaccines effective July 1, 1995.

I would also like to mention that the First Lady of Utah, Mrs. Jacalyn Leavitt, has expressed her support for this program and I would request that a copy of her letter be included in the hearing record.

Again, I welcome our distinguished witnesses. I look forward to reviewing your testimony and I thank the Chairman for conducting this important hearing.

Attachment.

April 24, 1995

STATE OF UTAH
OFFICE OF THE FIRST LADY
3132 STATE OFFICE BUILDING
SALT LAKE CITY, UTAH 84114

The Honorable Orrin G. Hatch
133 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Hatch:

When considering the possibility of health care reform in the 104th Congress, I wanted to write you regarding a program that should prove to be particularly cost effective: The Vaccines for Children (VFC) program.

VFC enables the federal government, through the states, to purchase vaccines from manufacturers at significantly reduced rates and provide them, through both the public and private sectors, to children who are uninsured, Native American, or Medicaid-eligible. Health care experts estimate that for every dollar that is spent immunizing a child, we save approximately ten dollars in subsequent health care costs. The program makes good economic sense.

I believe this is a program that will yield long-term health care savings. It demonstrates a productive partnership between government and business, between federal and state governments, that serves as an example of how our health care system can better serve our people.

We have worked very hard in Utah to develop an effective immunization education and delivery system. I chair the "Every Child By Two" task force that has worked diligently for over two years to improve our state's immunization rate. This will be the third summer our immunization Care-A-Van will travel throughout the state providing free immunizations. We have worked with the Utah Broadcasters Association to produce PSAs and have encouraged frequent airings on radio and television stations. An extensive distribution of education materials and schedules appear in clinics, doctors' offices, and public buildings. We even used McDonald's and Wendy's tray liners as a means to educate.

We feel this is a critical element to our efforts in providing a complete immunization program for the children of Utah.

Sincerely,

Jacalyn S. Leavitt

PREPARED STATEMENT OF LLOYD F. NOVICK, M.D., M.P.H.

Good morning. My name is Lloyd Novick and I am the First Deputy Commissioner of the New York State Department of Health. I am here on behalf of Dr. Barbara DeBuono, Commissioner, New York State Department of Health, who serves on the Advisory Committee on Immunization Practices to the United States Public Health Service. I am pleased to have the opportunity today to present to the Committee New York's experience with the Vaccines for Children program (VFC). Since its inception a little over six months ago, VFC has become an important link in the chain of our efforts in New York to improve the vaccination status of our children and, ultimately, to prevent unnecessary illness and death in these our most vulnerable citizens.

We at the state level have designed a unique system which success fully serves children in New York. In our state, we have invented a vaccine distribution system which allows children to be vaccinated by their own pediatrician or family doctor, thus preserving continuity of care.

States should have the opportunity to design their own programs, and the federal government should continue to support state programs that have demonstrated track records of success. States can benefit from both federal assistance and flexibility in the design and implementation of programs of this type. I strongly recommend to you this morning that you continue to provide support for immunization of children to achieve our goal to eliminate vaccine-preventable diseases in this country. States need both federal assistance and flexibility in the design and implementation of programs of this type.

In recent years, New York children have suffered because vaccine preventable diseases were not prevented. In 1990 and 1991. we had the largest measles outbreak in recent memory with almost 5,000 confirmed cases and 24 deaths. In 1993 and 1994. we had the highest rates of pertussis or whooping cough, in over a decade. The root of the problem is poor vaccination levels in preschool children. In New York, we have only recently achieved the level of 58% of two year olds up-to-date for the basic series of vaccines.

We take a very aggressive approach to childhood vaccination in New York. We adopted a routine 2-dose measles vaccination schedule be fore the rest of the nation. We were among the first states to require screening of pregnant women for hepatitis B and treatment of at-risk newborn babies, and we are the first to require routine hepatitis B immunization for entry into school.

The National Vaccine Advisory Committee's "Measles White Paper" in 1991 spelled out the barriers to timely preschool immunization. These run the gamut from educating and motivating parents to get their children vaccinated and making preventive health services available, to ensuring that these services are actually provided including ensuring that vaccines are available. We will not succeed by removing only one or two of these barriers; all are critical links in the chain leading to the goal of full vaccination coverage. In New York, we have aggressively attacked these barriers on all fronts, as outlined in the attachments to my testimony.

The focus of many of our efforts to improve vaccination status is the concept of a "medical home" for each child: a health care provider who the family can know and trust, and who is able to provide vaccinations and other preventive health services. The Vaccine program is an important link in our efforts to build a partnership for immunization between public health and the medical care community in New York. This partnership is vital because between two-thirds and three quarters of children in New York receive their routine medical care in the private and voluntary sector and not in public health department clinics. This is in sharp contrast to the situation our colleagues face in Mississippi and some other states where the vast majority of vaccinations are given in public health clinics. No amount of effort directed at the public health clinics in New York will solve our immunization problems because that is not where most children are vaccinated.

Despite the problems you may have read about in the newspaper with the federal VFC vaccine warehouse, New York's VFC program began on time last October and has grown rapidly into a major success. We have enrolled over 2,800 physicians and 47B health facilities including 95% of major Medicaid fee-for-service billers. We have shipped over 2.8 million doses of vaccine. We have begun a media campaign informing parents of the program highlighted by a television spot by the Harlem Globe Trotters.

Have we had problems? That goes without saying in a program of this magnitude. Overall, there have been remarkably few problems.

Have physicians embraced the program? The enrollment numbers speak for themselves. A recent satisfaction survey of 55 enrolled physician practices showed good acceptance of the program.

Will immunization levels improve as a result of VFC? Again, I believe the answer is yes, although the impact of VFC will be hard to separate from that of all of our other efforts.

There are a number of ways that we can already measure the impact of VFC in New York. First, we view VFC as more than a vaccine distribution program and are already using it to educate enrolled providers on good vaccination practices. We have also taken steps to protect VFC vaccines by supplying many enrolled providers with continuous temperature recording thermometers. We have also seen a tremendous demand for hepatitis B vaccine suggesting that VFC has helped to speed acceptance of this vaccine. Steps like this will be increasingly important as new vaccines, like the chickenpox vaccine which requires lower storage temperatures and different handling practices than other vaccines, are introduced. We are coordinating VFC with immunization registry development and should be able to use the registry as an accountability tool in the future. We have also seen a tremendous demand for hepatitis B vaccine suggesting that VFC has helped to speed acceptance of this vaccine for routine use.

Finally, and most significantly, we have preliminary evidence that referrals for vaccination to public health clinics have declined dramatically. Data on vaccine usage from the first 37 counties for which they are available indicate an average 30% drop in vaccine administered in county health department clinics in December 1994–February 1995, compared with the same time period in 1994. If this trend continues and is seen in other counties, it will provide significant. evidence suggesting that VFC has reduced some referrals to public health department clinics.

I want to conclude by reiterating our support for federal immunization assistance in New York. The program is up and running in New York and is working well as an important link to improving our commitment to immunization for the sake of our children's health.

Thank you, and I would be glad to answer any questions.

PREPARED STATEMENT OF SENATOR DAVID PRYOR

Mr. Chairman, I welcome this hearing and the opportunity to review our progress in providing universal immunization for children. When the Vaccines for Children program was begun, almost half of our nation's preschoolers were not fully immunized. Today, our country is closer to the goal of assuring full immunization of 90 percent of all our 2-year old children.

There is no question that immunization remains one of the most cost-effective and essential forms of health care we can provide. In the absence of comprehensive health reform, it is all the more important that the Federal and state governments continue to cooperate with private providers in achieving complete immunization coverage of our children. This morning, I hope we may identify ways of strengthening successful initiatives and improving on the progress which has already made.

There is also no question that cost has also been a barrier to comprehensive immunization when the price of a full series of vaccines has risen ten-fold since 1983. For families which lack private immunization coverage yet fail to qualify for Medicaid, the Vaccines for Children program helps reduce costs and assure coverage. This is possible in part because states can purchase vaccines for children at lower prices available to the Federal government. This stands is sharp relief to the recent past, when states who sought to acquire vaccines at federally negotiated prices were refused outright by manufacturers.

In spite of this progress, many serious obstacles remain to guaranteeing the health of our children through immunization. The Administration has successfully sought to expand national outreach and provider education, improve comprehensive vaccine registries and strengthen the role of public health clinics. Further steps must be taken to assure that states have reliable distribution systems and that the government continues to make effective use of its bargaining power in purchasing negotiations with manufacturers.

I thank the chairman for calling this hearing and look forward to working with my colleagues on the committee and the Administration on making our country a world leader in improving the health of children.

PREPARED STATEMENT OF IRWIN REDLENER, M.D.

Chairman Packwood, members of the committee, I am here to support the Vaccines for Children Program - but qualify this support based upon certain concerns which must be addressed by introducing a few important modifications. In general I am suggesting three over-arching goals for the program:

1. As increasing attention is paid to budget deficits and state versus federal control of public programs, we need to protect the integrity of the VFC program and health care access for children. The national agenda for children should not be undermined by multiple state interpretations of what America's children need. And, VFC should not be endangered by limitations related to possible fundamental changes in Medicaid structure.

2. We must safeguard against unanticipated consequences of the program as it is currently organized - including the use of precious resources in ways which will not accomplish the goals of VFC in the most efficient manner possible.

3. Conversely, we need to maximize all available resources -including those provided through VFC - so that the program targets the children most in need with expenditures targeted to address their specific barriers to health care and immunizations.

I am Dr. Irwin Redlener, director of community pediatrics and associate professor of pediatrics at the Montefiore Medical Center and Albert Einstein College of Medicine in New York. I have had some 25 years experience in delivering health care and developing programs for disadvantaged children.

I am also president of the Children's Health Fund, a foundation responsible for establishing comprehensive pediatric programs for some of the most medically underserved children in the nation, including the children of homeless, migrant and otherwise severely disadvantaged families in a wide range of communities.

Children's Health Fund programs operate in New York City; Newark, New Jersey; Dallas, Texas; rural Mississippi; West Virginia; South Florida; South Central Los Angeles; and Washington, D.C. These programs have, to date, provided nearly 180,000 medical primary health care encounters to our designated target populations.

The projects included within our network take children who have had very little organized, quality health care and provide them with care that is delivered by medical teams who are committed to quality and continuity.

Testimony - 5/4/95
Irwin Redlener, M.D.
Senate Finance Committee

We ascribe to a notion that the care all children receive should be the kind of care we expect for our own children. This care should be comprehensive, preventive and organized. Immunizations should be administered at a place where the rest of their health care is delivered; where follow-up vaccinations and follow-up for medical problems can be tracked and managed. Where, if needed, specialty care and hospital care can be coordinated and ensured.

Pediatricians refer to this kind of care as being provided in a "medical home." It is the appropriate way to do what's right. It's what all children deserve to have.

Children without a medical home may get health care, but it is the worst kind of episodic, fragmented and expensive medical attention in emergency rooms and drop-in clinics. This kind of care typically entails little or no follow-up; and, it often does not happen until illness has progressed too far.

In other words, medically homeless children get the wrong kind of care, in the wrong places, at the wrong time. It is precisely these children, without regular, dependable access to primary care that are most likely to be underimmunized.

Conversely, the most important piece of evidence that a child is medically underserved is **underimmunization.**

In fact, our programs provide medical care to some of the most medically underserved children in the United States. For the homeless and extremely indigent children cared for by our flagship mobile unit program, the New York Children's Health Project, the immunization rates are devastating:

Some 90% of our pediatric patients, on their first visit to our program are behind in - or cannot document - their routine immunizations.

This is an extraordinary indictment of the health care system for indigent children and is, to our knowledge, one of the absolute worst immunization situations in the United States.

Actually, in all of our sites, rural and urban, immunization rates are terrifyingly low and, importantly, reflective of the sorry state of the child health safety net in the United States. It is my opinion, that because of factors ranging from lack of health insurance to severe maldistribution of health professionals, **at least 15 million children under the age of 18 years lack appropriate access to appropriate health care.**

Testimony - 5/4/95
Irwin Redlener, M.D.
Senate Finance Committee

I need to emphasize this reality: in terms of the most significant causes for the nation's problems around immunizing our children, the cost of vaccine is not the major factor. **Rather, it is lack of access to a medical home type of health care relationship and the absence of a functioning child health care safety net in this country which are overwhelmingly responsible for our seeming inability to consistently protect our children through on-time immunizations.**

The Vaccine for Children Program (VFC) is clearly based on an essential and laudable principle that all children need to be immunized in an appropriate and timely manner. Our country cannot afford otherwise. President Clinton and his entire administration are committed to this goal and it needs to be achieved.

We are, therefore, strong supporters of the VFC but have insisted that it be modified in several important ways in order to enhance the program's ability to improve the nation's childhood immunization rates.

Modifications are necessary because of certain problems and issues which have become apparent as the program unfolds.

I would like to share with you my four principal concerns and specific recommendations to re-shape VFC:

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Concern #1

George Washington University's Center for Health Policy Research recently reported a study of immunization issues in 12 states where there is universal purchase of vaccine for all children. In these states, cost - associated barriers have been effectively dealt with as factors in underimmunization.

However, this study verifies our clinical experience in providing immunizations and primary care to underserved children around the U.S.: **VFC, in its current form, does not confront the factors responsible for severe underimmunization in the millions of children who have no regular place for health care.** These are the children who really need assistance in getting and sustaining up-to-date immunizations. They need medical homes.

You might look at the issue in this way: underimmunization is a symptom of lack of access to relevant pediatric health care. The real "treatment" for this problem is guaranteeing access to

comprehensive health care where immunizations can be given over time and on-schedule.

For the 15 million medically underserved children in the United States the total amount of funds including the VFC program, Section 317 and other public sector initiatives is insufficient to meet existing needs. However, right now I am concerned that the relationship between funds spent on vaccine purchase versus new health provider capacity for disadvantaged children is not in appropriate balance.

Recommendation:

Congress needs to safeguard the total expenditure for vaccine-related programs so as not to jeopardize the long-term national agenda for children. **But, tax dollars should not be used to purchase or subsidize vaccines for families with sufficient income or insurance coverage.** These dollars should be re-directed to providing access to health care for as many medically underserved children as possible. **This means support for infrastructure that is, new capacity to provide comprehensive, primary health care. Such investments will help public sector provider systems become more consistent with the medical home model. At the same time, we need to ensure that funds to provide vaccines are always sufficient to meet the needs of the children identified as "at risk."**

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Concern #2:

The VFC purchase and distribution plan helps families who have a regular source of health care - pediatrician, family physician, clinic, etc. - but cannot afford or are not covered for vaccines in that setting. Some are directed to use public health clinics, thereby fragmenting care. Studies have shown that VFC can help many of these families. **But under current VFC guidelines, there is insufficient monitoring and oversight of under what circumstances and for how long these families would be eligible for free or subsidized vaccine. In addition, certain VFC provisions permit states to inappropriately use public funds to provide vaccines for insured or non-needy children.**

Recommendation

VFC should not offer opportunities for states to use limited public

resources to provide free or subsidized vaccines to non-needy or insured patients. In addition, VFC funds should only provide vaccine to families until Medicaid or private insurance coverage is obtained.

Concern #3

The VFC program is, of course, a great assistance to private physicians and their patients since it eliminates the need to utilize public clinics for vaccinations. Yet, although the private practitioner benefits from the VFC as a government subsidy, **private doctors may still refuse to provide subsidized vaccine, or any health care, to Medicaid or low-income patients - precisely the children who are most in need.**

Recommendation

Physicians or clinics participating in any aspect of VFC should be required to accept children covered by Medicaid, children who are uninsured or those who are otherwise unable to obtain appropriate health care.

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Concern #4

Many insurance companies do not include immunizations in their family coverage. Companies may surmise that responsibility for the cost of vaccines will simply be assumed by a tax-supported program.

Recommendation

All insurance policies covering families, whether fee-for-service or capitated premium based, should be required to include all recommended vaccines for children.

****

Members of the Committee:

As I stated earlier children need real medical homes. If every child in this country had a medical

home, we would not have the unconscionably low immunization rates we experience in rural and urban areas around the country.

We need VFC. But it must be modified so that it can really take on and solve one of the most important challenges of our time.

Finally, it is my hope - and that of virtually every health professional and provider organization - that we can find a way to make sure that every child in the United States has access to appropriate and essential health care.

At the end of the day, it is health care, not vaccines, that should be guaranteed for children by government.

I know that the President and the Administration are deeply committed to VFC and access to health care for the nation's children.

Our job now is to make the adjustments in an important program that will permit it to function with maximal impact and in the spirit intended by its original drafters. In this day and age, where ever more children are vulnerable, endangered and facing an uncertain future, making VFC as effective as it can possibly be is the least we should do.

Thank you.

PREPARED STATEMENT OF DAVID SATCHER, M.D., PH.D.

Mr. Chairman, I am Dr. David Satcher, Director of the Centers for Disease Control and Prevention (CDC). I am accompanied by Dr. Walter Orenstein, Director of CDC's National Immunization Program.

Thank you for the opportunity to appear before this Committee to discuss childhood immunization. I am pleased to be here to tell you about the progress we have made since October 1 when the Vaccines for Children (VFC) Program became operational, according to law, and to clarify issues that have been raised in the process. Your letter asked that we bring you up-to-date on several issues, including successes and problems of VFC implementation, barriers to immunization, and impact of VFC on immunization rates.

IMPLEMENTATION OF THE VFC PROGRAM

The VFC Program began only 7 months ago. We have made significant progress.

- VFC is operating in all States.[1]
- Vaccine purchase contracts were signed with the manufacturers to provide vaccines for eligible children at discounted CDC contract prices for all vaccines routinely recommended for children.
- State Health Departments are rapidly enrolling public providers into the program. As of March, over 8,100 public sites, such as local public health departments, community health clinics, maternal and child health clinics, and public hospitals, in every State are participating in the program.
- Private providers are also being rapidly enrolled. As of March, over 21,000 private provider sites, many with multiple physicians per site, have enrolled so far. This is a 32 percent increase in private provider sites since the program began. We expect to increase the number of private providers enrolled as more States develop systems to deliver vaccine to private providers.
- The vaccine ordering system is working well. Over 1,700 bulk orders have been processed, totaling over $150 million in vaccine.

[1] Alaska, which already delivers vaccines to all providers in the State, is not participating in the VFC program. Alaska is able to use other Federal vaccine funds to purchase all vaccines for all children in the State.

• Since October, over 13 million doses of vaccines have been shipped through the VFC program to public and private providers to immunize our nation's children.

The good news is that we are making progress towards our goal of immunizing 90 percent of the nation's children against vaccine-preventable diseases. Our most recent immunization coverage information, from the first quarter of 1994, indicates that we are at record high levels of immunization coverage for two-year-old children. I believe if we stay focused, we will achieve our goal.

We still, however, have work to do. Our data tells us that about 600,000 to 2 million of our nation's children between 19 and 35 months of age still had not received recommended vaccinations against specific diseases. For example, about 2 million of these children had not received the full series of vaccinations. About 1.4 million of these children had not received necessary polio vaccinations. Table 1 presents these most recent vaccination levels and the associated estimates of children who have not received all recommended vaccines.

TABLE 1.—VACCINATION LEVELS AND ESTIMATED NUMBERS OF TWO YEAR OLD* CHILDREN NOT FULLY PROTECTED IN THE U.S., 1ST QUARTER 1994

Vaccine	Vaccination Levels (Percentages)	Estimated Numbers of Children Not Fully Protected
DTP 3+	87	800,000
DTP4	67	1,900,000
OPV 3	76	1,400,000
MMR	90	600,000
Hib 3+	71	1,700,000
4DTP/3OPV/1MMR	66	2,000,000

*Children 19–35 months old.

Note (1): A "+" next to a vaccine indicates 3 or more doses. For example, DTP 3+ is receipt of 3 or all 4 recommended DTP doses.

Note (2): Hepatitis B, although a recommended childhood vaccine, is not included in the table. The coverage for Hepatitis B was only 26%, leaving 4.3 million children not fully protected. However, many of these children were born before the Hepatitis B recommendations were in effect.

Recognizing that there are multiple barriers to childhood immunization, CDC and its State and other partners, developed a comprehensive approach to increase and sustain these percentages. The Childhood Immunization Initiative (CII) was launched in early 1994. CII includes five key strategies that will (1) improve the quality and quantity of vaccination delivery services, (2) reduce vaccine costs for parents, (3) increase community participation, education, and partnerships, (4) improve the monitoring of disease and vaccination coverage, and (5) improve vaccines and vaccine use. The VFC Program, one component of the CII, was designed as one of these key strategies to address immunization barriers.

The VFC Program is important for several reasons, including

• allowing eligible children to obtain immunizations in their medical homes,
• providing greater access to vaccines, and
• forging public/private partnerships to get more children immunized.

Cost is a barrier that contributes to delays in achieving full immunization of preschool children with today's vaccines. The cost of the vaccine series has increased about 10 fold in the past 12 years. This is the result of more doses recommended for older vaccines, new vaccines added, excise taxes, and increases in the cost of the old vaccines. Regardless of the cause of the increased cost of the vaccine series, when parents must pay about $270 in vaccine costs and almost an equal amount in administration fees to have each child fully vaccinated, it stands to reason that parents without adequate insurance seek immunizations, not from their private doctor, but from public health clinics where the vaccine is free or available at nominal cost. Having to make the extra visits to these public clinics can delay the timely immunization of children.

SUCCESSES AND PROBLEMS IN THE VFC PROGRAM

There have been many successes in the implementation of the VFC Program. Through the purchase of vaccines at discounted CDC contract prices, the VFC program helps assure cost savings to Medicaid. Before VFC, the cost of vaccines for most children on Medicaid was based on higher catalogue prices. VFC allows States to purchase their vaccines at discounted CDC contract prices without having to ne-

gotiate these prices directly with manufacturers. By shifting children on Medicaid from higher catalogue vaccine prices to lower CDC contract prices, millions of Federal and State taxpayer dollars will be saved. The catalogue price for the total series of vaccines is about $270, while the CDC price is about $130. California alone has estimated that it saves $40 million a year from the ability to purchase vaccines at the lower CDC contract price.

Of course, we know that addressing cost alone will not solve the underimmunization problem. It is clear only a comprehensive approach with interventions against multiple barriers is likely to raise and sustain immunization levels among preschool children in the U.S.

A cornerstone of the VFC Program is the forging of new partnerships with private providers. Support from public and private medical communities at the National, State and local level have strengthened our efforts to immunize children.

The major private physician associations and tens of thousands of private physicians are supporting the VFC program. CDC has made it a priority to listen to these groups' views and develop an acceptable and workable program. It also should be remembered that not all private physicians, such as those that only serve children with insurance, would see a VFC benefit to their practices.

Total Federal and State vaccine expenditures will not be much more when VFC is fully operational than what they were before. VFC allows us to buy more life-saving vaccine for about the same amount of money. This is because vaccine purchase under the "317" grant program has been significantly reduced. Also, Medicaid vaccine (which makes up well over one-half of VFC vaccine) is now purchased at discounted CDC contract prices, rather than more expensive catalogue prices.

Most State Health Departments strongly support the VFC program and value its benefit to individual children and communities as a whole. Several States, including California, Georgia, Oregon, South Dakota and Rhode Island, have reported to the Association of State and Territorial Health Officials that, without the VFC program, their immunization efforts would suffer "catastrophic" consequences. Some States, such as Connecticut, Kentucky, Idaho, and Michigan, advised they would have to limit the availability of some vaccines, including the Haemophilus Influenzae type b and Hepatitis B vaccines, and South Carolina reported that immunization rates would plummet.

While some physicians remain skeptical, primarily because of the perceived paperwork burden, we expect continued increases in enrollment as more States establish delivery systems to private providers, and the facts about the operation and benefits of the VFC program become more recognized.

The VFC program has strengthened and institutionalized the partnership between public and private medical communities at the National, State, and local level. More than 30 private medical professional associations are working with us to implement the VFC program. These groups include the American Medical Association, the American Academy of Pediatrics (AAP), the American Academy of Family Physicians, the American Osteopathic Association, the National Medical Association, and the Interamerican College of Physicians and Surgeons. Dr. Frances Rushton, President, South Carolina Chapter, AAP, recently told my staff that the VFC partnership has been the single greatest public/private partnership effort in his medical career.

PROBLEMS IN THE VFC PROGRAM

The complex nature of the implementing legislation and the relatively short time allowed to kick-off the VFC program have complicated its implementation. I would like to address two issues: accountability systems and vaccine delivery to private providers in some States.

VFC Accountability Systems

GAO has expressed concern about accountability. Financial accountability is an essential component of the VFC program. States have primary responsibility for accounting for vaccine. States have over 30 years experience managing immunization programs and are in the best position to account for vaccines because of their knowledge of unique circumstances and provider practices.

It is crucial to maintain the right balance between effective accountability and provider participation. Private provider organizations have warned us that paperwork would keep physicians from enrolling. If providers had to report each immunization transaction, they would be burdened with filling out and sending in over 14 million pieces of paper a year. CDC has been reluctant to impose such bureaucratic accountability requirements. In building an effective accountability system, several activities are underway, including the development of State accountability plans, monitoring orders, and the submission of three annually required forms. Overall,

CDC feels it has instituted the appropriate balance between accountability and provider participation.

Vaccine Delivery to Private Physicians in Some States

CDC initially proposed distributing vaccine to private physicians in selected States through a national distribution center, as requested by most States. In September 1994, CDC began negotiations with vaccine manufacturers anticipating delivery to private physicians in December. On April 10, CDC had to discontinue these negotiations. Although final agreement was reached with one manufacturer, time was not available to reach agreements with remaining manufacturers. CDC is planning to meet with interested parties to determine how best to conduct vaccine delivery.

Despite this, VFC vaccine is being delivered to tens of thousands of public and private providers. Forty-nine States are delivering vaccines to public clinics, which account for about 50 percent of immunizations nationwide. As of March 30, 35 States had informed CDC they were delivering vaccine to enrolled private providers. All of the 14 remaining States reported they plan to begin delivering vaccine to private providers this year or next year.

BARRIERS TO IMMUNIZATION

There are numerous risk factors for failure to vaccinate children on time which have been identified from research and from the experience of health professionals directly involved in providing vaccines to infants and children.

Recent studies are also emphasizing the crucial role of the provider in improving immunization coverage. Children are seeking health care, but that health care may not be translated into high immunization coverage. Based on a study of the immunization records of children in 5 public health clinics around the United States, the average number of visits during the first 2 years of life ranged from 5 to 15, yet coverage for the complete vaccination series ranged from only 18% to 61%. The number of health care contacts should have been adequate to provide all vaccinations needed in the first 2 years of life.

Providers have a crucial role in making sure all opportunities to vaccinate are taken, in reducing obstacles or barriers parents may face in getting their children vaccinated, and stimulating parents to return for immunization visits. The potential impact of taking advantage of all vaccination opportunities was studied in 4 inner cities. DTP-4 coverage could have improved from 8 percentage points in Los Angeles to 16 points in Baltimore.

Another serious barrier is the condition of the public health system. About 50% of immunizations in this country are given in public clinics. A variety of impediments exist to delivering vaccines in these public settings, including insufficient clinic staff, inconvenient clinic hours, or lack of recall systems. Also, vaccine cost, by increasing referrals from private to public providers, further stresses these delivery systems. Federal infrastructure grants address these problems. The CII has increased grant funding for infrastructure enhancement by over 200 percent from $45 million to $141 million (See Table 2).

TABLE 2.—GRANT FUNDING FOR INFRASTRUCTURE ENHANCEMENT (FY 93–FY 96)

($ in millions)

	FY 93 Approp.	FY 94 Approp.	FY 95 Approp.	FY 96 Estimate
Infrastructure	$45	$129	$108	$108
Incentives	$0	$33	$33	$33
TOTAL	$45	$162	$141	$141

Immunization must be a shared responsibility of both providers and parents. Data from a variety of studies indicate the vast majority of parents want to immunize their children. But parents do not understand the complexity of the immunization schedule and the fact that more doses and visits are needed now, than when they were children. Frequently, parents have believed that their children were fully immunized, when they were not. Through community outreach and education, parents need to understand that immunizing a child requires at least 5 visits to providers, and that they should have the immunization status of their child checked at every health care contact whether the child is ill or well.

With increasing numbers of available vaccines complicating the immunization schedule, parents and providers need help in keeping track. As part of the CII, and

in partnerships with the states, computerized, State-based immunization registries, when operational, will remind parents when immunizations are due, or overdue, and assist providers in determining the immunization needs of their patients, old or new, at the time of each visit. Some States are now developing these systems. One example is Delaware, which has developed a statewide registry system for public and many private providers.

Numerous surveys of both practitioners and health departments have documented increasing referrals of patients from their primary care providers or medical homes to public clinics, with cost to the patient as the most important reason. A 1992 AAP study revealed 55 percent of pediatricians refer some or all of their patients for immunizations to a public provider. A 1992 North Carolina survey documented 93% of physicians referred patients to health departments for immunizations. A recent survey of pediatricians and family practitioners in New York found that 50 percent referred all or some of their patients for vaccinations, generally to public health clinics. Finally, in a 1993 survey of 538 families attending public immunization clinics in California, Lieu and colleagues concluded that financing reform has the potential to improve vaccination rates, if it is combined with improved parent education, and reduced non-financial barriers to immunization.

Clearly, cost contributes to making immunization harder to obtain and plays a role in the delay in getting children fully immunized according to the recommended schedule.

IMPACT OF VFC ON IMMUNIZATION RATES

Childrens health will improve as a result of VFC. A I have indicated earlier, the VFC program is only one of the five components of the CII. Under the CII, we have launched a major public awareness campaign. I am proud to say that you can't visit a state of a major city without seeing public education announcements about the importance of immunizing our nation's children.

Of course, I believe the VFC Program will definitely improve the health of our nation's children, although it may be difficult to document the increases in immunization rates directly related to VFC. But let us not forget our goal is to fully immunize 90 percent of preschool children by the year 2000 and that we intend to achieve that goal, in part through the VFC. I'll be happy to return to this Committee to share with you our progress in achieving that goal.

CONCLUSION

Immunization represents one of the most, if not the most, cost-effective public health intervention. However, vaccines can only be as good as the system we have to make sure children in need get them when they need them. There is no magic bullet to solve the problem. No one approach, such as school laws, will suffice for the preschool population. We are close enough to our goals to be convinced we can reach them with intensified use of our current comprehensive strategy.

This nation has too often responded to crises rather than preventing them. We need a system that will assure that children born yesterday, today, and in the future will be vaccinated at the time in their lives when vaccines can prevent the greatest amount of disease. This system must function not only during and immediately after the threat of epidemic disease, such as occurred after the recent measles resurgence between 1989-1991; but, more importantly, the system must function during the period of absence of disease which often lasts for many years after an epidemic. Never again should epidemics be the primary motivation of immunization efforts.

The CII is designed to build this disease prevention system by enhancing vaccine delivery infrastructure, building partnerships, involving the community, establishing data systems to help parents and providers remember when immunizations are due, and much more. If we are to prevent disease, we must build a system that has secure vaccine financing, not only for today's vaccines, but tomorrow's as well. VFC does that with the added benefit of returning children to their medical homes where they can get so many other preventive services, such as growth monitoring, screening for anemia, and much more. The VFC is a major step forward in improving the health of our children, and the CDC is committed to doing its best to fully implement the program to gain its full benefits.

PREPARED STATEMENT OF F.E. THOMPSON, JR., M.D., M.P.H.

Mr. Chairman and members of the committee, I am F. E. Thompson, Jr., M.D., M.P.H., Director of the Mississippi State Department of Health. Prior to assuming

my position as State Health Officer, I was State Epidemiologist and Chief of the Bureau of Preventive Health Services, which included our immunization program.

As a practicing public health professional with continued direct involvement in a statewide immunization program, I want to express my appreciation for the interest and support being given children's immunization by the President and the Congress. The increased resources already provided for childhood immunization are a clear indication of both the President's and the Congress's intent to protect our children against diseases no child should have.

CURRENT STATUS

Mississippi, a state with one of the lowest per capita incomes in the Nation, and one with limited public resources to address the prevention of disease, has achieved one of the highest immunization levels for its two year old children of any state. Compared to a national level of at most 71.6 percent of children who have completed their basic series of immunizations by the age of 27 months, Mississippi consistently documents approximately 76.1 percent of its 27 month old children having completed their basic series. One of our nine public health districts has already reached the goal of 90%, and two others are above 80%.

We know our immunization levels with confidence because we perform an annual statistically sound survey of two year old children's immunization levels. It is done using a probability sample selected from the entire birth cohort of two years prior to the year of study. The immunization records of the sample children are then located and examined so that we are able to demonstrate, with extraordinarily narrow confidence intervals, what our immunization levels actually are. Very few other jurisdictions perform such a statistically rigorous survey.

As depicted in Attachment 1, approximately 80 percent of Mississippi children receive all or most of their immunizations in health department clinics. Another five percent receive their immunizations in community health centers and other publicly funded clinics, and approximately 15 percent are immunized by private physicians. While we do not suggest that this is the best approach in every state or even in most states, it does demonstrate that immunization levels well above those found in most states can be achieved largely through public health clinics.

BARRIERS TO HIGHER IMMUNIZATION LEVELS

To achieve our goal of 90% completion by two years of age, we must look at the major barriers that have prevented higher levels of completion. The cost of vaccines has not been one of them. Mississippi's experience clearly demonstrates this. We have accomplished the high immunization levels we have, and can reach our 90% goal, without furnishing free vaccine to private providers. In analyzing the reasons why 24% of our two-year olds are not fully immunized, we have not found the availability of vaccine, or its cost, to be a significant barrier. MMR is currently the most expensive vaccine we give, yet in 1993, 86% of Mississippi children had received MMR by 27 months of age. Availability of vaccine is not the problem. Like all states, we purchase our public health vaccines through federal contracts at prices significantly below the retail prices paid by private providers. We have been able to provide immunizations to any child in Mississippi who wants to receive them through the health department at minimal charge ($5 per dose) for those who can afford it , and at no charge to those who cannot. We have had enough vaccine, and as long as new vaccines and cost increases are provided for, we will have.

The real barriers are (1) the complexity of the vaccine schedule, (2) our failure to track children's immunizations and remind parents of needed doses, (3) lack of accessibility of clinics and staff to give the vaccine, and (4) our missed opportunities to immunize many children we are already seeing.

By addressing these real barriers and developing activities to get vaccine out of bottles and into children, such as reminder notices, outreach, checking records, and better clinic hours, one of our public health districts raised completion levels for all two-year olds from 58% to 80% in one year, without doing anything about the cost of vaccine.

The two most important barriers are actions not taken: Failure to track children's immunizations and missed opportunities. Overcoming these two barriers would take us to our national goal of 90% of children complete by age two.

Failure to Track Children's Immunizations

Because the immunization schedule for children is complex and requires at least 4 to 5 visits to complete, parents need help in knowing what shots their child needs, and in remembering when the next ones are due. Immunization tracking systems or "registries" can provide that help.

Mississippi has just implemented a computerized immunization tracking system or registry. Its purpose is twofold. First, it makes available immunization records of children to health care providers who see that child so that they can assess the child's immunization status and provide any needed immunizations. Secondly, and much more importantly, a registry allows us to track children's immunizations. We can then send notices to parents of immunizations about to be due, send additional notices to parents whose children fail to be immunized by a scheduled time, and identify children who are falling too far behind in immunizations so that we can make phone calls or home visits to get them back on schedule and protected.

Recalling children is a critical element in increasing immunization coverage. As noted in Attachment 2, in 1993, although only 76 percent of Mississippi two year olds were fully immunized by their 27th month, another 16 percent needed only one more visit to a clinic to complete their series. If we could have recalled these youngsters just once, we would already have reached the 90 percent goal. We can do so if we develop tracking systems that allow us to identify and recall them.

Missed Opportunities

The other major area of emphasis is to avoid missed opportunities to immunize children. Missed opportunities fall into two main categories: 1) times when the child is seen in a clinic for other services and immunizations are due according to the schedule but the schedule is not checked and the child leaves without being immunized; 2) times when the child presents in the clinic for an immunization or for another service when the immunization is due and the provider realizes an immunization is due, but defers the immunization for inappropriate reason, such as "being on antibiotics" or a minor upper respiratory infection or any of numerous "false" contraindications that do not really preclude immunizations.

At one of our largest Health Department clinics we found that 50 percent of children being seen in that clinic had completed their basic series by 19 months of age, but if all opportunities to immunize had been taken and none missed, the percentage would have been 67 percent. This is illustrated in Attachment 3.

We have made it our policy in the Department of Health's clinics to assess a child's immunization status on every encounter for any of our clinic services and to "stick 'em while you got 'em" if any immunizations are due. Minimizing or eliminating missed opportunities is critical to raising our nation's immunization levels.

IMPLEMENTATION OF THE VFC

The main problems encountered with implementation of the VFC in Mississippi have been the numerous changes in the program before it was implemented, the added responsibility of the Health Department for distributing the VFC vaccine to providers, and the lack of private provider participation. We sent out 1300 enrollment kits to providers; as of today, 77 private providers have signed up.

The main success has been that we have at least implemented the program. Also, in some states, state medicaid matching funds previously used to pay for vaccines which VFC now covers have been made available for other uses.

EFFECT OF THE VFC ON IMMUNIZATION LEVELS

Even as originally proposed, the VFC would have had little if any impact in raising our immunization levels. The cost of vaccine was not the problem in the first place, and making more vaccine available at public expense was not the solution. However, as originally proposed, the VFC was at best overkill, and at worst wasteful, spending a huge amount of money for a minimal impact on immunization levels. As it now exists, at least in some states, the VFC itself stands to become a major barrier to improving immunization levels, and is very likely to lower them.

The reason for this is the restriction of VFC vaccine use to Federally Qualified Health Centers (FQHC's) for "underinsured" children, those who have health insurance which does not cover vaccine. Such children are the majority of those we see in Health Department clinics, and in most private practices. In Mississippi, as seen in Attachment 4, 53% of children have insurance, but that insurance does not cover vaccine. If those children have a private doctor, that doctor cannot give them VFC vaccine; if they come to the Health Department, which has clinics in every county in the state, we can't give them VFC vaccine. Under the program as it now stands, their doctor, or the health department must send them to a FQHC or give them non-VFC vaccine. For the private doctor, this means charging the patient or absorbing the cost. For the health department it is far more serious.

Vaccine for Health Department clinics has long been purchased with funds provided through the CDC under section 317 of the Public Health Service Act. With the advent of the VFC, 317 funds to health departments have been reduced, on the

theory that VFC will replace them. In 1993, Mississippi received $3.2 million in VFC funds; in 1994, we got $3.9 million; for 1995 our allocation is $1.7 million. Meanwhile, we have $3 million for VFC, but we can't use that vaccine for most of the children we see. We cannot immunize half the children coming to us with the 317 dollars available. And they do come to us. They come for the WIC program; they come for well child care; they come for immunizations because our clinics are convenient. Under the VFC as it now stands, we will be faced with turning these youngsters away. Rather than avoiding missed opportunities, the VFC will create them, and multiply them.

The VFC as presently constituted threatens to result in a working, successful immunization system being dismantled. It is a major concern on our part that federal efforts to increase immunization levels do not tear apart a system which is working well and which, if continued and improved upon will take us to the 90% goal before many other states.

The restriction of VFC vaccine for the majority of children to FQHC's is the reason many of our private providers have chosen not to participate in the program. Citing the fact that well over half their patients have insurance that does not cover vaccine, they tell us that it just doesn't help them very much, and it's not worth the trouble.

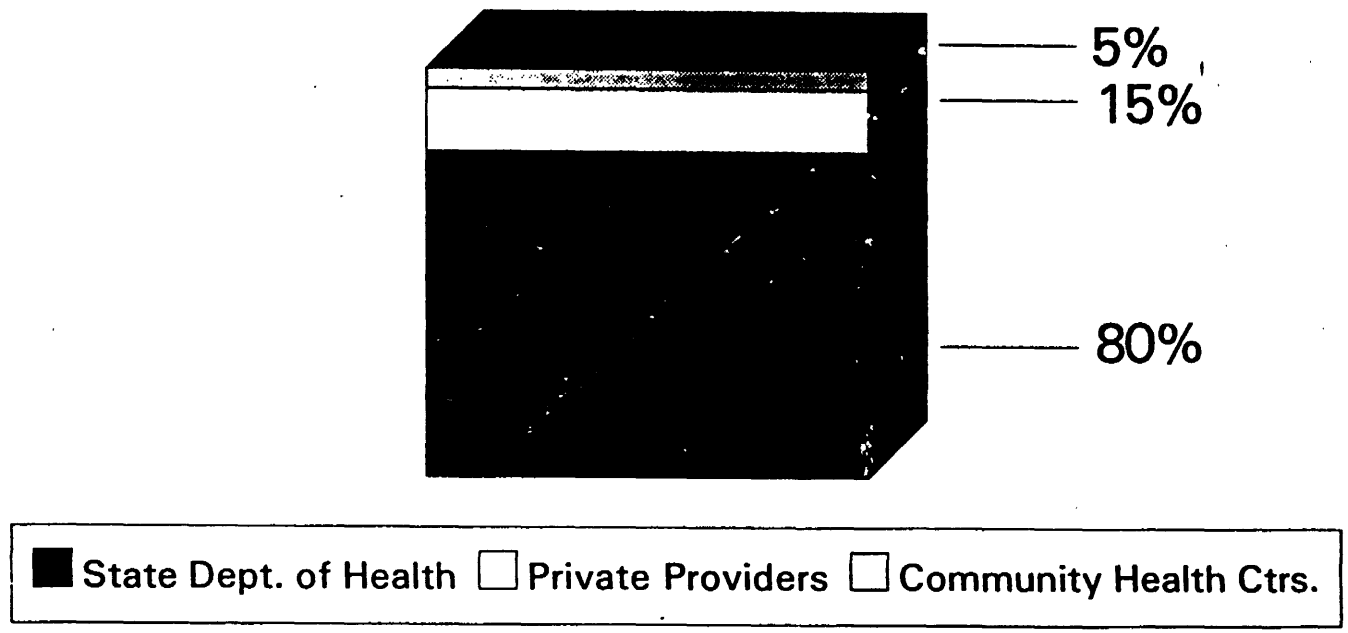
RECOMMENDATIONS FOR CONGRESSIONAL ACTION

I recommend that this committee and the congress consider the wisdom of the VFC as a whole, in addition to examining the mechanics of its implementation and operation. If the VFC is to be left in place, I strongly urge this committee to recommend that the restriction of the use of VFC vaccine for underinsured children to FQHC's be removed. If it cannot be removed, at least extend the ability to give VFC vaccine to underinsured children to Health Departments. Otherwise the VFC, a well intentioned program, will do more harm than good.

Another critical action from our State's perspective is to restore funding of the 317 program to its pre-VFC levels. Finally, and also critical, if the VFC is left in place, any changes made to it should preserve the ability of states to purchase vaccine at federal contract prices using state funds, at least for use in Health Department clinics. These two actions will at least insure that existing, working immunization programs are not impacted adversely.

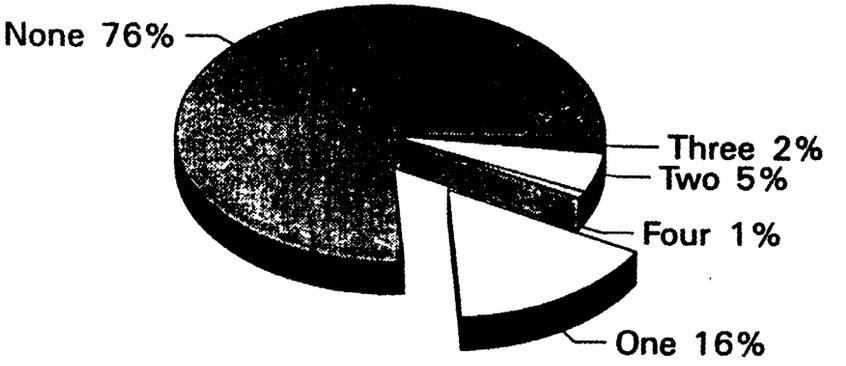
Source of Immunization

Mississippi, 1994



Attachment 1

Immunization Levels for Two-Year-Olds
by Number of Additional Visits Required to Complete
Mississippi, 1993



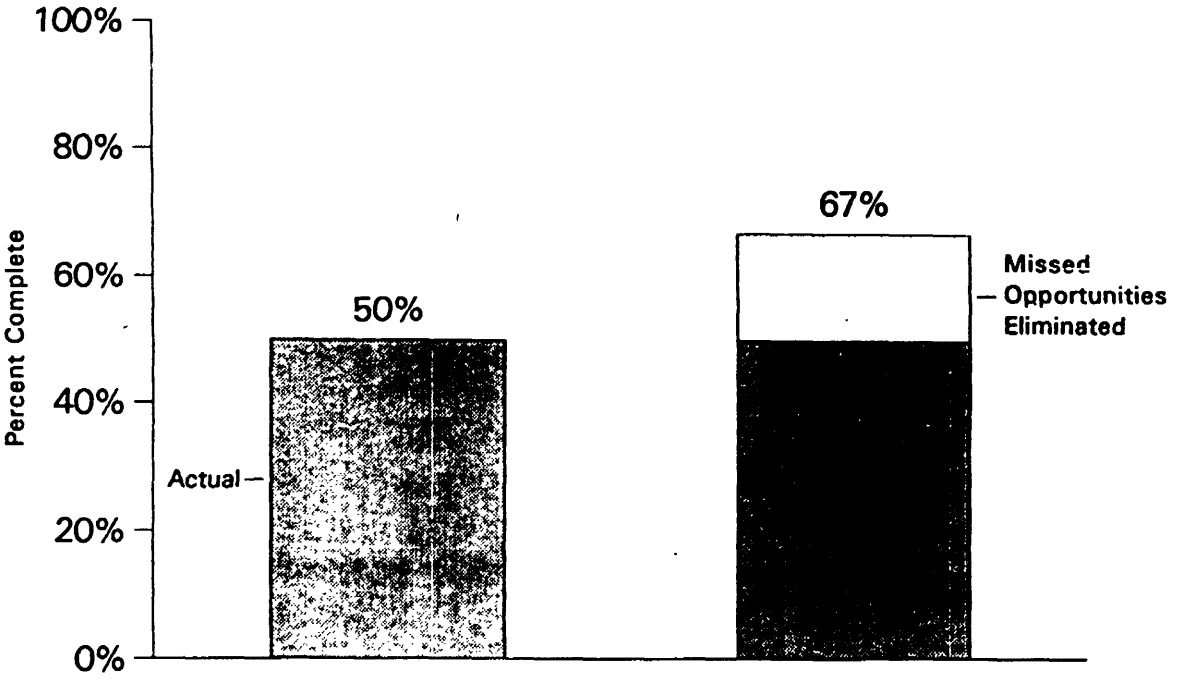
Source: Mississippi Immunization Survey of Two Year Olds

Attachment 2

HINDS COUNTY, MISSISSIPPI HEALTH DEPARTMENT CLINIC

Children Already Being Seen, 1993

19 Month Olds

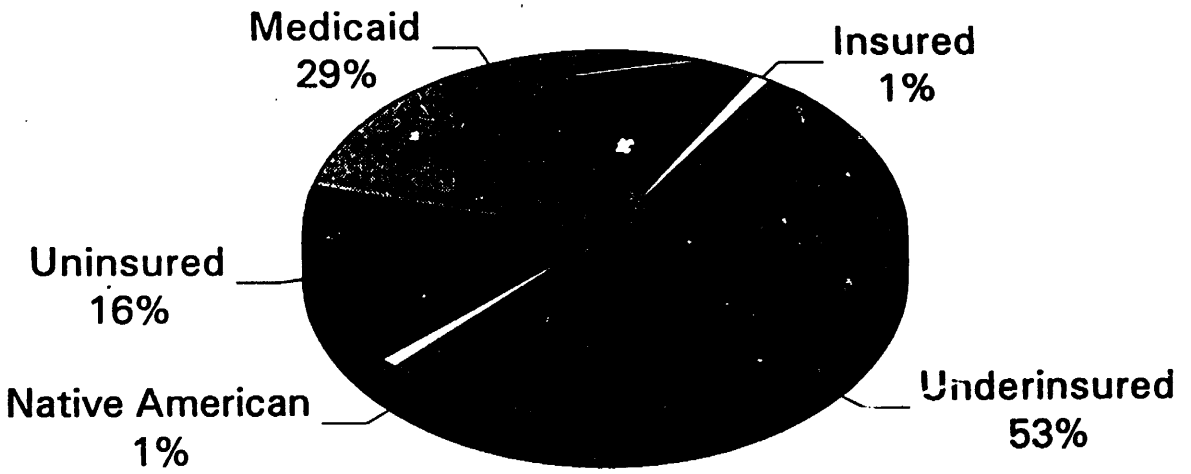


Source: Hinds County Health Department Clinic Audit, 1993

Attachment 3

Insurance Coverage

Mississippi, 1994



Source: Governor's Commission On Health Care Reform

Attachment 4

PREPARED STATEMENT OF DR. DAVID WOOD

Thank you Mr. Chairman for the opportunity to address you today on this important topic. My name is Dr. David Wood. I am a pediatrician practicing in an inner city clinic in Los Angeles called Para Las Americas. I am also a Assistant Professor of Pediatrics at UCLA at a health services researcher at RAND and Cedars-Sinai Medical Center in Los Angeles. I am the principal investigator on a CDC funded research project to diagnose the causes of under immunization in Los Angeles. The research team is composed of health sociologists, maternal child health experts, economists and statisticians from UCLA School of Public Health and Dept. of Sociology and RAND, Santa Monica, CA.

The major points I would like to make today are:

1. There continues to be a significant percentage of children who are under-immunized in this country, especially in poor, urban populations. A sustained and coordinated effort is needed by government and the private health care system to raise immunization rates and keep them high.

2. According to current research, the interventions most likely to make significant gains in immunization rates are those focused on the delivery and financing systems for well child care and immunizations. The primary goals of the interventions should be to; 1) increase the access for all children to timely well child visits for all preschool children; 2) increase financial incentives and reduce administrative barriers for well child care and immunizations for both providers and parents; and 3) improve the quality of well child care and immunization delivery by utilizing all opportunities to delivery the appropriate immunizations. Due to the complexity of the child health care delivery and financing systems, the accomplishment of these goals may require substantially different approaches for different health sectors.

A significant under-immunization problem still exists.

While surveys of immunization coverage conducted by the Centers of Disease Control and Prevention (National Health Interview Survey) have shown increasing rates of immunization coverage for the population as a whole, disparities in coverage persist.[1] Poor children, those from traditionally underserved minority groups, and those who live in urban areas are significantly less likely to be immunized than the general population. When these risk factors converge, as they do in many inner city areas, immunization rates are much lower than for other parts of the US. According to our data in Los Angeles, at 3 months only 70% of Latino and 51% of African Americans had received their first immunizations and by 24 months only 42% of Latino children and 25% of African American children were fully immunized.

However, these demographic indicators identify not only people-groups but also the health delivery systems that serve them. Research clearly demonstrates that the problem lies in these health delivery and financing systems. While we do know that variation exists in parental knowledge of immunizations and motivation to seek immunizations, parents of both immunized and unimmunized children are equally likely to value immunizations, believe in the seriousness of vaccine preventable disease and believe in their efficacy.[2,3] The data suggest that children are immunized not because of their parents' belief or motivation, instead parents rather passively follow the advice and direction of their doctors. Again, problems in the child health delivery and financing system are largely responsible for the under-immunization of preschool children in the US.

Moreover, rather than blame parents it is important to search for new methods to empower families to increase demand for immunizations with their providers, especially among particularly high risk populations. Health passports, distributed widely in Utah and recently instituted in California and case-management demonstration projects are all important pieces to the puzzle of more actively involving parents in the delivery of immunizations. These efforts need to be sustained long-term, and they must be coordinated with other educational efforts in WIC and other programs.

Where do we need to intervene?

It is imperative that we make the existing health delivery and health financing system improve its efficiency at delivering immunizations to young children. An important first step in this process is to promote timely entry into the well child and immunization system. We must reach the mothers before they give birth. Several studies have found that timely receipt of the first set of immunizations is related to receipt of prenatal care, early education at WIC visits during prenatal care, and receiving the appointment for the first well child visit.[4] Prenatal care provides a crucial bridge for a smooth and timely entrance to a series of recommended health maintenance visits. Increasing the connectedness between prenatal care and early well child care can be accomplished by 1) increasing access to prenatal care for poor, inner city families, 2) expanding access to WIC and other prenatal care education programs (such as California's Perinatal Case-management Program (CPSP) and 3) insuring the connection to a primary provider for the newborn with an appointment before leaving the hospital.

Making the well child and immunization delivery system work.

The American Academy of Pediatrics and EPSDT recommend 7-9 well child visits during the first two years of life, most of which correspond with the schedule for immunizations. Half of all

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vaccines delivered in the public clinics in Los Angeles and almost all of the vaccines delivered in private doctors' offices occur during well child visits. However, in many areas the majority children receive less than adequate numbers of well child visits during the first two years of life, as few as two or three.[5] Moreover, even among those that receive adequate numbers of well child visits only approximately half receive the recommended vaccinations. Why isn't the health care system delivering these important services to our Nations' children?

To answer that question one must examine our complex child health delivery and financing system in several discreet sectors; 1) Medicaid fee-for-service, 2) Medicaid capitated systems, 3) private health insurance fee-for-service, 4) private capitated systems and 5) and the uninsured and the systems of care they access. Each of these sectors has a unique set of incentives and disincentives for the delivery of well child care and immunizations. I will examine the barriers to well child care and immunizations and potential interventions to raise immunization rates within each of these sectors.

Medicaid Fee-for-service.

Medicaid and EPSDT are the primary financing systems for well child care and immunizations for approximately 25% of America's children. In our study we found that African American children with Medicaid insurance were only one-fourth as likely to be fully immunized by 24 months as African American children with private insurance.[6] A 1990 American Academy of Pediatrics study of preventive services use by California Medicaid children found that only 20%-30% received preventive EPSDT services in the prior year.[7] Children on Medicaid are much less likely to have had a preventive health examination in the past year than privately insured children.[8]

Why is Medicaid so ineffective at promoting timely well child care and immunizations? The answer is primarily that Medicaid does not adequately reimburse providers for the services. Under Medicaid fee-for-services, reimbursement rates for well child care and immunizations are notoriously low and payments are often delayed.[9] State reimbursement rates to private providers for a vaccine and its administration average approximately one-half of the UCR for these services. Compared to UCR fees, the typical Medicaid program underpays physicians $40 to $60 per well child visit (physical examination and immunization administration). Medicaid payment rates for these services have eroded badly over the past decade as States have been slow to review and raise payment schedules. California has not raised the immunization administration fee in over a decade.[10]

As a result of these poor reimbursement rates providers are either neglecting to provide these services to their Medicaid patients as compulsively as recommended or they are increasingly referring patients to the public sector for these services. Under either

scenario, fewer and fewer children are receiving timely well child care and immunizations under the current Medicaid fee-for-service system.

Recommendation. Reimbursement rates for well child care and immunizations under Medicaid must be increased in order to promote their timely delivery. A state or federal based bulk vaccine purchase program is one vehicle to accomplish this. It has the substantial advantage of being cost-neutral. Under Medicaid fee-for-service programs, physicians purchase vaccine at the catalogue price and States reimburse providers for the catalogue price of a vaccine, approximately double the cost of the bulk purchased vaccine.[11] The substantial savings accrued under bulk purchase can be invested in increasing the administrative fees to providers. This approach was suggested by a California nonpartisan task force report in 1992.[12]

Thus, under a bulk purchase program positive incentives to private providers include relieving them of carrying the substantial cost of a vaccine supply, and raising reimbursement rates for vaccine administration. In States that already bulk purchase and distribute vaccine this approach has been successfully at increasing providers willingness to administer vaccine and reduce referrals to the public clinics.[13] Important factors in the success of a bulk purchase program are that; 1) the distribution system be efficient, and 2) providers not be overly burdened with eligibility determinations nor vaccine use reporting. The California Vaccines for Children has recently instituted a bulk purchase program with a private pharmaceutical distributor that appears to be user friendly and makes minimal paperwork demands on providers.

An alternative approach is to simply raise Medicaid fee-for-services reimbursement fees to providers for well child visits and for the administration of immunizations. However, this approach would entail substantial increases in costs in the Medicaid program.

Medicaid Managed Care.

We found the lowest immunization rates in the inner city of Los Angeles among children enrolled in Medicaid managed care.[14] Of children in HMOs only 33% were UTD. Between 1987 and 1992 states' total enrollment in Medicaid managed care more than doubled.[15] In December of this year approximately 2.5 million California Medicaid recipients will be switched from Medicaid fee-for-service to Medicaid Managed care.[16] The few studies that have examined Medicaid managed care indicate that it may or may not increase access to routine preventive services.[17] In some settings, access to well child care and immunizations may even deteriorate.

Private managed care premiums are established based on the cost of providing a determined set of benefits. Medicaid managed care benefits are set by federal regulation and are generally broader

than those provided in the private sector. In order to reduce costs, however, States set Medicaid capitation rates based capitation rates not on the costs of providing the benefit package but on a reduced percentage of expenditures in the Medicaid fee-for-service program. Moreover, to the extent that Medicaid programs are already among the lowest paying third-party payers, further discounting rates in managed care can leave providers without sufficient funds to provide needed care and may dramatically increase the incentive to under-serve.[18] Routine preventive services such as well child care and immunizations comprise a significant proportion of the capitated reimbursement during the first two years of life (after birth related health expenses), and they may be easy targets for under-service by plans.

Health Maintenance Organizations under managed care capitated contracts traditionally have actively promoted preventive services as a means to prevent more costly events in the future, such as a hospitalization for a measles infection. Indeed, Kaiser and other HMOs serving the middle class have some of the highest immunization rates in the Nation. However, under Medicaid managed care the incentive to provide preventive services is largely eroded by the extreme instability of the enrolled population. It is estimated that 40% of Medicaid AFDC enrollees loose Medicaid coverage each year.[19] When they regain coverage after of period of months, they are likely to join a different health plan, causing dramatic populations shifts among managed care plan. One managed care medical director characterized the problem in the following terms; "If our plan expends significant resources to bring children that are behind, up-to-date on their immunizations, which we do, we are doing the work the previous plan should have done, and we are saving money for the next plan in which the child will enroll six months from now"[20]

Recommendations. The Federal and State governments must structure the Medicaid managed care programs such that all children have access to well child care and immunizations according to the EPSDT guidelines. States should set Medicaid managed care capitation rates to insure that there are adequate resources to provide the mandated services at high quality. States must provide adequate oversight to Medicaid managed care plans. The Federal Health Care Financing Administration strongly criticized the State of California for its near complete lack of oversight of early experiments with Medicaid managed care.[21] Many abuses of Medicaid managed care resulted, including very low immunization rates in inner-city Los Angeles.

To increase the effectiveness of States' oversight of Medicaid managed care plans delivery of preventive services, States should requiring plans to report encounter based data on EPSDT services, including immunizations and population based immunization rates.. In the fall California passed legislation requiring this kind of reporting of all Medicaid managed care plans. To put teeth into the oversight process, States should provide financial incentives

to plans for raising immunization rates and providing other EPSDT services according to the guidelines as well as penalize plans that do not perform well. This program could be financed in part from the savings accrued from a vaccine bulk purchase program similar to the Vaccines for Children program.

Private Insurance system.

Approximately 60% of US children are covered by employee based private insurance.[22] A 1989 by the Health Insurance Association of America Survey found that only 45% of conventional employment based insurance plans covered basic childhood immunizations.[23] Health maintenance organizations provide much better coverage of well-child care, with 98% paying for immunizations.[24] Many states, including California, have passed laws in recent years to require employer based health plans to cover immunizations. However, up to 60% of employer self-insured health plans are exempt from state regulation under the Employer Retirement Income Security Act (ERISA) of 1974.[25] The combined effect of the lack of coverage in private insurance and rising vaccine costs and rising administration costs for providers has placed a significant economic burden on families. Rather than pay these costs, up to $500 dollars for the cost of the full set of childhood immunizations and their administration,[26] many families are opting to refuse immunizations at the private providers office. More and more private providers are referring families to the public clinics for immunizations, overwhelmingly citing cost of the vaccine to families as the primary reason.[27] This shift from the private to public sector has placed increase strain on an already overburdened public sector. Moreover, the added transportation and time costs will likely discourage many families from obtaining immunizations in a timely fashion.

Recommendation. The Vaccine for Children program makes provision for children with health insurance that does not cover immunizations, however, the program as designed also prevents them from receiving the immunizations at their private provider's office. Under the VFC program, children in this category can receive free vaccine ONLY at Federally Qualified Health Centers (FQHCs). FQHCs are generally located in poor, inner-city or rural areas, relatively inaccessible to the large percentage of middle class families that will fall into this category. Moreover, no provision in made in the VFC program to increase the capacity of FQHCs to handle the increase demand for well child care and immunizations.

A more rational approach would be to amend ERISA to give states the authority to mandate employer self-insured health plans to cover child preventive health services. This may not be politically feasible at this time. However, there are two private sector trends may reduce the children who have insurance but no coverage for immunizations. First, various forms of managed care plans, such as Preferred-Provider-Organizations, are rapidly replacing classic fee-for-service indemnity plans and a growing

percentage of these managed care plans cover child immunizations and well child care. Secondly, employer purchasing cooperatives are increasingly demanding outcomes based reporting or health report cards from health plans. All of these health report cards include child immunization coverage levels as one indicator of the quality of care provided within plans. In order to optimize quality ratings, more and more plans are voluntarily covering immunizations and well child care for children.

Uninsured Children.

Almost 15% of US children lack any form of health insurance. In our studies, lack of insurance is an important predictor of under immunization. Uninsured Latino children were only half as likely to be fully immunized by 24 months as privately insured Latino children.[28] There are two fairly distinct groups among the uninsured; the poor and the non-poor (the later is the larger group). The poor, uninsured are the traditional users of public clinics, which have become even more overburdened by the increasing numbers of referrals of privately and publicly insured children. While in our studies over half of poor, uninsured children utilized public health clinics for well child care and immunizations, almost 40% sought care at private providers offices. This number is certainly higher among non-poor, uninsured children. Families of non-poor, uninsured children face similar financial barriers to receipt of immunizations at their private doctor's office as we describe for insured but uncovered children. Many will seek free immunizations rather than pay the high cost of receiving the immunizations in the private sector.

Poor, uninsured families should qualify for EPSDT payment programs for well child care and immunizations at a private doctors office. The California EPSDT program covers children in families with incomes of up to 200% of the poverty line (approximately $28,000 annual salary for a family of 4). However, the California EPSDT program only reaches 30% of eligible poor children with well child or immunization services.[29] Few providers accept EPSDT clients due to low reimbursement rates, late payments, frequent and often capricious denial of claims and burdensome paperwork requirements. the billing requirements of EPSDT are also a significant barrier to physicians. EPSDT in California does not utilize standard CPT or ICD9 billing codes and therefore is not accessible to most office computer billing software.

The Vaccines for Children program allows provider to administer vaccine received at no cost to poor or non-poor, uninsured children. Providers are allowed to charge up to a $15 administration fee for each vaccine. Subtracting the cost of the vaccine product, the cost of immunizations for the parent will decline at least 40%. Some providers may reduce their administrative fee for uninsured families, further reducing the families' financial burden. This may allow many non-poor families to receive immunizations from their private providers.

For poor, uninsured populations eligible for EPSDT, the VFC program or similar bulk purchase program will strengthen the EPSDT program's financial incentive to providers by relieving them of the cost of advance purchase of vaccine and by increasing the vaccine administration fee (in California the fee is projected to rise from its current rate of $4.52 per vaccine to approximately $7.50 per vaccine). This may induce many more providers to participate in the EPSDT program or accept more EPSDT clients.

Recommendations. The VFC program could strengthen its provisions for uninsured children by reimbursing providers for both the cost of vaccine and its administration. This would eliminate the financial barrier to immunizations for uninsured children. However, since immunizations are generally delivered in private offices only accompanied by a full physical exam, the cost of the visit would still be born by the families. The EPSDT program will be significantly strengthened by the VFC program or a similar bulk purchase program. In order to induce the maximum number of providers into the program, EPSDT program should also dramatically reduce the paper work burden to providers though the institution of a simple, electronic billing capabilities similar to Medicaid or other health insurance, utilizing standard CPT and ICD9 codes.

The last major factor contributing to the low immunizations rates is an issue of quality, generally unrelated to the structure of health delivery systems or health financing systems. In many well child and other health care visits, children fail to receive the immunizations that are due. This is referred to as a missed opportunity to vaccinate. Missed opportunities to vaccinate are responsible for approximately 50% of the delay in immunization receipt.[30]
Children coming into public and private offices for well child care fail to receive the needed immunization at approximately 40% well child visits and at the vast majority of illness visits..[31] Studies have shown that even when children receive adequate number and timing of well child care visits, immunizations may not be received, resulting in significant delays in the receipt of immunizations.[32]

Why do providers miss so many opportunities to vaccinate? Data indicate that physicians and nurses do not adequately understand the immunization schedule.[33]. In our chart abstraction study nurses accurately assessed immunizations needed only 27% of the time. Secondly, providers have misunderstandings of what constitutes a contraindication to vaccinate a child, so that they frequently defer immunizations inappropriately.[34]

Recommendations. The CDC and the professional societies have already taken a number of positive steps to address the epidemic problem of failure to give the appropriate immunizations at a health visit. The AAP and the ACIP recently jointly published a simplified immunization schedule, making it easier for providers

to understand the schedule and assess a child's need for immunizations.[35] In addition, the CDC has published and disseminated the Pediatric Standards for Immunization Practices, which explicitly refute many commonly held misinterpretations of contraindications, and clearly delineate the true contraindications for each vaccine. These true contraindications are in fact, rare.[36]

The Standards need to be disseminated more widely and more clearly adhered to by providers in both the public and private clinical setting. In addition, education efforts for providers should be intensified to raise the knowledge level of providers on immunization practice. However, it is unlikely that simply making information available to providers will change their beliefs or their behavior.[37] Studies indicate that the dissemination of practice guidelines or clinical recommendations may not change provider beliefs or cause behavior to conform to the new recommendations.[38] Incorporating provider education on guidelines into an ongoing, active process of quality improvement would greatly increase the chances of successful adoption of clinical guidelines.[39] This includes, but is not limited to, active participation by providers in the construction and measurement of outcomes (e.g., immunization levels and rates of missed opportunities to vaccinate) in their own practices, and the institution of an evaluation and feedback process to measure the impact of policy changes. The American Academy of Pediatrics has produced simple but effective materials for providers to apply Quality Improvement principles to their delivery of childhood immunizations.[40] The CDC, through local health departments and Immunization Action Plans, should provide the technical leadership to institute the quality improvement processes in the public and private provider organizations. In order to do this in a cost effective manner our nation must invest in an automated data system that tracks immunizations and other important quality indicators on all children.

Conclusions

Immunizations rates remain dangerously low in the many areas in the United States, providing a potential reservoir of susceptible for disease epidemics. Our child health delivery and health financing systems are complex and interventions must be tailored to the specific delivery/financing system. It is imperative to assure that adequate financial incentives are built in to induce physicians to administer immunizations under all public and private health care delivery and financing systems. In Fee-for-service systems adequate first dollar coverage for well child care and immunizations must be provided at reimbursement levels adequate to cover provider costs and to induce them to participate vigorously in the delivery of these essential services. Managed care plans should be monitored carefully and performance based incentives should be built into capitation rates based on their documented well child care and immunization performance standards. High risk, poor and inner-city populations may continue to be

largely dependent on the public sector and may be more costly to immunize. Adequate support for basic public health infrastructure is crucial to the provision of high quality services to these populations and the prevention of future epidemics.

Thank you, Mr. Chairman for the opportunity to speak to your committee today.

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May 4, 1995

The Honorable Bob Packwood
Chairman
Committee on Finance
U.S. Senate
Washington, D.C. 20510

Dear Chairman Packwood:

Thank you for allowing us the opportunity to provide written testimony on the subject of the Vaccines for Children program. The Association of State and Territorial Health Officials (ASTHO) represents the public health department in each state and U.S. territory. One of the unique and most positive aspects of the Vaccines for Children program is that states may innovate in their maximization of the program's benefits; therefore, state health officials have a unique perspective on the program's successes and future potential to impact our nation's childhood immunization rates. As your committee is conducting an oversight hearing on the Vaccines for Children program, I hope I will be of service in describing states' experiences with this initiative.

While states understand that the Vaccines for Children (VFC) program has had some start-up problems, it is nevertheless a very valuable tool for many states and promises to be of ever greater value as implementation proceeds. I would like to describe some of the benefits provided to states by the VFC program:

Increasing Immunization Rates - First and foremost, VFC helps states come closer to reaching their 90 percent immunization goals. The state of Delaware estimates that the Vaccines for Children program will increase the state's immunization rates by 10-15 percent.[1] North Dakota states that, "immunization levels in 1994 were approximately 68 percent. Immunization levels in 1995 are anticipated to increase to 85 percent with the 90 percent goal reached in 1996 as a result of the universal vaccination program."[2] The Oregon Department of Human Resources says that "there are thousands of children being immunized through VFC who would not be eligible for state-supplied vaccine any other way."[3]

As a nation, we have been successful in recently increasing our childhood immunization rates, yet we should not forget that millions of children are born each year in this country. Our immunization strategy should be long-term, not sporadic. VFC establishes a system for the long-term immunization of children, not only for existing vaccines, but for new ones such as chickenpox. While some antigen-specific data may appear to indicate that we are close to our 90 percent goal, when considering which children have had all their shots, the numbers are lower. (For example, some children may have had their DTP, some their polio, and some their MMR, but they are not necessarily all the same children.) There are two million children between 19 and 37 months of age who are not series-complete (4 doses of DTP, 3 polio

[1] *Excerpts From States' Responses on Impact of VFC/317*, ASTHO, 1995.

[2] Ibid.

[3] Ibid.

and one MMR).[4] Moreover, this series does not consider vaccines that we normally administer to infants, including Hib and Hepatitis-B. In summary, our work is far from over.

Universal Purchase Option - Another benefit of the Vaccines for Children program is that states may supplement the federal purchase of vaccines with state purchases at the "federal contract rate." This allows states that wish to provide vaccine for all their children to do so by adding their vaccine orders to the federally negotiated contracts with vaccine manufacturers. As an example, Illinois estimates that without this option to purchase, its buying power would be reduced by at least 25 percent, or approximately 120,000 fewer doses of vaccine.[5] This arrangement also benefits vaccine manufacturers, which achieve market stability from the commitment of the federal and state government contracts. The importance of this aspect of the program to states cannot be overemphasized.

Strengthening the Public-Private Partnership - Vaccines for Children also takes a positive view of health care by strengthening the public-private partnership. The program provides free vaccines for eligible children to be given in the child's "medical home" which reinforces the importance of a primary care provider and strengthens the link to other medical services. Florida has stated that "physicians across (the state) have embraced the VFC program ... VFC has increased the availability of culturally sensitive immunization services for historically hard-to-reach patients."[6] In many states, any remission of the VFC program would represent a serious breach of faith with the provider community. Oregon is another active participant in the program and believes the public-private link is critical. The Oregon Department of Human Resources is "actively recruiting and training private providers to initiate or increase immunization services. Without VFC, this public/private partnership would cease to exist. Even more devastating is the likelihood that this team approach would be forever destroyed. The private sector would never again trust the government to assist their efforts to improve immunization rates."[7]

Cost Savings for States - According to an informal ASTHO survey of state health departments conducted in March, many states are expecting that they will experience significant savings due to implementation of the Vaccines for Children program. The estimates of such savings range from approximately $200,000 per state to one state that anticipates about $12 million in savings. States are demonstrating creativity and innovation in redirecting savings anticipated from the program, including:

- bolstering of vaccine administration fees for physicians;
- financing for immunization of "underinsured" children (those whose insurance does not cover immunizations) in public and private settings;
- provision of new vaccines such as varicella, and for other additional cohorts of specific vaccines such as Hepatitis B and measles, mumps and rubella (MMR);
- development and enhancement of state-wide immunization information tracking systems;
- vaccine purchase for children who are not VFC eligible;

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[4] *MMWR*, March 1995.

[5] *Excerpts From States' Responses on Impact of VFC/317*, ASTHO, 1995.

[6] Ibid.

[7] Ibid.

- financing of new vaccines, such as varicella, for children in universal purchase states; and
- supplemental funding for development of community-based Immunization Action Plans.[8]

In spite of the benefits to states described above, several issues have been raised about the usefulness of the program. The argument is occasionally made that the price of vaccines is not the true impediment to achieving high childhood immunization rates. While cost is only one of the several identified barriers to immunizing children fully, there is substantial research to indicate that cost is a factor requiring a remedy for many families. For example, a 1993 survey of licensed pediatricians and family physicians in North Carolina showed that 93 percent of doctors referred some children to public clinics for immunizations. Nearly all (95 percent) cited parents' concerns over the cost of vaccines as a very important determinant in their decision to refer children to the health department.[9] Clearly, cost is an issue which should be addressed if our effort to increase immunization rates are serious. Additional impediments including inadequate outreach, education and tracking, and insufficient clinic hours, are also being tackled at the state level, often with the help of VFC savings. We encourage Congress to support these efforts and to work with states and providers to address all barriers to full childhood immunization, including cost.

Finally, some questions have been asked about the method by which VFC vaccines are distributed, given that CDC was unable to sign distribution contracts with all the vaccine manufacturers. Of the 49 states participating in the Vaccines for Children program, 35 have public and private distribution systems in place; the remaining 14 states were left without a system of distributing to private providers when the planned national distribution system was cancelled just before the program's start date. However, these 14 states are in various stages of developing their own distribution system to private providers and plan to be fully operational later this year or sometime in 1996, at the latest.

Mr. Chairman, I appreciate having the opportunity to provide state health departments' views on this important program. While state health officials recognize that the Vaccines for Children program's implementation has encountered its share of challenges (not unlike many programs in their earliest stages), the program's current benefits and potential bode well for states and our nation's children. Moreover, ASTHO believes that the commitment has been made by the federal government to states, private providers and parents and should not be withdrawn, nor the program scaled back, especially at this critical implementation stage. Thank you for your interest in this important public health matter.

Sincerel

Christopher Atchison

Christopher Atchison
Director, Iowa Department of Public Health
President, Association of State and Territorial Health Officials

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[8] *ASTHO Statement on Estimctes From States on Anticipated Savings From the Vaccines for Children Program*, ASTHO, 1995.

[9] W.C. Bordley, G.L. Freed, J. Garrett, et al, "Factors Responsible for Immunization Referrals to Health Departments in North Carolina," *Pediatrics*, 1994.

STATEMENT OF THE CHILDREN'S DEFENSE FUND

We appreciate the opportunity to present written testimony in support of the Vaccines for Children program. The Children's Defense Fund is a national children's advocacy organization that exists to provide a strong and effective voice for all the children of America who cannot vote, lobby, or speak for themselves. The Vaccines for Children program is essential to the health of America's children—to wiping out preventable diseases that cause children suffering, disability and sometimes death, and cost society billions of dollars. Despite some initial administrative difficulties, the Vaccines for Children (VFC) program has made an excellent start and is rapidly fulfilling its original promise of significantly reducing financial barriers to the timely immunization of children, especially infants and toddlers. The widespread support for, and success of the VFC program leave no doubt that the rationale of the program is correct and that the program is essential to protect all children from vaccine-preventable diseases.

Reports that the nation already has reached the goal of immunizing 90 percent of two-year-old children are incorrect. While it is true that several specific immunization rates (rates of immunization for a single vaccine) are between 67 and 90 percent, the rate of immunization for the entire basic vaccine series (4 DTP, 3 polio and 1 MMR) is only 66 percent. It is this measure—immunization against the full range of preventable diseases—that public health experts use. Yet one third of our two-year-old children (more than 1.3 million) are inadequately protected against one or more common, preventable, potentially fatal or disabling disease. In many inner city and rural areas fewer than half the preschool-age children have received all the recommended vaccinations, making outbreaks of vaccine-preventable disease a real threat. It is also true that rates for individual vaccines went up in early 1993 compared to 1992. But the rosy picture some seek to portray based on that is incorrect:

- First, the increases are *not* as described in the piece of paper being circulated to Senators by a pharmaceutical manufacturer saying "Source: CDC," and saying 1993 rates for two-year-olds for DTP and polio (3 doses) were 90 percent. This is not a CDC document. The actual numbers for 1993 were: for the recommended 4 doses of DTP, 72%; for polio, 79%; for MMR, 84% (see attachment).
- Second, the modest increases in 1993 compared to 1992 are very encouraging, but are not enough, and were probably bumps created by publicity on the importance of immunization engendered by this legislation and by attention to the recent epidemics. But the multi-year data *and* the 1993 data for children fully immunized show the nation has a long-term system problem that needs a systemic solution.

One reason for this long-term systemic problem is the cost of vaccines. Certainly there are other factors contributing to low immunization rates for preschool-age children, including missed immunization opportunities by providers, inadequate immunization registry and reminder systems, inadequate hours and accessibility of clinics, especially for working parents, and lack of parental and public awareness of the importance of timely immunization. Opponents of the VFC program have disputed the role of vaccine cost. But it was precisely during the period that vaccine costs were skyrocketing (and young families' incomes dropping) that our nation's immunization problems worsened. There is abundant evidence in medical and public health studies that the high cost of vaccines plays a role in parents not seeking immunizations and providers not immunizing children, with regular private providers offices referring children to overwhelmed public clinics for immunization. Initial vaccine purchase costs and poor reimbursement rates also have prompted the referral of many Medicaid-enrolled children to public clinics for immunization. There can be no question that vaccine costs play a significant role in the under-immunization of many infants and toddlers. (Attached is a short summary of studies that document the impact that the cost of vaccines has on immunizing children).

Pediatricians and family physicians increasingly are referring to public immunization clinics children whose families have no health insurance (62 percent of uninsured children use private providers) or whose insurance does not cover vaccinations. As the number of uninsured children rises—an additional 800,000 children will lose insurance in 1995—the number of referrals is likely only to increase. Whatever the reason, children who are in a doctor's office or private clinic but are referred to a public clinic not only immediately miss an opportunity to be immunized, but face the potential additional barriers of an extra visit, inconvenient clinic hours, and long waiting times. The resulting attrition—fewer children immunized—is inevitable. By providing federally purchased vaccines to children in their own doctors' offices, the VFC program decreases the number of referrals, addressing the cost barrier in an efficient way that cannot be matched by the provision of free vaccines at public clinics alone.

There are some, including some of the vaccine manufacturers, who have pressed for repeal of this program. This would be a serious mistake and reflect a major setback to the public health of our nation's children. Repeal of the VFC program at this stage in its implementation would be a disaster, and dozens of state health officials have indicated their belief that children's health would be damaged. The many children who now have access to free vaccines from their regular provider would be forced to choose between paying the high cost of vaccines or being referred for a special trip to a public clinic, if the clinic was accessible. The resulting missed opportunities would delay immunizations and result in lower immunization rates. Public clinics again would face the burden of providing immunizations for children referred by private physicians.

States also would be severely affected by a repeal of the VFC program. Most states have invested time and dollars in developing the partnerships and infrastructure necessary to integrate the VFC program into their existing immunization programs. The VFC program has provided the first real opportunity for states to forge strong preventive care partnerships between the public and private health care sectors—partnerships that will improve the delivery of a range of health care services. Repeal of the program would irrevocably damage these relationships.

All states have taken the opportunity provided by the VFC program to purchase additional vaccines at the federal contract price for some (in a few cases, all) children not eligible for federally-purchased vaccines. This guaranteed option for additional state purchase is recognized by almost all states as a vital component of the VFC program.

Repeal of VFC also would mean that state Medicaid programs again would be required to pay the cost of vaccines for Medicaid-enrolled children. This would be particularly difficult in those states that already have re-allocated these funds for other purposes. For example, New York and Kansas have used the funds to raise the Medicaid reimbursement rate for vaccine administration so more doctors will treat Medicaid children, and California has invested the funds in other childhood immunization services.

The assertion that the Vaccines for Children program will reduce the research and development of new vaccines is unfounded. The VFC program should stimulate vaccine manufacturers to invest in the development of new and combination vaccines, protecting children against additional diseases, requiring fewer vaccinations, and ultimately lowering treatment and immunization costs to society. Not only does the VFC legislation specify that research and development costs be considered as federal contract prices are negotiated, but it requires that new vaccines are not subject to any price cap. Through Vaccines for Children, vaccine manufacturers therefore are provided a large and guaranteed market for new vaccines, at prices that will allow both adequate profit and research and development costs, immediately upon recommendation by the Advisory Committee on Immunization Practices. In addition, the program ensures that children in low and moderate income families have access to all recommended vaccines, including new vaccines, as soon as they are added to the immunization schedule. In contrast, the Centers for Disease Control and Prevention's "Section 317" program, while another essential component of the nation's war on preventable disease, provides insufficient quantities of some currently recommended vaccines, such as hepatitis B, does not provide other more expensive vaccines, such as the DTP-Hib combination, and does not guarantee the provision of new vaccines.

Overwhelmingly the opinion of state health departments and private health care providers is that the Vaccines for Children program boosts immunization rates; is a key factor in maintaining the continuity of health care for thousands of children; forms a vital collaboration between the public and private health care sectors; reduces the burden on public health clinics, enabling them to serve more effectively their regular patients; allows the development of innovative state immunization programs that customize the provision of immunization services to specific populations; provides children in low and moderate income families with the same access to new vaccines as those in higher income families—an important public health consideration in the control and eradication of disease; and encourages the development of new and combination vaccines, leading to a simpler and more manageable immunization schedule. It is imperative that the Vaccines for Children program be retained in its current form so that states can continue to make progress toward the 90 percent immunization goal and the protection of all children from vaccine-preventable diseases.

VACCINATION LEVELS AMONG CHILDREN AGE 19–35 MONTHS BY SELECTED VACCINES—UNITED STATES, 1992 to 1994

(Percent of children in that age group immunized)

Vaccine	1992 %	1993 %	First quarter 1994* %
DTP/DT [1]			
3+ doses	83.0	88.2	87.0
4+ doses	59.0	72.1	67.2
Polio			
3+ doses	72.4	78.9	76.0
Hib [2]			
3+ doses	28.2	55.0	70.6
Measles	82.5	84.1	89.6
Hepatitis B			
3+ doses	.....	16.3	25.5
4DTP/3 polio/1MMR [3]	55.3	67.1	66.0

Source: Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report 1994;43:705–718 and 1995;44:142–143,149–150

*The Vaccines for Children program did not start until the last quarter of 1994.
[1] Diphtheria and tetanus toxoids and pertussis vaccine.
[2] Haemophilus influenzae type b vaccine.
[3] Four doses of DTP vaccine, three doses of poliovirus and one dose of measles-mumps-rubella vaccine.

SUMMARY OF SELECTED STUDIES DOCUMENTING THE ROLE OF VACCINE COST IN GROWING REFERRALS OF CHILDREN (SUCCESSFUL AND UNSUCCESSFUL) FOR IMMUNIZATION, AND IN THE UNDER-IMMUNIZATION OF CHILDREN

- A 1993 survey of licensed pediatricians and family physicians in North Carolina showed that 93 percent of doctors referred children to public clinics for immunizations. Nearly all of the physicians (95 percent) cited parents' concerns over the cost of vaccines as a very important determinant in their decision to refer children to the health department. [1]
- The number of children in Dallas referred to public clinics for immunization increased nearly **700 percent** between 1979 and 1988. The report stated, "A new influx of patients are using public sector immunizations, potentially creating additional financial stress for public health programs. In addition, this shift to the public sector may undermine the health departments' ability to provide new vaccines or protect greater numbers of children with immunization." In an earlier study, the authors found that 65 percent of children using public clinics for immunization did so because of high costs in private facilities. [2]
- Milwaukee physicians reported immunizing uninsured patients in their offices less often than patients with insurance. Physicians estimated that approximately half of their uninsured patients decline private immunizations. The authors concluded that when children leave their physicians' offices without receiving immunization, an opportunity is lost. There is no assurance that families who decline immunizations in their physicians' offices for financial reasons will subsequently have their children immunized in a timely manner. [3]
- After experiencing dramatic increases in the number of children seeking immunizations at public clinics, Orange County, California, health officials wrote, "Most private health insurance plans in the nation fail to provide coverage for preventive immunizations. As a result, many parents forego having their children immunized or use public clinics for immunization services. The public health system has been overloaded by the need to provide immunizations. As those in moderately difficult financial circumstances use the immunization services provided by the public sector, the traditionally underserved population in greatest need of immunization and at higher risk for vaccine-preventable diseases may be increasingly displaced. This factor may be exacerbating and feeding the U.S. measles epidemic. American families must be given the financial means to gain access to private physicians in their communities for childhood immunizations." [4]
- In a northern California study, 61 percent of public immunization clinic patients had a family doctor or other medical home and would have preferred to have their children immunized by those providers. Most named cost as the main barrier to immunization at their usual well-child care sources. [5]
- Medicaid and lack of health insurance were significantly associated with undervaccination in a medical chart review conducted in primary care offices in

Rochester, NY. This review showed not only that missed immunization opportunities occurred frequently and contributed significantly to the undervaccination of preschool age children, but that the impact of missed opportunities was twice as great for children having Medicaid or no health insurance as for children covered by private insurance.[6]

- When a random sample of members of the American Academy of Pediatrics was surveyed a majority (55.2%) of respondents reported referral of some or all of their patients to other providers for immunizations because of cost to the patient.[7]
- Half of the physicians responding to a survey in New York state referred some or all of their patients elsewhere for vaccinations. Most of the referrals were to a local health department clinic and respondents identified financial hardship as a "very important" reason for referral. In addition, more than half of the responding physicians indicated that some or all of the cost of childhood vaccination should be underwritten by the government.[8]

Footnotes:

1. Bordley W.C., Freed G.L., Garrett J., et al., "Factors Responsible for Immunizations Referrals to Health Departments in North Carolina," *Pediatrics,* 1994; 94:376–380.
2. Schulte J.M., Bown G.R., Zetzman M.R., et al., "Changing Immunization Referral Patterns Among Pediatricians and Family Practice Physicians, Dallas County, Texas, 1988." *Pediatrics,* 1991; 87:204–207.
3. Arnold P.J., and Schlenker T.L., "The Impact of Health Care Financing on Childhood Immunization Practices." *American Journal of Diseases of Children,* 1992; 146:728–732.
4. Wagner G.A., Gellert G.A., Ehling L.R., "Insurance Coverage for Preventive Immunizations in Childhood." *New England Journal of Medicine,* 1992; 326:768–769.
5. Lieu T.A., Smith M.D., Newacheck P.W., et al., "Health Insurance and Preventive Care Sources of Children at Public Immunization Clinics." *Pediatrics,* 1994; 93:373–378.
6. Szilagyi P.G., Rodewald L.E., Humiston S.G., et al., "Missed Opportunities for Childhood Vaccinations in Office Practices and the Effect on Vaccination Status." *Pediatrics,* 1993; 91:1–7.
7. Ruch-Ross H.S., O'Connor K.G., "Immunization Referral Practices of Pediatricians in the United States." *Pediatrics,* 1994; 94:508–513.
8. "Physici.. Vaccination Referral Practices and Vaccines for Children—New York, 1994," *MMWR,* 1995; 44:3–6.

A CAGW SPECIAL REPORT

CITIZENS AGAINST GOVERNMENT WASTE

1301 Connecticut Ave., NW, Suite 400, Washington, D.C., 20036 (202) 467-5300

AN OUNCE OF PREVENTION

WHY CONGRESS SHOULD REPEAL THE VACCINES FOR CHILDREN PROGRAM

They say an ounce of prevention is worth a pound of cure. That adage works well for human beings, but could just as easily apply to federal entitlement programs, which tend to metastasize uncontrollably and are next to impossible to eradicate if left untreated. The Department of Health and Human Service's (HHS) new Vaccines for Children (VFC) program offers a unique opportunity to put this bromide into action.

In spite of its youth (born in October, 1994), the VFC already exhibits many of the symptoms common to wasteful and mismanaged government programs. Its existence was predicated on a phony premise. It is clearly not structured to accomplish its purported mission. Its authorizing legislation was poorly constructed. And it is rife with the kind of bureaucratic bungling that has become Washington's trademark and, ultimately, the taxpayers' burden.

In an era when the costs of the current stable of federal entitlement program are exploding, Congress should seriously consider the repeal of this program. The Fiscal Year 1996 budget request for the VFC is $850 million, but the cost of the program is projected to hit $1.3 billion by 1997. Repealing it today, before it has had time to take deeper root, will not only save taxpayers a lot of pain later on, but will also make way for saner and more cost-effective solutions to the problem at hand: vaccinating America's under-immunized children.

According to Bob Woodward's book *The Agenda: Inside the Clinton White House,* it was during the battle over the Omnibus Budget Reconciliation Act (OBRA) 1993 and the preparation for a complete overhaul of the nation's health care system that the President and Mrs. Clinton dreamed up the idea of the VFC program. Woodward writes that the Clintons hatched the VFC plan as a "dry-run" for their subsequent attempt to overhaul the nation's health-care system.

The idea was to empower the Centers for Disease Control (CDC) to purchase pediatric vaccine from the manufacturers at a discount and then redistribute these vaccines to private doctors and clinics. The vaccines would be aimed at children under 18 years of age who fell into four categories: low-income, the uninsured, the underinsured (those whose insurance didn't cover vaccinations), and Native American children.

Department of Health and Human Service (HHS) Secretary Donna Shalala made the administration's case when she testified before the Senate on April 21, 1993: "The United States has one of the lowest immunization rates for pre-school children

when compared with European countries," she said: She stated at that hearing that immunization rates were below 60 percent.

Whether by design or by mistake, it is clear now that the data Secretary Shalala quoted in her testimony was eight years old. The National Center for Health Statistics and the CDC had collected more up-to-date coverage data which showed that the nation's immunization rates were, in fact, much higher at that time: For the three major series of vaccinations recommended for two-year olds (three to four shots for diphtheria, tetanus, and pertussis; three doses of oral polio vaccine; and one shot for measles, mumps, and rubella), the rates were closer to 90 percent. Dr. Walter Orenstein, director of the CDC's National Immunization Program (NIP) confirmed this more favorable assessment when he testified before the Senate on May 18, 1994 that the nation's "immunization levels among pre-school children are the highest ever." In fact, by the time American children reach the age of five, when the law requires them to be fully vaccinated for school, rates are closer to 98 percent.

The administration's presentation of this outdated data elicited the anticipated sense of moral outrage in Congress, thus setting the stage for the them to outline the reasons for this failure and to unveil their solution. President and Mrs. Clinton denounced the pharmaceutical manufacturers for their greed and profiteering at the expense of children's health and proceeded to construct a case that vaccine cost was *the* problem. The VFC program was their solution.

Trampled in the frenzied discourse over rapacious pharmaceutical manufacturers was the fact that the federal government had been in the vaccine purchasing and redistribution business since 1962. Under the Public Health Service's (PHS) Section 317 program, the CDC spent $465 million in 1994 for vaccine purchase and redistribution, up 57 percent from $296 million in 1992. Under that program, the CDC already controlled nearly 50 percent of the domestically manufactured pediatric vaccine. Now, between the VFC and the 317 program, the federal government controls nearly 80 percent of the nation's pediatric vaccine.

In addition to the purchasing portion of 317, the federal government in 1990 also began furnishing the states with additional monies under Sec. 317 to develop Immunization Action Plans (IAP), outreach initiatives, public service campaigns, and other marketing strategies.

There are still millions more allocated each year for incentive programs, ostensibly to spur the states to boost their coverage rates. And, if state governments wanted to chip in to buy more vaccine for their universal coverage programs, they had the option, until the onset of the VFC program, to negotiate directly with the vaccine manufacturers.

All of these expenditures beg the question: If vaccine cost is the major barrier to pediatric immunization, how is it that immunization rates in universal coverage states, where vaccine is free for everyone, aren't higher for preschoolers? If cost is the issue, how is that more than 98 percent of America's five-year-olds manage to get have their shots fully updated in order to register for school?

The glaring fact remains that there *are* communities in this country with woefully low immunization rates for preschoolers. In 1989–91, for example, a measles epidemic took the lives of 130 children, mostly poor residents of inner cities where immunization rates had fallen below 60 percent. Yet when the CDC conducted a series of surveys following the tragedy to find out what went wrong, their data revealed that cost was *not* the biggest impediment to immunization. In fact, those studies indicated that these at-risk children had seen doctors dozens of times before the age of two and had ample opportunities to complete a series of vaccinations: Furthermore, the children with the lowest immunization rates already had access to free vaccine, either through Medicaid or at public clinics. Between 1991 and 1994, the CDC funded a total of four diagnostic studies attempting to discern the true barriers to pediatric immunization. A multitude of others have been conducted by epidemiologists and pediatricians in the private sector. All of the studies reach the same inescapable conclusion: *Contrary to the assertions of the Clinton administration and VFC proponents, vaccine cost has never been reported as a major impediment to getting children immunized.*

In reality, a complex range of other factors (mostly behavioral) prevent children from becoming fully immunized by the age of two: delay in getting the first shot in the series, confusion about the vaccination schedule on the part of both parents and pediatricians, failure of pediatricians to evaluate and update a patient's vaccinations when they visit for other complaints (the "missed opportunities" phenomenon), reluctance on the part of pediatricians to vaccinate when a child is ill for fear of litigation (real or perceived), difficulties faced by parents in getting time off from work, long waits at overcrowded public health clinics, pediatricians who are less than enthusiastic about vaccinating Medicaid patients because of the abysmally low

Medicaid reimbursement rates for vaccinations in many states, and the lack of a good immunization tracking system. All of these problems, alone or in combination, play significant roles in impeding age-appropriate immunization.

But rather than tackling these real problems, the Clinton administration chose the "Washington way. " They decided to make vaccine cost the issue in order to justify the creation of a new entitlement program, one that promises to be costly to taxpayers and which may never fulfill its promise to vaccinate children.

First, the federal government is now operating two vaccine purchasing and distribution programs simultaneously, for all 50 states.

Second, there is the thorny problem of distribution. The CDC apparently never had a clue about how to disburse the millions of doses of pediatric vaccine it now owns through the VFC program. In the early stages, somebody dreamed up the bright idea of using the General Services Administration for warehousing and distribution, the same agency that has a hard enough time accounting for the government's office supplies. After the laughter died down, that plan was scrapped. Then, in April 1995, the CDC dropped any attempts to devise a centralized distribution network, leaving the states to fend for themselves (with the federal government footing the bill). About a dozen states have entered into contracts with private distributors. New York State at first contracted with a private distribution service at a cost of ninety-five cents per dose, high by any standards.) They recently changed distribution companies and negotiated a more reasonable deal.

Third, when it comes to the VFC's accountability mechanisms, there is apparently a vacuum. Who, for example, will make sure that private practitioners won't use the taxpayer-funded vaccine on all their patients, regardless of eligibility? How are the private practitioners supposed to verify a patient's income status to determine eligibility?

That "accountability gap" extends to other portions of the program, as well. Unbelievably, the Act stipulates that an unelected body, the CDC's Advisory Committee on Immunization Practices, will have the power to make legally binding "recommendations" regarding which vaccines will be covered by VFC program money. Some members of the panel of epidemiologists, pediatricians, and state health officials, whose slightest official pronouncement can drive up the cost of the program by hundreds of millions of dollars, have publicly expressed discomfort about their newly conferred power over the federal purse. They have nevertheless just added two new vaccines (chicken pox and hepatitis B) to the VFC schedule.

The Clinton administration's breezy promise of 79,000 private pediatricians who were reportedly eager to sign up for the VFC program has not materialized. In fact, doctors are apparently treating the program like the plague. Why? Because what sounded like a wonderful vaccine purchasing program, with no strings attached in theory, has revealed itself as a paperwork nightmare in practice.

Dr. Daniel Shea, a member of the National Vaccine Advisory Committee and former president of the American Academy of Pediatrics, was quoted recently as saying, "These criteria are crazy. We are going to force providers to become their own social service people. Even the simple questions do not cut through this. There is inequity here. It would appear to the private practitioner that this is just one more crazy way to approach a problem by government."

In its zeal to build in belatedly some accountability mechanisms into the program, Congress may cobble together a Frankenstein-style monstrosity of confusing and contradictory legislative and regulatory add-ons, inviting further waste and mismanagement.

Even unimpeachable children's health advocacy groups like the New York-based Children's Health Fund have expressed deep concern about the misdirected focus of the VFC program. The fanfare and political posturing associated with the VFC have predictably drawn attention and resources away from promising and cost-effective initiatives currently underway at the CDC and in states across the country to combat real barriers to immunization.

In Maryland, for example, childhood immunization has been successfully linked to the Aid to Families with Dependent Children (AFDC) program as part of the state's welfare reform program. AFDC clients (both parents and children) are now required to get preventive health screenings and present documentation to show that immunizations are up to date. Early results have shown a 93-percent compliance rate and a 40-percent increase in preventive health screenings.

The CDC has launched more than a dozen linkage demonstration projects with the United States Department of Agriculture's Women, Infants and Children (WIC) food program. These programs, which build upon an established relationship with the target population and can make use of existing infrastructure, are reaching under-immunized children and dramatically improving their coverage rates. In New York, the site of the first experiment, immunizations rose from 29 percent to 63 per-

cent. In Chicago, rates rose from a baseline of 34-40 percent to 72-78 percent after one year. According to many epidemiologists, focusing resources and energy in this way is the most effective way to prevent epidemics and increase overall immunization rates.

Sen. Dale Bumpers (D-Ark.), a widely-respected advocate for children's health and a recognized expert on pediatric immunization, has described the VFC program as "indescribably complicated. A fairly simple law, designed to benefit a relatively small group of uninsured children, was transformed into a bureaucratic nightmare that put the safety and availability of our nation's vaccine supply at risk." He asserted that the plan has "taken us dangerously close to nationalizing the pediatric vaccine market," and has predicted that the VFC "will not immunize a single additional child."

Congress, which had its hands full fending off accusations of hostility toward the nation's poor children, is probably loath to take aim at a program called Vaccines for Children. That's unfortunate, because VFC, even based on its six-month track record, promises to be grossly disorganized and wasteful. It is a prime candidate for repeal. Achieving universal immunization for our children is not just morally correct, it is also cost-effective public health policy. Every dollar spent to immunize a child saves $14 down the road by preventing disease.

But from all appearances, implementation of the VFC program has become the goal in and of *itself*, regardless of whether or not the program will actually improve the nation's immunization rates. Better to repeal the program now, replenish dwindling funds to the PHS's 317 program, and continue to build on some of the creative framework being laid out at the CDC and across the country. It may have arrived all bundled up in the rhetoric of good intentions and a warm, fuzzy moniker, but the truth is that VFC is the offspring of a dangerous and costly Washington pair: political calculation and bureaucratic ineptitude.

STATEMENT OF THE GEORGE WASHINGTON UNIVERSITY
CENTER FOR HEALTH POLICY RESEARCH

May 4, 1995.

Hon. JOHN D. (JAY) ROCKEFELLER IV
U.S. Senate

Dear Senator Rockefeller:

We are writing in response to your request for further information about our recent study, *Universal Childhood Vaccine Distribution: The Experience of Twelve States.** This study is the first comprehensive study of state universal vaccine distribution programs. It analyzes the 12 state universal pediatric vaccine procurement and distribution programs which were in effect during the 1993–94 time period.[1] The study has been cited by Dr. Irwin Redlener in testimony prepared for the Senate Finance Committee's hearing today on the Vaccines for Children (VFC) program. In his testimony Dr. Redlener states that our study "verifies" that the "VFC in its current form does not confront the factors responsible for severe under-immunization in the millions of children who have no regular source of care."

We would like to take this opportunity to clarify our findings. We request that both this letter and the full study (a summary version of which was sent to more than 250 state policy makers) be included in today's hearing record.

Study findings. As part of the study we conducted extensive interviews with state officials responsible for the administration of their state's childhood immunization programs. We found as follows:

- As Dr. Redlener notes, virtually all states with universal vaccine procurement and distribution programs continue to report barriers to childhood immunization that arise from factors other than the lack of availability of low cost vaccine. The only exception is Vermont, which has been able to provide a medical care home to nearly all children. Officials in that state reported that because vaccines are distributed free of charge to all pediatric providers, children are routinely immunized as part of their ongoing health care. Data available at the

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*The text of the full study will be kept in the Committee files, however, a "briefing paper" that is based on the report follows this letter.

[1] Of the 12 states with universal programs that we studied four are represented on the Finance Committee (Rhode Island Wyoming, South Dakota and Alaska). Additionally, since October 1, 1994. five states and the Commonwealth of Puerto Rico have instituted universal vaccine purchasing and distribution systems. Of these. two (North Dakota and Illinois) are represented on the Finance Committee.

time our study showed that Vermont had the highest rate of childhood immunization among the universal states.

However, state officials also uniformly reported that the universal availability of free vaccine was an essential component of their childhood immunization improvement efforts (Rosenbaum and Wehr, p. 73). Officials considered the availability of free vaccines to both publicly funded and office-based providers as a basic building block for all state pediatric immunization improvement efforts. State initiatives include both the expansion of the public administration infrastructure for children without health care homes, as well as efforts to improve the performance of office-based primary care providers in order to reduce the problem of "missed opportunities." According to the officials whom we interviewed, the problem of "missed opportunities" emerged as second most commonly reported barrier after inadequate pediatric primary care services for underserved children (Appendix 16, table 12).

It is our understanding that the fundamental purpose of the VFC program is to ensure that in all states there is a sufficient supply of affordable vaccine at least for Medicaid-enrolled, uninsured, Indian, and medically underserved children cared for at rural and urban health clinics. In this sense, the VFC program acts as a companion to other federal immunization initiatives including initiatives to improve infrastructure which are carried out by the CDC with appropriated funds. Were VFC funds to be reduced or eliminated, it would appear that the CDC would be forced to withdraw some or most funding for infrastructure improvements in order to once again buy vaccines for many of these children.

The task of improving childhood immunization levels a three-part undertaking. All three parts are of equal importance. One part is ensuring the availability of a sufficient and stable vaccine supply. Another is improving vaccination practices among providers. According to national statistics provide half of all care received by low income children is furnished by office-based physicians. The final task is the development of a strong publicly funded preventive health care infrastructure for children without a health care home. We believe that all three activities are essential. Given the enormous cost-effectiveness of pediatric immunization according to innumerable studies, we would recommend that the nation invest in all three legs.

Sincerely

SARA ROSENBAUM, *Co-Director.*
ELIZABETH WEHR, *Research Associate.*

Attachment.

UNIVERSAL DISTRIBUTION OF CHILDHOOD VACCINES: THE EXPERIENCE OF TWELVE STATES

A Briefing Paper by
The George Washington University
Center for Health Policy Research[1]

INTRODUCTION

As a result of state school entry laws, nearly all American children are immunized against the nine vaccine-preventable childhood diseases[2] when they begin kindergarten or first grade. But state immunization efforts aimed at preschool entry have been less successful in assuring the timely immunization of all children by age two, when 80 percent of childhood vaccines should be administered. Current data from the Centers for Disease Control and Prevention show that a third of the nation's two-year-old children are inadequately immunized against preventable disease.

Several published studies, including a 1995 CDC report, also show that half or more of U.S pediatricians and family practitioners have been sending some or all of their young patients to local health departments for free immunizations, primarily for financial reasons.[3] Such immunization referrals were first reported at the end of the last decade, when the cost of the basic series of childhood vaccines had risen sharply and the U.S. experienced a multi-year measles epidemic.

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[1] Based on a December, 1994 report of the same name by Sara Rosenbaum, co-director of the George Washington University Center for Health Policy Research, Elizabeth Wehr, Stephanie Spernak, Peter W. Shin and Yvonne Goldsberry. The report was funded by the Robert Wood Johnson Foundation. Copies of the full report may be requested from the Center, at 2021 K Street, N.W., Washington, D.C. 20006, (202) 296-6922.

[2] The vaccine-preventable diseases are: diphtheria, tetanus, pertussis, measles, mumps, hepatitis B and *Haemophilus influenzae* type B.

[3] At least six reports of a high immunization referral rates have been published recently by the federal Centers for Disease Control and Prevention (CDC) and in medical journals. For example, 1995 CDC report indicated that 50 percent of New York physicians referred some or all of their patients out of practice for immunizations and that "financial hardship" was a "very important" reason for eighty-eight percent of the referrals. Sixty-eight of North Carolina physicians referred all or most uninsured children according to a 1994 report in PEDIATRICS, the journal of the American Academy of Pediatrics. These referrals increase the risk of delayed immunizations and make it more difficult for the clinics to care for children who have no other source of primary medical care.

Sending a child out of a physician's office without administering specific vaccines at the time that they are medically indicated is considered a major factor in low U.S. immunization rates. But in certain states, which operate universal childhood vaccine distribution programs, children may receive free, state-supplied vaccines along with with other routine primary care at their physician's office or clinic.

Until now, little was known of the universal childhood vaccine distribution programs outside the states in which they operate. However, a new study from the George Washington University Center for Health Policy Research provides the first comprehensive description of how the programs operate, how states provide a legal basis for them, and what barriers to timely immunization of young children remain when vaccine costs have been eliminated as a problem for clinicians and families. The study examines the vaccine programs in twelve states: Alaska, Connecticut, Idaho, Maine, Massachussetts, New Hampshire, North Carolina, Rhode Island, South Dakota, Vermont, Washington, and Wyoming. The study states have been operating the programs for years or decades except for North Carolina.[4] In addition, the study describes related federal programs including grants for vaccine purchase and other immunization activities and the new federal Vaccines for Children (VFC) program. The study findings indicate that:

- *Universal states have established safe and reliable vaccine delivery systems, which primarily utilize commercial carriers.*

- *Immunization referrals out of private practices are not reported as a problem in the universal states. Universal programs create a seamless web in which all children may be immunized in their "medical homes."*

- *Universal vaccine distribution receives high marks among both states that rely primarily on private practitioners to vaccinate children and those with strong public health agency traditions.*

- *While universal vaccine distribution is by no means a cure for low immunization rates, many universal states achieve impressively high rates for the basic series of vaccines or specific antigens.* (Table 1)

The Center for Health Policy's report is in three parts. The first analyzes immunization laws in the study states and provides annotated tables of various statutory and regulatory options for establishing a universal distribution program. The second section describes how the universal distribution programs actually work and identifies immunization barriers other than vaccine cost in the study states. The third section reports opinions of universal vaccine distribution by program participants. Characteristics of the universal states and of their programs are shown at Table 2.

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[4]Since October 1, 1994, at least five additional states (Illinois, Nevada, New Mexico, North Dakota, South Carolina and the Commonwealth of Puerto Rico) have begun universal distribution programs.

BACKGROUND

Origins of state universal vaccine distribution programs. As with other activities designed to protect public health, states historically have played the primary government role in assuring the immunization of children. In addition to achieving universal immunization through school entry requirements, virtually all states have also provided direct pediatric immunization services through state and local health agency personnel. As part of their direct immunization services, states supply providers with free childhood vaccines financed in part with federal subsidies. The publicly-funded vaccines and services were commonly intended for use by low-income children without other access to primary medical care. But the services generaliy operate without restrictions -- other than their limited resources, crowded schedules and nominal fees -- on who may use them.

In the universal vaccine distribution states, childhood immunization programs have evolved into several forms. In New England, the typical model was distribution of free vaccines by state health agencies to private-sector providers and to the limited number of publicly-funded clinics in this region. Because these states did not develop extensive public health systems, health officials saw distribution to the private sector as the only way of assuring immunization of resident children, poor and non-poor. In effect, physicians and other private-sector providers acted as agents of the state health agency in preventing the communicable diseases. Providers who accepted the free vaccines generally agreed to limit their administration fees or waive them for families who could not afford them. The New England universal distribution programs have been in operation for decades, under express statutory authorizations or as well-established administrative practices under general grants of authority to public health agencies. In recent years several of these states have codified existing practices in law, created special vaccine financing mechanisms, and otherwise revised/restricted their immunization programs.

In Southern states, which have a long history of furnishing personal health services to low-income and medically underserved children through public clinics, state-supported vaccine procurement was historically undertaken solely for distribution to public health agency staff. Nurses in state and local health agencies immunized children with state-distributed vaccines as part of an overall program of well-child care. North Carolina was the sole southern state to have adopted universal distribution at the time of the CHPR study.

A third model emerged the thinly populated Western states of Wyoming, South Dakota, and Alaska where health officials historically relied on private sector physicians, some under state contract and traveling public health nurses to immunize children. Publicly-financed vaccines were supplied for these providers.

Federal assistance for childhood immunization activities. Beginning with the 1921 passage of the Shepherd-Towner Act, Congress has recognized the importance of federal leadership in preventive health services for children. Beginning in 1962, Congress provided

federal immunization project grants to states. These grants take the form of federally-purchased vaccines, personnel salaries and "Section 317" technical assistance, and as cash assistance. The grant program, as well as other federal grant programs and Medicaid, have played a major role in funding state vaccine supplies and immunization activities. To further assist states and remove vaccine price as an immunization barrier Congress created the VFC program in 1993, several years after measles epidemics of 1989-1991 hospitalized many young children and caused 136 deaths.

The new program is an entitlement for both certain groups of children and for states. Thus, VFC entitles millions of children to free vaccines that are fully funded (including delivery to children's physicians or clinics) by the federal government. Eligible children include those enrolled in Medicaid and children without insurance for immunizations. Additionally, the VFC law also entitles states to buy vaccines at the same low contract price as the federal government, on behalf of other children who are not eligible for the federally-financed vaccines. For example, under the current federal purchase contract, a state could buy oral polio vaccine at $2.31 per dose, compared with a private sector retail ("catalogue") price of $10.47 per dose. Prior to VFC, vaccine sales to states at the federal contract price were at the sole discretion of vaccine manufacturers. Tables 3 and 4 show details of the VFC program and current vaccine prices.

By relieving families and their children's physicians of the cost of vaccines, the VFC program is intended to stem the tide of cost-related referrals of children out of private medical practices, for immunizations at local health departments and other publicly-funded sites. It also relieves state Medicaid programs of vaccine costs.

THE LEGAL STRUCTURE OF STATE UNIVERSAL CHILDHOOD VACCINE PURCHASE AND DISTRIBUTION PROGRAMS

An analysis of universal state programs shows that states vary widely in the extent to which they write the legal framework for their vaccine distribution and related activities into law. The variation in state laws reflect, a number of factors, including the tradition within each state of delegating legislative rulemaking power to the executive branch, state administrative practices acts and political traditions in different regions of the U.S. For that reason, rather than selecting one model statute the study presents the array of legislative and regulatory options as developed in the study states.

- *Express versus general legislation.* Some state vaccine procurement and distribution laws, like those of North Carolina, are parts of extensive state immunization authorities spelled out in statute and regulations. In other states, the legal authority for vaccine distribution and related activities may be minimal or implied from other sources of law. The Wyoming vaccine distribution law consists of a few lines in the state's public health statute and a one-page agreement with participating providers. The Alaska and Washington state distribution programs have no express authorization

in law. In Alaska, the state health department promulgated program regulations for distribution on the basis of the state's school- and preschool-entry laws and a state constitutional mandate for "promotion and protection of public health." In Washington state, universal distribution was effectively authorized by an appropriation.

Only four states (Maine, Massachusetts, North Carolina, Wyoming) expressly mandate vaccine distribution to providers in statute. In the other eight states, distribution is carried out pursuant to either discretionary statutory authority or targeted appropriations.

•*Legal status of distribution mechanism.* In all twelve study states, universal vaccine distribution is authorized expressly or impliedly as a public health measure. Unlike VFC, none of the state laws are expressed as individual entitlements to vaccine.

•*Program funding.* At the time of the study (before VFC implementation), the states financed their vaccine procurement and immunization programs from four major sources: general state revenues, special state vaccine purchase funds, federal Section 317 grants and transfers from Medicaid. Most states used just two funding sources, general revenues and the federal grants, with the proportion of federal to state funds varying considerably. For example, state funds constituted just five percent of the financing for the Wyoming immunization program, but more than two thirds of Massachusetts' program.

Three universal distribution states have established special vaccine purchase funds in statute. A Massachusetts fund is financed by transfers from a larger health fund that is financed by cigarette taxes, discretionary transfers from Medicaid federal financial participation receipts and fund earnings. Rhode Island's fund is financed by a .075 percent assessment on the value of premiums for insurance sold in the state. New Hampshire's fund is financed by voluntary annual contributions of nearly a million dollars from insurers and health plans doing business in the state.

Among the universal states, only Vermont appears to fund its vaccine programs on an open-ended general basis. In other states, funding limits are either expressly set forth in statute or else are implied. Rhode Island, for example, expressly limits its vaccine fund purchases to availability of funds.

•*Vaccine distribution.* Like states with limited vaccine distribution programs, the twelve universal states receive vaccines shipped by manufacturers to a state depot, which may be a state health agency or laboratory. From this point, the states either distribute vaccines directly to providers by commercial carrier or make them available at local pickup points. A few of the states supplement commercial carrier service with delivery by visiting nurses.

Ten of the twelve universal states provided for direct delivery to all or some providers. Some also permitted providers to pick up vaccines between delivery orders if needed or distributed vaccines on a pickup basis for providers in the same city as the state depot or at a district health agency. Two universal states in New England do not arrange for direct delivery to physicians and other providers. Rhode Island makes vaccines available through hospital pharmacies and Massachusetts delivers vaccine to local boards of health and permits boards in smaller towns to use hospitals or pharmacies as distribution agents.

Only two states, Massachusetts and North Carolina, provide detailed authority in statute for the vaccine distribution systems. States generally have moved to direct delivery to providers without amending their laws expressly to reflect this policy.

•*Specific identification of vaccines for distribution.* Eight states identified all or nearly all distributed vaccines in statute or in rule. Two states (Connecticut, Rhode Island) provided for automatic updates in the scope of their distribution programs by referencing American Academy of Pediatrics (AAP) and the Federal Advisory Committee on Immunization Practices (ACIP) schedules in statute rather than naming specific vaccines. (There is now a single vaccine schedule approved by both the AAP and ACIP.)

•*Provider conditions of program participation.* Every study state expressly prohibits providers in statute, rule or provider agreement from charging for state-distributed vaccines. Eleven states expressly limit vaccine administration fees.

Every state maintains certain provider recordkeeping requirements in statute, rule, provider agreement or as a duty implied from express reporting requirements. These state requirements typically are a function of vaccine ordering and inventory record-keeping duties. Some state laws reiterate requirements of the 1986 National Child Vaccine Injury Act for detailed provider records, discussion of immunization benefits and risks with parents and reporting of adverse events following vaccine administration.

•*Limitation on legal liability for providers for injuries arising out of vaccine administration.*[5] One state (Rhode Island) shields providers in statute from legal liability for injuries and deaths arising out of vaccine administration under the state's universal program (unless a provider acted with gross negligence). A second state (North Carolina) operates a vaccine injury compensation program which can make awards of up to $300,000 and also state rehabilitation and other required services. The program may recover awards from physicians whose negligence caused a compensated injury or death.

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[5]Suggestions that providers' immunization referrals are motivated by liability concerns are not supported by the referral studies noted in footnote 1.

PARTICIPANTS' ATTITUDES TOWARD THE RHODE ISLAND UNIVERSAL CHILDHOOD VACCINE DISTRIBUTION PROGRAM

For a publicly-administered vaccine distribution program to succeed, it must be acceptable to the physicians and other clinicians who use it. To determine provider attitudes toward a state-based universal vaccine program, CHPR sent a single-mailing survey to all participants in Rhode Island's well-established state program. In this state as elsewhere in New England, approximately 80 percent to 85 percent of pediatric vaccines are administered in the private sector. Thus, survey results were heavily weighted toward private provider attitudes.

Responses to the survey showed overwhelmingly positive opinions of the program. They may not represent opinions of all program participants because a low, 20 percent response rate resulted in a relatively small sample. (Higher response rates are generally achieved with repeated mailings of a survey questionnaire). It was striking, however, that just one of nearly 100 practitioners who returned the survey frankly disapproved of the program (as an improper government activity), while 94.5 of respondents agreed with a statement that they would recommend participation in the program to other clinicians.

As the survey cover letter indicated that the survey offered participants a chance to complain directly -- and anonymously -- to state officials responsible for the program, results were expected to be skewed toward negative rather than strongly positive opinions. Some respondents would prefer less paperwork or the newest versions of vaccines yet nearly 86 percent indicated that they got all the vaccines they preferred to use and 73 percent found the program's record-keeping and reporting rules "reasonable."

Positive provider expectations. Of respondents who described their expectations of the program, nearly three-fourths saw positive benefit to their patients and their practices. The Rhode Island vaccine program met the expectations of 92 percent of respondents. The most frequently-stated expectation was that program participation would result in good immunization rates. The second most frequently-stated expectation was for a reliable and easily accessible source for all vaccines needed in a participant's practice.

The survey results suggest that there would be strong provider support for a state's decision to establish a universal distribution system on the basis of their VFC vaccine purchasing authority. While the study states were sufficiently different as to make no state representative of the others. It seemed likely that paperwork, reliability and other possible problems would concern Rhode Island providers as much as those elsewhere. The positive survey responses are consistent with the experience of the three states that have acted most recently with regard to universal distribution. In all three states, medical groups joined state health officials in urging state legislatures to make take these actions. North Carolina and Washington State began universal distribution in 1994 and 1990 respectively, after surveys showed large numbers of immunization referrals for pediatric patients. New Hampshire,

facing falling state revenues and potential loss of universal vaccine distribution, acted in 1990 to create a special vaccine purchase fund to receive contributions from insurers and health plans.

IMMUNIZATION BARRIERS AND THE ROLE OF UNIVERSAL VACCINE DISTRIBUTION

If policymakers know what factors other than vaccine costs contribute to underimmunization in children, they can understand what reasonably should be expected of a universal vaccine distribution program. CHPR approached the problem of identifying immunization barriers and evaluating the role of universal distribution in four ways. The first was a literature review. The second was review of the states' applications for federal Section 317 grants, which include states' Immunization Action Plans. One function of the plans was to assess factors in underimmunization as identified by community health officials, private practitioners and others, as well as state immunization program officials. The third study technique was on-site visits with immunization program officials and institutional and individual participants in the Rhode Island vaccine distribution program. The fourth was a series of semi-structured interviews with state immunization program officials in the twelve universal states. Interview questions covered the mechanics of how the distribution programs actually worked, the role of universal distribution in a state's immunization efforts and immunization barriers in a state.

Because the high cost of health care plays a significant role in determining who receives it, eliminating the substantial cost to families of pediatric vaccines might be expected to result in appreciably higher immunization rates. A number of the universal states reported impressively high rates for the basic series or specific antigens to the Center researchers. Other investigators have reported higher immunization rates in states with universal distribution than elsewhere.[6]

This evidence of high rates in universal states is noteworthy because, except for vaccine costs and immunization referrals, the Center found that these states face virtually all the other barriers to timely immunization of young children that have been reported by the National Vaccine Advisory Committee, the Institute of Medicine and individual investigators.

The role of universal distribution. Despite readily acknowledged structural problems such as shortfalls in primary pediatric care sites, all twelve states saw universal childhood

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[6]David H. Frankel, *U.S.A.: Vaccine debate continues*, 341 THE LANCET 1270 (1993). (Average immunization rate of children in "uniform purchase" states is 65 percent compared with 53 percent for other states). Alphonse G. Holtmann, *The Economics of United States Immunization Policy* (in the forthcoming proceedings, edited by Mark V. Pauly, of the Conference on The Economic Underpinning of Vaccine Supply, National Vaccine Advisory Committee, Centers for Disease Control and Prevention and National Vaccine Program Office, (Washington, D.C., Nov. 12, 1993) (use is with permission of author) (Rates in universal states are nine to ten percentage points higher than elsewhere when effects of poverty, day care use and certain other factors are controlled. The author notes that his study does not prove a causal relationship between universal distribution and the higher rates, but that assertions that universal states do not have higher rates are based on inappropriate techniques.)

vaccine distribution as an essential component of their efforts to protect residents from communicable diseases. This strong reliance on public financing and distribution of vaccines for all children was present whether a state relied mostly on private or public providers to immunize children, or combinations of both.

In states with relatively few publicly-funded sources of pediatric primary care, supplying private physicians with free vaccines was seen as the only way to reach resident children. In states with more evenly mixed private and public sources of primary care universal distribution was seen as a way of minimizing the negative effect that vaccine costs would have on the accessibility and quality of health care, by keeping children who might otherwise be referred with their private-sector care-givers and by lessening the immunization burden on public sites.

For most of the immunization program directors, the free vaccines helped them bridge the gulf that often exists between private practitioners and the public officials who are responsible for preventing communicable diseases. Program directors commonly referred to the private practitioners that participated in their programs as partners in the disease prevention. One director characterized the practitioners as "an extension of our department" while others contrasted support from "their" private sector physicians with adversarial relationships experienced in some other states. Directors in New Hampshire, North Carolina and Washington cited strong physician support during consideration in their state legislatures of universal distribution and other immunization program initiatives. In three of the twelve states, universal vaccine distribution was viewed as an affordable alternative to the cost of establishing an extensive public health system.

In eight of the states universal vaccine distribution was seen as potential vehicle for influencing providers' clinical and administrative practices and thereby reducing missed opportunities. The free vaccines were found to open doors to presentations at in-state medical meetings and informal discussions with physicians and their staffs about immunization contraindications and other clinical issues.

Systemic barriers to immunization. In none of the twelve states was universal vaccine distribution seen as a remedy, in itself, for underimmunization. Rather it was seen as a successful remedy for the problem that it specifically addresses, namely, high vaccine costs. Primary health care in the United States is delivered through a complex mix of publicly-funded and private sector services. This mix in itself is considered a barrier because parents may be confused or discouraged by navigating multiple sources of care with differing financial and non-financial barriers, and may delay immunizations until they face school-entry requirements. Access to care is often uncertain and sufficient population-based information that would help locate children who are not protected from vaccine-preventable diseases does not now exist.

Eleven of the twelve study states reported that the fragmented and incomplete nature of the primary health care service system created major barriers to immunization. The

exception was Vermont, where state-sponsored insurance for children in families up to 225 percent of poverty is available. In this state, 90 percent of children were reported to have a medical care "home." But elsewhere, inadequate service capacity was seen as a substantial problem.

Specific health services problems were found to be:

- Access problems reflecting uneven distribution of physicians, high turnover rates of public health nurses and other factors
- Inadequate hours at immunization sites
- Poorly-developed or deteriorating public health systems

Eight states identified inadequate information on the immunization status of children, at the provider level and at the health system level, as a substantial barrier. While six states are developing population-based, state-wide computerized immunization information systems, all reported that putting these systems in place was taking much longer than anticipated.

Six states identified inadequate public information about immunization and insufficient outreach to families as barriers. None of the universal distribution states identified out-of-practice immunization referrals as a factor in underimmunization, with two important exceptions. Both North Carolina and Washington State experienced substantial immunization referrals before they adopted universal distribution (in 1994 and 1990 respectively).

CONCLUSIONS

In all the universal states, vaccine costs were perceived as a significant problem that had been eliminated, throwing into sharper relief the inadequacy of primary pediatric health care services, inadequate information on the immunization status of young children and other major factors in the underimmunization of young children.

However, the study indicates that state agencies have the capacity to design and administer childhood vaccine distribution systems that ensure safe and timely delivery of vaccines and that are acceptable to private as well as public practitioners. What the study did not find is also instructive. Parental attitudes, sometimes blamed for underimmunization, were considered a relatively unimportant problem in the states. And immunization referrals of private-sector patients were not reported, except in several states before their adoption of universal distribution.

Table 1

VACCINATION STATUS OF CHILDREN AT AGE TWO IN TWELVE UNIVERSAL VACCINE DISTRIBUTION STATES IN 1989, 1990†

	1992-93 survey: Percentage of children that had received 4 DTP, 3 OPV, 1 MMR vaccine doses at age two. [source: Centers for Disease Control and Prevention of U.S. Public Health Service]	**1993-94 survey: Percentage of children that had received 4 DTP, 3 OPV, 1 MMR vaccine doses at age two** (source: state immunization program directors)	**1993-94 survey: Percentage of children that had received vaccine series or single antigens, as indicated, at age 2 (source: state immunization program directors)**
Alaska	59.7	62.8	interior: 73.5 (4 DTP, 3 OPV, 1 MMR)
Connecticut	63.6	71	
Idaho	53.8	64	
Maine	70.1	71	97: (3 DTP, 3 OPV, 1 MMR*)
Massachusetts	69.3	71	96: 3 DTP* 74: 4 DTP 91: 1 MMR 86: 3 OPV
New Hampshire	70.3	68.1	
North Carolina	na	58.7	
Rhode Island	63.5	68.9	97.4: 3 DTP* 86: 3 OPV 88.3 1 MMR
South Dakota	61.7	60.3	
Vermont	70.4	70.4	92: 3 DTP* (1993-1994)
Washington	50.5	54.6	
Wyoming	63.1	+/- 60-64	

† Based on data collected for school enterers 1992-93, 1993-94.

Table 2

CHARACTERISTICS OF TWELVE STATE UNIVERSAL CHILDHOOD VACCINE DISTRIBUTION PROGRAMS 1994

	Percentage of vaccines administered by private providers (estimated)	Birth cohort (annual)	Vaccine loss (annual rate of vaccines not accounted for)	Vaccine Distribution System (after vaccines received from manufacturer at state depot)	Annual Program Cost*, 1993-1994 (in millions) (Section 317 grants for vaccines, personnel, Immunization Action Plan) (numbers may not add due to rounding)
Alaska	40	12,000	5	State agency ships directly to providers outside state capitol (site of agency); providers in capitol pick up from agency.	Total: $ 5.4 Federal: 2.9 State: 2.5
Connecticut	85	50,000	5 ≤	State agency ships to local health agencies for provider pickup; some shipping directly to providers.	Total: $ 4.2 Federal: 2 4 State: 2 4
Idaho	25	17,000	1.65	State agency ships to local health agencies; providers pick up vaccines at local agencies. Some shipping directly to providers.	Total: $ 1.8 Federal: 75% State: 25% (estimated federal, state shares)
Maine	80 - 85	16,800	± 2	State agency ships directly to providers. Providers missing an order or needing additional vaccines before next order may get them by sending courier to agency.	Total: $ 3.7 Federal: 2.8 State: .9
Massachusetts	80-85	87,000	≥ 10	State agency ships to six regional depots, which are pickup points for local health boards. Providers pick up vaccines from boards. Regional depots also contract with visiting nurse association for direct delivery to some providers.	Total: $19.5 Federal: 5.8 State: 14. ** **Includes costs of state manufacture of certain vaccines

	Percentage of vaccines administered by private providers (estimated)	Birth cohort (annual)	Vaccine loss (annual rate of vaccines not accounted for)	Vaccine Distribution System (after vaccines received from manufacturer at state depot)	Annual Program Cost*, 1993-1994 (in millions) (Section 317 grant* for vaccines, personnel, Immunization Action Plan) (numbers may not add due to rounding)
New Hampshire	90	±15,000	1 ≤	State agency ships directly to providers; small amount of pickup from agency, by providers who cannot wait for a shipment.	Total: $ 3.5 Federal: 2.0 State: 3 Medicaid .2 Private: .9** **voluntary contributions to vaccine purchase fund by insurers in state
North Carolina	50	110,000	nc n.a. (universal distribution began January, 1994)	State agency ships directly to providers.	Total: $20.2 Federal: 8.9 State: 11.3
Rhode Island	85	15,000	5 ≤	State agency ships to hospital pharmacies. Providers pick up vaccines from pharmacies.	Total: $ 2.8 Federal: 1.9 State: .9
South Dakota	60	10,700	5 ≤	State agency ships directly to providers.	Total: $ 2.1 Federal: 2.1 State: .3**** ****Immunization also uses unspecified share of community nursing funds totaling $0.68 million
Vermont	90	8,300	5 ≤	State agency ships to district health agencies. Providers pick up vaccines from district agencies.	Total: $ 1.2 Federal: 66% State: 33% (estimated federal, state shares)

	Percentage of vaccines administered by private providers (estimated)	Birth cohort (annual)	Vaccine loss (annual rate of vaccines not accounted for)	Vaccine Distribution System (after vaccines received from manufacturer at state depot)	Annual Program Cost*, 1993-1994 (in millions) (Section 317 grants for vaccines, personnel, Immunization Action Plan) (numbers may not add due to rounding)
Washington	65	79,000	2 ≤	State agency ships directly to providers.	Total: $ 7.9***** Federal: 4.6 State: 3.3 *****Personnal and Immunization Action Plan funds not included
Wyoming	50	6,700	1 ≤	State agency ships directly to providers outside state capitol (site of agency). Providers in capitol pick up from agency.	Total: ±$ 1.2 Federal: 95% State: 5% (estimated federal, state shares)

Table 3

FEDERAL VACCINES FOR CHILDREN PROGRAM

Program name and statutory citation	P.L.103-66, §13631, establishing new §1928 of the Social Security Act
Administering agenc(ies)	Federal: Centers for Disease Control and Prevention and Health Care Financing Administration; State: State health agency and or Medicaid program
General program structure	•Statutory entitlement in four classes of federally-eligible children for all pediatric vaccines recommended by the federal Advisory Committee on Immunization Practices (ACIP). Vaccines are free for the children and for their health care providers. •Pull federal financing for vaccines and direct delivery to participating health care providers of eligible children. Participation is voluntary. •Statutory entitlement in states to buy pediatric vaccines at federal contract prices, for children who are not federally-eligible. States may use federal grants, other financing to pay for vaccines. Vaccines are free for the children and their health care providers. •Prices for basic series of vaccines (those under contract in May 1993) capped, with annual inflation adjustments.
Eligibility for vaccines (federally-eligible children)	•Medicaid-eligible •Uninsured •Indian •Uninsured for immunizations, if immunized at federally-qualified health centers or rural health clinics
Eligibility for vaccines (state-eligible children)	At state option, any (or all) children not federally-eligible for vaccines may receive free vaccines purchased under the federal contract.
Authorized appropriations level	As needed for purchase and delivery of all vaccines for all federally-eligible children
State duties	•Encourage participation by private providers, providers serving Indian children; identify providers who can communicate with parents with limited English, of eligible children
Provider duties	•Assess eligibility status of child on basis of parents' self-disclosure form. No provider verification or redetermination of eligibility required. •Follow ACIP vaccine schedule (as a physician deems appropriate). •No charge for federal- or state-financed vaccines; charge only regional fee, set by the Department of Health and Human Services, for vaccine administration for federally-eligible children. Waive fee for families who cannot pay it.

Table 4

CURRENT VACCINE PRICES FEDERAL CONTRACT AND PRIVATE SECTOR OCTOBER, 1994*

Vaccine or product**	Centers for Disease Control (Federal Contract): Cost per dose	Private sector: cost per dose	Centers for Disease Control (Federal contract): Cost for vaccines recommended from birth to age two.†	Private sector: Cost for vaccines recommended from birth to age two.
Oral Polio Vaccine (OPV)	$ 2.21	$ 10.47	$ 6.63 (3 doses)	$ 31.41 (3 doses)
Diphtheria-Tetanus-Pertussis (DTP)	$ 5.96	$ 10.10	$ 23.84†† (4 doses)	$ 40.40†† (4 doses)
Measles-Mumps-Rubella (MMR)	$ 15.71	$ 25.87	$ 15.71 (1 dose)	$ 25.87 (1 dose)
Haemophilus influenzae type B (HIB)	$ 4.17	$ 15.13	$ 12.51 - $ 16.68 (3-4 doses, depending on vaccine types)	$ 45.39 - $ 60.52 (3-4 doses depending on vaccine type)
Hepatitis B (Hep B, HBV)	$ 7.09	$ 16.17	$ 21.27 (3 doses)	$ 48.51 (3 doses)

* Based on information from the Centers for Disease Control and Prevention, U.S. Public Health Service

** Certain vaccines, such as those for high-risk patients, are not shown

† Vaccine doses are as recommended by the American Academy of Pediatrics (AAP) and the federal Advisory Committee on Immunization Practices (ACIP). Doses are to be administered at specified intervals, from birth through 18 months of age. Additional doses are recommended by ages 4 years to 6 years, before a child enters school, as follows: OPV (fourth dose); DTP (fifth dose††); MMR (second dose recommended by ACIP; AAP recommends second dose by age 12, preferably before entry to middle school or junior high).

†† Fourth and fifth doses may be Diphtheria-Tetanus-acellular pertussis (DTaP), at per-dose cost of $ 9.81 (CDC) or $16.09 (Private sector).

ADDITIONAL COMMENTS RECEIVED ON THE
VACCINES FOR CHILDREN PROGRAM

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF HEALTH

Patricia A. Nolan, MD, MPH
Director of Health

3 May 1995

The Honorable John H. Chafee
Dirksen Senate Office Building
Room 567
Washington, DC 20510

Dear Senator Chafee:

The Vaccines for Children (VFC) Program, since its implementation in October 1994, has become an integral and important part of Rhode Island's Immunization Program.

Rhode Island has always been a universal vaccine distribution state, providing free vaccine to all children regardless of income or insurance status. Both state and federal funds are used to support this effort. The VFC Program has allowed Rhode Island to consolidate and augment this important public health policy position in the following ways:

1) Assurance of consistent availability of federal funds to purchase vaccine for all eligible children (approximately 40% of Rhode Island children qualify for such VFC support);

2) Assurance that new vaccines, such as the one for prevention of Chicken-Pox, are made available as recommended for all children regardless of ability to pay or insurance status;

3) Assurance that advocacy efforts to garner additional state funds to make available new vaccines for non-VFC eligible children are taken seriously; what is considered an essential entitlement for children in poverty must surely be made available to other children as well;

4) An extremely important benefit of the VFC Program for Rhode Island is the guarantee that vaccine can be purchased by the state at the federal contract rate, thus ensuring the biggest bang for the buck. This provision allows Rhode Island to purchase enough vaccine to consistently implement a universal vaccine policy. Without this provision, Rhode Island would be unable to continue providing vaccine for all children.

CANNON BUILDING, Three Capitol Hill, Providence, Rhode Island 02908-5097
Telephone 401-277-2231, FAX 277-6548

We firmly believe that Rhode Island and the other New England states have documented high immunization coverage rates over the years in large part as a direct consequence of free vaccine availability. In our conversation with your staff last week, we discussed other components of the immunization program, including education of providers and parents. We appreciate the support you have shown for this important public health effort.

Sincerely,

Patricia A. Nolan, MD, MPH

Patricia A. Nolan, MD, MPH
Director of Health

May 2, 1995

The Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood;

I strongly urge you to support the continuation of the Vaccines for Children Program, and other related legislation that will protect the health of our children and the general population against diseases that are capable of disabling and sometimes killing a child or adult. Strong local and federal efforts, teamed for complete coverage of children's immunizations, are necessary for the current and future health and welfare of our people.

As you may be aware, there is a diptheria epidemic in the former Soviet Union, partially as a result of the breakdown of consistent and coordinated federal and local efforts at prevention of this horrible disease. As an elected official charged with oversight of federal efforts that benefit the country and the state, I expect that you will consider this matter very, very carefully, and to ultimately support efforts and funds to support Vaccines For Children Program.

Thank you.

John Jenkins FNP
DAVID NEWMAN

(503) 731-4000
FAX (503) 731-4078
TDD-Nonvoice (503) 732-4031

Oregon

DEPARTMENT OF
HUMAN
RESOURCES

HEALTH DIVISION

May 2, 1995

The Honorable Senator Bob Packwood
Chair, Senate Finance Committee
259 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood:

The Oregon Health Division strongly supports the Vaccines For Children (VFC) Program as a critical piece of the Immunization Program in Oregon. The Division, which coordinates all publicly funded immunization efforts in the state, believes VFC promotes a unique partnership between private health care providers and federal, state and county governments to immunize approximately 60 percent of young Oregonians. The Vaccines For Children Program has been endorsed by the Oregon Preschool Immunization Consortium, a private/public partnership of over 40 organizations dedicated to achieving the Oregon Benchmark Goal of age-appropriately immunizing 90 percent of Oregon children by the year 2000.

One key strategy for improving immunizations rates is to ensure that all children are immunized as part of their routine medical care. A major benefit of VFC is that it allows children to receive immunizations in their private physician's office, and eliminates the need for referral to a county health department for vaccination. We know that such referrals mean parents often delay care for several months and sometimes they do not return for care at all. We are in the final stages of implementing VFC in the private sector, and Oregon providers are excited about how the program facilitates comprehensive well child care and reduces the need for referral to public clinics.

While many VFC-eligible children could receive immunizations at county health departments through the 317 program, there are thousands of other Oregon children immunized through VFC who would not be eligible for state-supplied vaccine any other way. The Division, working through the Immunization Consortium, is attempting to increase the capacity of private sector immunization services. Our concern is that a repeal of VFC would be a substantial blow to that working public/private partnership.

We respectfully request your consideration of these facts in your deliberations, and we hope you will support the Vaccines For Children Program as it assists the Division in our mission to improve the health of Oregon's children and adolescents.

Sincerely,

Grant Higginson, M.D.
Acting State Health Officer

David Fleming, M.D.
State Epidemiologist

John A. Kitzhaber
Governor

800 NE Oregon Street #2
Portland, OR 97232-216
(503) 731-4030 Emergenc
(503) 252-7978 TDD
Emergency

24-36 (Rev. 12-94)

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

May 3, 1995

The Honorable Bob Graham
United States Senate
Washington, DC 20510

Dear Senator Graham,

I am writing to you on behalf of the children of the state of Florida in support of the Vaccines for Children (VFC) program. VFC is sound public policy and is instrumental in advancing the adequate immunization of 90 percent of Florida's two-year old children by the year 2000 and meeting the antigen-specific coverage goals by 1996. I urge you to support Vaccines for Children and to protect the program from repeal.

Physicians across Florida have embraced the VFC program. The VFC Program has enrolled over 1,500 public and private sites. These sites represent over 3,000 doctors and other health care professionals such as ARNPs and physician's assistants. Approximately 300 new private providers have enrolled in VFC since it began on October 1, 1994, usually as the result of word-of-mouth recommendations from fellow colleagues already enrolled in the program.

It is this outreach to the private physician community that has proven to be one of the most significant accomplishments of VFC. VFC has received strong support from the Florida Medical Association, The Florida Academy of Family Physicians, The Florida Pediatrics Society, The Florida Osteopathic Medical Association, The Florida Association of Community Health Centers and Florida's county public health units. These organizations are influential advocates for Florida's children, and all of them understand the importance of having vaccine readily available and have voiced their support for VFC.

There are public and/or private VFC sites in every single county in Florida. VFC has increased the availability of culturally sensitive immunization services for historically hard-to-reach patients. For example, in Miami there are 237 enrolled private provider sites in addition to the Dade County Public Health Unit. Sixty-five different Miami zip codes have at least one enrolled private provider, and a number of zip codes have multiple enrolled providers. This vaccine distribution infrastructure has been built with a great deal of effort and care and has become a valuable resource It is not in the interest of our children to dismantle what has become so valuable to them.

Because the legislation which authorizes VFC empowers CDC's Advisory Committee on Immunization Practices (ACIP) to approve new vaccines and vaccination schedules, these recommendations can be implemented directly without being subject to fluctuations in annual appropriations. VFC makes it possible to bring the benefits of new vaccines like the one for chicken pox to Florida's children and allows Florida to be prepared for emergency situations like epidemics. In addition, the Florida immunization program has used VFC computer hardware and software systems to redesign and significantly strengthen our ability to monitor and control vaccine distribution and usage.

During its 1994 session, the Florida Legislature relied on the Congressional promise of free vaccine through VFC and reduced the Medicaid budget for vaccines by over $3,500,000. Therefore, Medicaid will not have funds to reimburse physicians for the vaccines they are purchasing with their own funds to immunize Medicaid children. A Medicaid default of this proportion would constitute a serious breach of faith with the Medicaid provider community. In addition, Medicaid children who would no longer be immunized in private physicians offices would likely turn to county public health units for immunizations. This would create both a missed opportunity to immunize a child in the physician's office and a totally unanticipated workload on the county public health system for which it is neither funded nor staffed.

I can assure you that Florida has implemented the VFC program in an outstanding manner to the undoubted benefit of Florida's children. If the federal government repeals the program, Florida will be hard-pressed to deny children vaccines, and parents and providers will surely look to the state to continue the program. It is in the best interests of the state and our children to maintain the VFC program and I hope you will strongly support its continuance.

Sincerely,

Richard G. Hunter, Ph.D.
Deputy State Health Officer

RGH/HTJ/AS
[illegible]
[illegible]

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Gaston Caperton
Governor

Gretchen O. Lewis
Secretary

May 1, 1995

The Honorable John D. Rockefeller IV
The United States Senate
109 Hart Senate Office Building
Washington, DC 20510

Dear Senator Rockefeller:

Thank you for your continuing quest to ensure that West Virginians and all other Americans have access to adequate medical care. As you know, preventive health care is central to maintaining a healthy population. In West Virginia and the nation, the Vaccines for Children (VFC) program is playing a major role in keeping our children free of preventable diseases. VFC has greatly aided West Virginia's Immunization Program in its effort to immunize children against nine infectious diseases.

VFC is helping to strengthen the public-private partnership in health care in West Virginia. Before VFC there were 135 private health care providers administering readily available state-supplied vaccines and, as of today, there are 240 private providers giving free vaccines to West Virginia's children. With an estimated 62,000 uninsured children in West Virginia, this partnership with the private medical community is essential to the vaccine delivery system. As a result, VFC allows us to reach kids who otherwise would likely not get properly vaccinated. Although this is of invaluable benefit to the immunization delivery system, it is not the only reason that VFC is good for West Virginia and the nation. Families maintain their medical home and VFC allows the option for the state to move to a universal purchase system whereby vaccines are provided for all children regardless of method of payment.

BUREAU FOR PUBLIC HEALTH
Building 3, Room 518, State Capitol Complex
Charleston, West Virginia 25305-0601
Telephone: (304) 558-2971 FAX: (304) 558-1035

The Honorable John D. Rockefeller IV
May 1, 1995
Page Two

It is estimated that for every $1 invested in vaccines, $30 is saved in health care costs. Retaining the VFC program and the accessibility it provides to preventive health care is a win-win proposition. We can protect West Virginia's children and maximize health care spending. A repeal or modification of the VFC program would result in a loss of credibility with private providers and parents. I urge you and all members of the Senate Finance Committee to continue the support of the VFC program.

Sincerely,

William T. Wallace, Jr., MD, MPH
Commissioner
Bureau for Public Health

The Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood;

I strongly urge you to support the continuation of the Vaccines for Children Program, and other related legislation that will protect the health of our children and the general population against diseases that are capable of disabling and sometimes killing a child or adult. Strong local and federal efforts, teamed for complete coverage of children's immunizations, are necessary for the current and future health and welfare of our people.

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Thank you.

Children deserve proper immunization, regardless of income

Susan Blake MD

Edwin W. Edwards
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS
Rose V. Forrest
SECRETARY

May 2, 1995

Honorable John Breaux
SH 516 U.S. Senate
Washington, D.C. 20510

Dear Senator Breaux:

I'm writing to inform you of the importance of the Vaccines for Children (VFC) program for Louisiana. This program supplies federally-purchased vaccines for children who are uninsured, Medicaid-eligible, Native American, or who receive care through a Federally Qualified Health Center.

In Louisiana, this program is currently providing free vaccine to children seen in public health clinics, reducing the state funds necessary to provide for the large number of uninsured children in Louisiana. With CDC vaccine grant funds reduced sharply this year and an unclear future for Medicaid in Louisiana, it is clear that we can not provide vaccine to the uninsured population in Louisiana without VFC.

Our Immunization Program is very close to implementing a statewide distribution system to provide VFC vaccine to private medical providers. The outreach efforts to prepare the private medical community for VFC has resulted in a new sense of goodwill and cooperation between public and private providers. This provides a basis for the collaboration necessary in the ongoing changes in the Medicaid system in Louisiana. If VFC is lost, this cooperative spirit will be severely damaged. The private sector will believe that public health care is unreliable and an unfit partner for collaboration.

In summary VFC not only provides needed vaccines to Louisiana's children, but also to helps us continue to move toward a cooperative, collaborative system of health care in Louisiana.

If you have questions about the VFC program in Louisiana, please call Dr. Meg Lawrence at (504) 568-5015. Thank you for your attention.

Sincerely,

Eric T. Baumgartner, M.D.
Assistant Secretary and
State Health Officer

ASSISTANT SECRETARY • OFFICE OF PUBLIC HEALTH
P.O. BOX 3214 • BATON ROUGE, LOUISIANA 70821 • PHONE - 504/342-8092 • LINC 421-8092 • FAX 342 8098

NORTH DAKOTA
STATE DEPARTMENT OF HEALTH
AND CONSOLIDATED LABORATORIES
600 E. Boulevard Avenue
Bismarck, ND 58505-0200

OFFICE OF
STATE HEALTH OFFICER
701-328-2372
FAX 701-328-4727
TDD 701-328-2068

April 28, 1995

Senator Kent Conrad
724 Senate Hart Building
Washington, DC 20510

Dear Senator Conrad:

I would like to express my support of the federal Vaccine for Children program. The North Dakota State Department of Health & Consolidated Laboratories has been able to use the additional funds and opportunities available to us through the Vaccine for Children program to enhance the immunization practices throughout the state. North Dakota has traditionally aggressively pursued immunization of its children. After the tax cutback measure in 1989 we were not able to continue to supply all vaccines to physicians. We saw a shift of responsibilities from physicians to public health units for immunization with added confusion about immunization. We noted a marked increase in the cost of vaccines to self pay patients. We noted a decrease in the documented immunized rate. The addition of the Vaccine for Children has allowed us to become more consistent with our vaccine practices and develop a Prevention Partnership with practicing physicians.

As a practicing physician, who practiced when vaccines were provided and we were able to give immunizations to children in the office prior to 1989, then one who experienced the turmoil of patients and the added costs and lack of record keeping that resulted when patients could not be immunized in the office, I am very happy to be able to provide vaccines so that all children can be immunized. A cutback in the Vaccine for Children program would probably again take vaccine out of the physicians offices in this state. This would result in renewed confusion, the impression that the State Department of Health is unreliable as a source of vaccine and therefore not interested in the prevention of childhood illnesses, and loss of immunization rates as well as inconsistency in immunization reporting.

North Dakota has not had a case of measles since 1987. We have demonstrated a marked diminution of meningitis caused by Haemophilus influenzae Type B in the infants. We have had no cases of this disabling, life threatening disease since 1991. I have enclosed graphs demonstrating our successes in measles and Haemophilis influenzae Type B. These are results of our active vaccine program. I think it would be detrimental to the health of the population of this state to see the Vaccine for Children program cut back in any way.

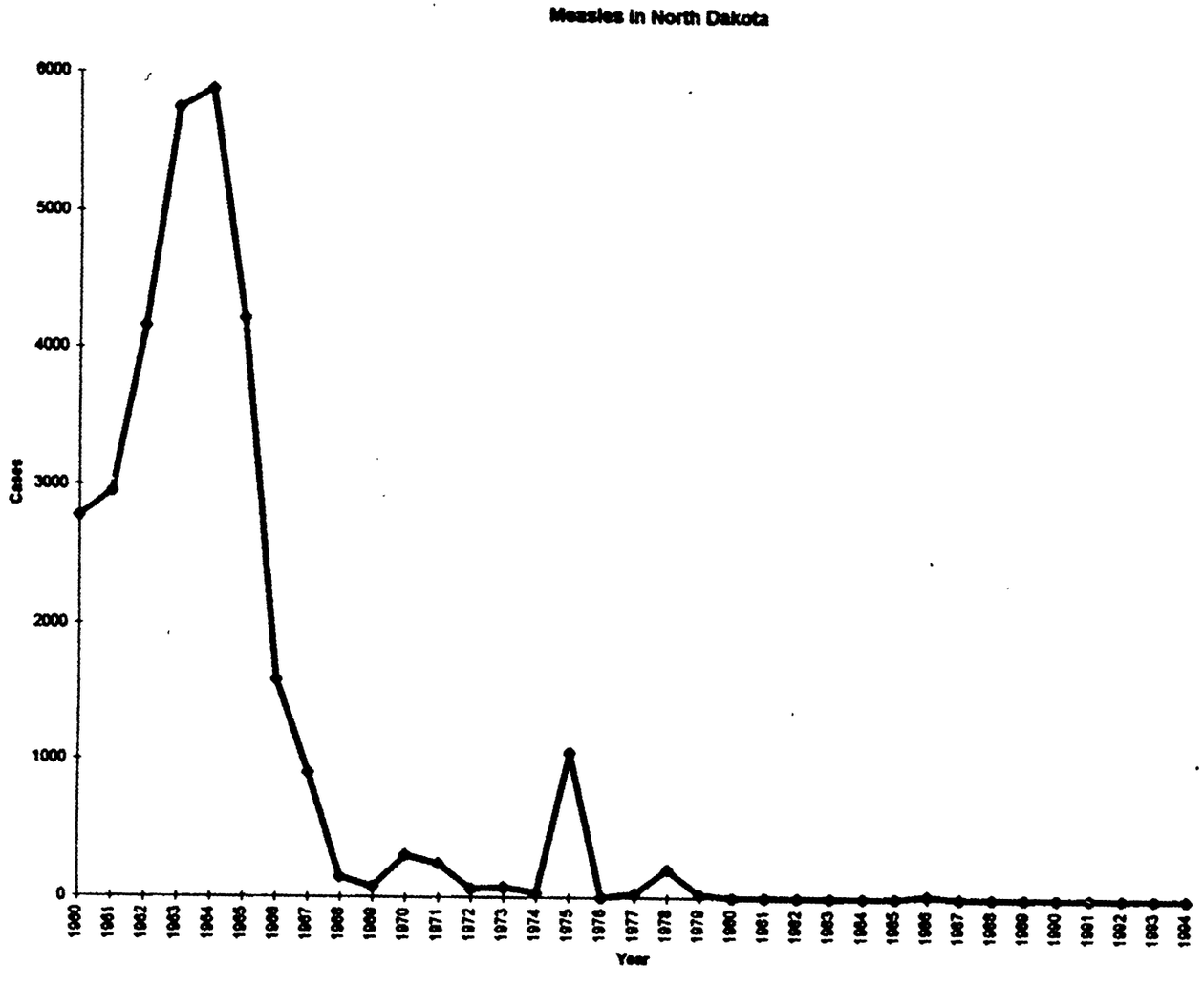
Prevention efforts are always a prime target for cutbacks as their cost benefits are somewhat difficult to predict. Prevention programs work in silence when they are working and are easily ignored. They only draw the attention of the public when they are ineffective and disease results because of the absence of the preventive effort.

I appreciate your support in health-related matters and will be happy to meet with you or your staff to discuss this further.

Sincerely,

John R. Rice, M.D.
State Health Officer

JRR:lrr
Enc.


Measles in North Dakota
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4000
3000
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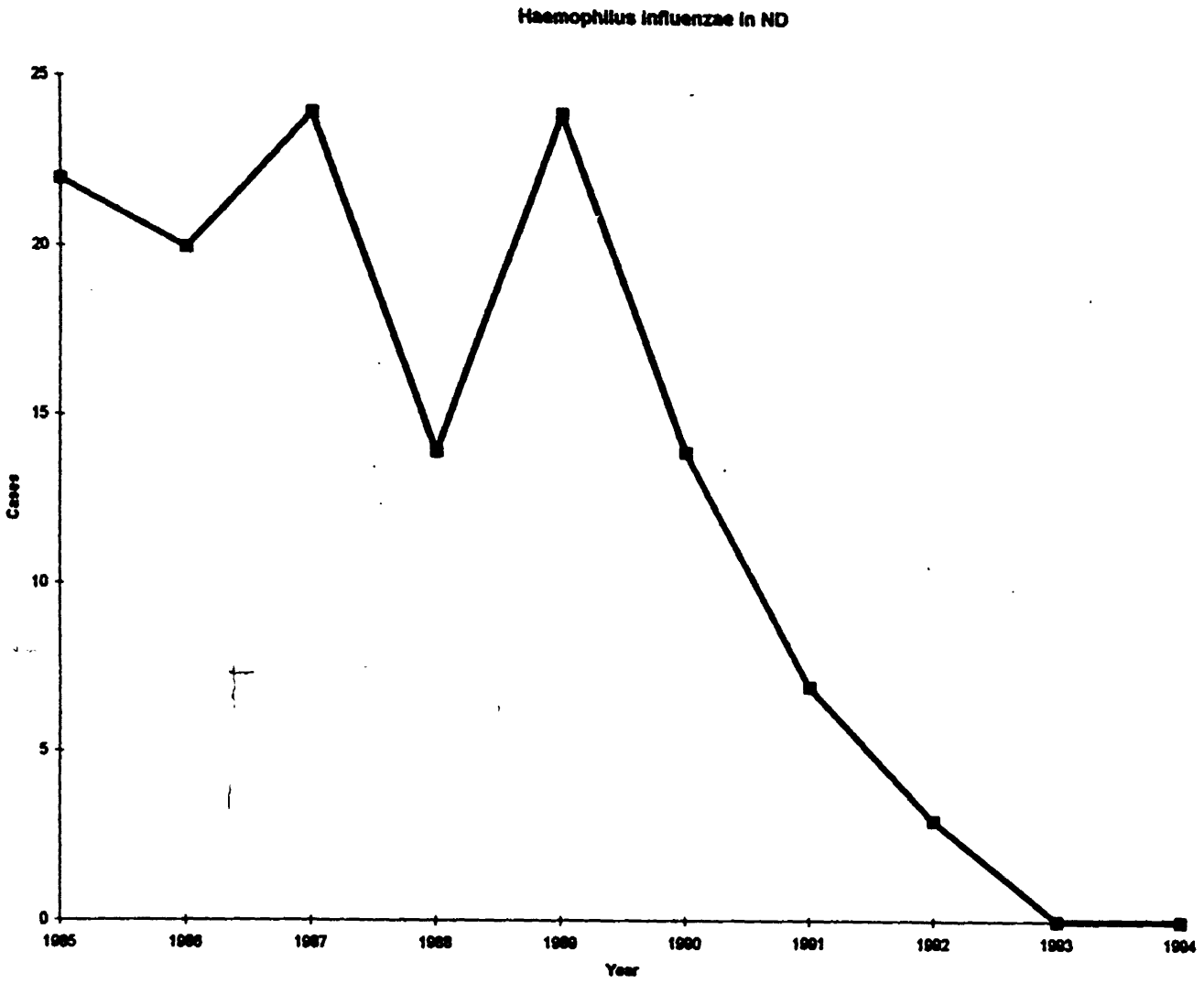
Haemophilus influenzae in ND
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15
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Cases
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1986
1987
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1989
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1991
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1993
1994
Year
Cases

May 2, 1995

The Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood;

I strongly urge you to support the continuation of the Vaccines for Children Program, and other related legislation that will protect the health of our children and the general population against diseases that are capable of disabling and sometimes killing a child or adult. Strong local and federal efforts, teamed for complete coverage of children's immunizations, are necessary for the current and future health and welfare of our people.

As you may be aware, there is a diptheria epidemic in the former Soviet Union, partially as a result of the breakdown of consistent and coordinated federal and local efforts at prevention of this horrible disease. As an elected official charged with oversight of federal efforts that benefit the country and the state, I expect that you will consider this matter very, very carefully, and to ultimately support efforts and funds to support Vaccines For Children Program.

Thank you.

Sincerely,

Lydia Villegas MD

PS. Senator Packwood, protecting against diseases with vaccination is the best form of ensuring the health of America's future.

South Dakota HEALTH 2000

DEPARTMENT OF HEALTH

OFFICE OF THE SECRETARY
445 East Capitol Avenue
Pierre, South Dakota 57501-3185
605/773-3361 FAX: 605/773-5683

May 2, 1995

The Honorable Larry Pressler
United States Senate
SH-243 Russell Building
Washington, DC 20510

Dear Senator Pressler:

Thank you for having staff available to meet with our Department of Health contingent last week to discuss public health in South Dakota. Our visit coincided with the Association of State and Territorial Officers (ASTHO) annual Hill Days, so we were able to bring back home a unique perspective on the federal "culture" and how changes in Congress will impact public health not only in our state but in the nation as well. As a follow-up to our visit, I wanted to summarize some of the issues we highlighted in our conversation with your legislative assistant Stephanie Lindquist.

We concur with ASTHO's position that the Preventive Health and Health Services and Maternal and Child Health Block Grants along with the CDC Immunization Program are appropriations priorities. These block grants along with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), constitute a majority of the federal funding received by our department to carry out core public health activities in the state. These block grants have provided us with the flexibility to address priority health issues within South Dakota and at a minimum, maintaining level funding to both of these programs is vital to continuing our mission.

Immunizations are also a priority. For every dollar spent on immunization, at least $8.80 in direct medical costs is saved. This constitutes a wise investment for our state and our nation. South Dakota receives funding through two federal fund sources, the CDC 317 program and the Vaccines for Children program, for vaccine purchases and administration. With the trend of substantially increasing vaccine costs over the past decade and an increase in the number of children served, it is ever more urgent that states receive adequate resources for assuring high immunization levels in preschool and school-age children.

Finally, I would offer our department's assistance in providing you and your staff with information on assessing the impact of block granting proposals on South Dakota's public health delivery system. Presently, we are watching with a great degree of interest the family nutrition block grant, a component of H.R. 4, as it moves on to the Senate for debate. While we are supportive of public health block grants, we would rather see categorical programs such as WIC combined with related health programs rather than welfare programs. We will be providing additional information on the WIC program to Ms. Lindquist and look forward to additional correspondence with your staff on the block granting initiatives which will have a significant impact on our state.

Very truly yours,

Barb Smith

Barbara A. Smith
Secretary of Health

Oklahoma State Department of Health
1000 NE 10th St. · Oklahoma City, OK 73117-1299
J.R. Nida M.D., Commissioner

The Honorable Don Nickles
U.S. Senate
Washington, D.C. 20510

Dear Senator Nickles:

I am very concerned about the possibility of modification or repeal of the Vaccine For Children Program (VFC). A total of 69% of our state's two year old population is currently immunized appropriately. This translates to approximately 14,880 (31%) of the children born each year in Oklahoma who are not protected against diseases that are preventable with vaccines. The VFC program provides the avenue for these children to receive the vaccine from their private provider.

The availability of the vaccine to the private physicians with the VFC program eliminates the cost and access barriers for approximately 56% of Oklahoma's children. Eliminating the VFC program will have a direct impact on their ability to be protected against these serious and sometimes deadly diseases.

The public and private partnership has been strengthened with our success with the VFC. All vaccine providers are working in unison toward a common goal to protect our children. Oklahoma's VFC providers submit vaccine accountability, and all vaccine orders are reviewed prior to shipment to access the legitimacy of the amount requested. Provider assessments provide the avenue to protect against misuse and fraud. If the VFC program is repealed now, after only seven months, the credibility with parents and our private providers will be lost.

I would ask consideration be given to allow the VFC program time to produce the results that are most important, the protection for our children. The Oklahoma State Department of Health has successfully implemented this valuable program with 847 vaccine providers. To date, 687 of the 1416 (49%) physicians are participating in the VFC program. On behalf of all Oklahoma VFC participants, I ask you not to repeal or modify the program now, and to please consider allowing a longer time frame to produce the results we believe the program will provide.

Sincerely,

J.R. Nida, M.D.

J.R. Nida, M.D.
Commissioner

OKLAHOMA'S 1995 IMMUNIZATION PROGRAM

Oklahoma's Immunization Program provides federally purchased vaccine for 71% of the children. The annual birth cohort is approximately 48,000 children. Each birth cohort receives a total of 613,440 doses of vaccine purchased with federal funds. These numbers are based on the results obtained from a survey of a sample of children born in Oklahoma. It is expected that 70% of these students will receive vaccine purchased with federal funds.

To date 677, of the 1416 (48%) physicians are participating in Oklahoma's Vaccines For Children program. The OSDH has expanded its existing centralized distribution system. Prior to the VFC program the Immunization Division shipped vaccine to 150 providers. This has been increased to 837 providers.

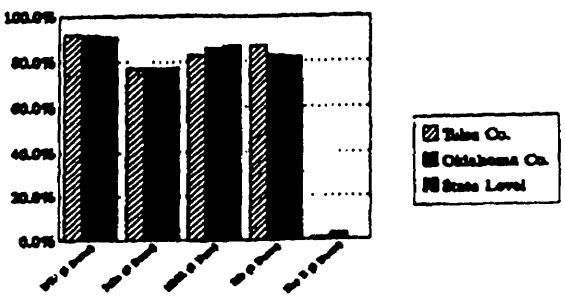
Using 317 federal funding, the Immunization Division has contracted with nine community based organizations, and Tulsa and Oklahoma County Health Departments. These contracts are to perform outreach activities and the salaries of nurses who administer the vaccines.

The "Immunization Corps" is the main infrastructure of Oklahoma's immunization program. The Corps consists of 32 nurses, clerks and outreach workers who have been assigned to help the counties increase their immunization levels. These activities include the formation of county coalitions, expanded clinic hours, local educational campaigns and special weekend clinics. The Immunization Corps is vital to the success of the immunization program. If this commitment is ended, the progress made thus far in networking with the private sector will be jeopardized.

In June, 1994, the Centers for Disease Control selected the Oklahoma State Department of Health (OSDH) as one of six areas selected as a pilot site for the national automated immunization registry. This system will furnish immunization providers with on-line access of up-to-date immunization information.

Oklahoma's two year old immunization level increased from 65% in 1993 adequately immunized to 69% in 1994. These levels were measured by a random sample survey of resident births. The same survey was also completed for Oklahoma and Tulsa Counties. The following table illustrates Oklahoma's progress toward achieving 90% immunization levels.

1994 Immunization Survey of Two Year Olds
Levels by Antigen



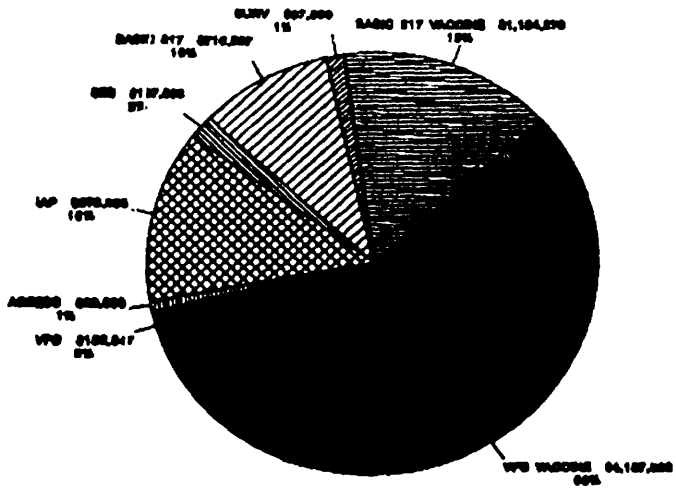
POTENTIAL IMPACT WITH REDUCTION IN 317 FEDERAL FUNDING

An example of the impact a 22% and 30% reduction in the immunization 317 federal funding is reflected in the chart below. It illustrates the current Oklahoma 1994 Two Year Old levels. A total of 70% of the vaccine received was provided through the public clinics using federally purchased vaccine. The data analysis reflects how a 22% and 30% reduction in available federal vaccine would reduce the coverage rates.

VACCINE	1994 TWO YEAR OLD SURVEY RESULTS
DIPHTHERIA, TETANUS & PERTUSSIS (DTP)	91%
- 22% Reduction	50%
- 30% Reduction	45%
ORAL POLIO VACCINE (OPV)	77%
- 22% Reduction	42%
- 30% Reduction	38%
HEAMOPHILUS INFLUENZAE TYPE b (Hib)	82%
- 22% Reduction	45%
- 30% Reduction	40%
MEASLES, MUMPS, RUBELLA (MMR)	87%
- 22% Reduction	48%
- 30% Reduction	33%
HEPATITIS B* (HEP B)	0.4%
- 22% Reduction	0.02%
- 30% Reduction	0.02%

* Vaccine recommendations for all children less than two, and the federal funding was provided in 1994. At current funding level it is projected to achieve a 90% protection rate by 1998.

OKLAHOMA 317 FEDERAL IMMUNIZATION FUNDING, BY CATEGORY, 1995



Funding Category	Amount Awarded	Percent of Total
VFC Vaccine	$4,187,528	56%
Basic 317 Vaccine	1,154,276	15%
IAP	973,205	13%
Basic 317	716,597	10%
SIIS	137,000	2%
VFC	185,947	2%
SURVEILLANCE	97,000	1%
ASSESSMENT	60,000	1%
TOTAL AMOUNT AWARDED	$7,511,553	

May 2, 1995

The Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood:

I strongly urge you to support the continuation of the Vaccines for Children Program, and other related legislation that will protect the health of our children and the general population against diseases that are capable of disabling and sometimes killing a child or adult. Strong local and federal efforts, teamed for complete coverage of children's immunizations, are necessary for the current and future health and welfare of our people.

As you may be aware, there is a diptheria epidemic in the former Soviet Union, partially as a result of the breakdown of consistent and coordinated federal and local efforts at prevention of this horrible disease. As an elected official charged with oversight of federal efforts that benefit the country and the state, I expect that you will consider this matter very, very carefully, and to ultimately support efforts and funds to support Vaccines For Children Program.

Thank vou.

Sherri Purcell RN, BSN - ortsu

P.S. Please consider that all children need vaccinations & if they are not given to low-income families, these children will not get them

May 2, 1995

The Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood;

I strongly urge you to support the continuation of the Vaccines for Children Program, and other related legislation that will protect the health of our children and the general population against diseases that are capable of disabling and sometimes killing a child or adult. Strong local and federal efforts, teamed for complete coverage of children's immunizations, are necessary for the current and future health and welfare of our people.

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Thank you.

Senator Packwood:
Immunizations need to be available to all Americans, to maintain the health of the country.
Sincerely,
A Pastor L.N.

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF PUBLIC HEALTH
CHRISTOPHER G. ATCHESON, DIRECTOR

May 2, 1995

The Honorable Charles Grassley
135 Hart Senate Office Building
Washington, DC 20510-1501

Dear Senator Grassley,

I would like to express my deep concern regarding recent information that has indicated Congress may modify or repeal the Vaccines for Children program.

The potential ramifications of such a decision would fundamentally affect the state's contemporary efforts to reach children who otherwise would likely not receive immunizations. As a direct result of the Vaccines for Children program, the total number of public providers within the state has increased from 113 providers to 206 providers which assisted the state to increase the immunization levels from 50% in 1993, to a current 77% immunization level in the public sector. In addition, the Iowa Department of Public Health is actively enrolling private physicians in the Vaccines for Children program to increase access and remove barriers to immunization. Repealing the program would fundamentally alter the current vaccine program and effectively erect barriers to timely immunization.

For example, given the existing alternatives, repealing the VFC program would likely result in the elimination of current immunization sites. The hardest hit would be those children who cannot be served in the private sector, the uninsured, and the underinsured working middle and lower income class families. As previously mentioned, this could eliminate many immunization services for many Iowa counties where no alternative immunization services are available due to financial constraints or a lack of health care providers.

It is the belief of the Iowa Department of Public Health that the VFC program is a critical contributor to enhanced cooperation between the private medical sector and the public health sector focused at removing access barriers, and reaching the ultimate goal of all children being age-appropriately immunized

LUCAS STATE OFFICE BUILDING / DES MOINES, IOWA 50319-0075 / 515-281-5787
FAX # (515) 281-4958 / TDD-DEAF SERVICES #(515) 242-6156

Furthermore, any change of plans at this time may result in a serious reduction in our credibility to the private medical sector. Credibility is a critical component in the effort to enroll private physicians, as we ask physicians to trust in our ability to supply vaccines in a reliable manner. Preliminary evidence in our state shows that private physicians may already be reluctant to enroll for this reason, in addition to the elimination of the National Vaccine Distribution Center Program.

Implementation of the VFC program in the private sector will allow the states current Medicaid Vaccine Replacement Program to be disbanded allowing for an increase of the reimbursable vaccine administration fee from $2.08 to $5.00 per dose.

I strongly encourage any efforts which may be taken to assure the continuation of the Vaccine for Children program. The Vaccines for Children program is a critical element of Iowa's immunization program.

Sincerely,

Christopher G. Atchison
Director

May 2, 1995

The Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood;

I strongly urge you to support the continuation of the Vaccines for Children Program, and other related legislation that will protect the health of our children and the general population against diseases that are capable of disabling and sometimes killing a child or adult. Strong local and federal efforts, teamed for complete coverage of children's immunizations, are necessary for the current and future health and welfare of our people.

As you may be aware, there is a diptheria epidemic in the former Soviet Union, partially as a result of the breakdown of consistent and coordinated federal and local efforts at prevention of this horrible disease. As an elected official charged with oversight of federal efforts that benefit the country and the state, I expect that you will consider this matter very, very carefully, and to ultimately support efforts and funds to support Vaccines For Children Program.

Thank you.

Yours sincerely,
Bruce Cole, director of patient information, Family M
Oregon Health Sci. Univ

I hope you will continue to support this needed program, as far more money will be spent in the future on sick kids if they aren't helped now.

Oregon Academy
of Family Physicians

12300 S W Tooze Road
Sherwood, Oregon 97140
Phone (503) 682-1846
FAX (503) 682-1454

May 1, 1995

The Honorable Bob Packwood
United States Senate
295 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood

Oregon children need your support of the Vaccine for Children (VFC) program, the fate of which may be determined at Senate hearings this week.

The Oregon Academy of Family Physicians, in concert with other members of the Oregon Preschool Immunization Consortium, have worked for several years to establish mechanisms to improve the woeful immunization status of Oregon children. The Vaccine for Children program will be a major part of our ongoing effort.

As you may know, 60% of vaccines administered to preschool children in this state are administered by private practicing family physicians and pediatricians The VFC program enables them to expand their outreach to unimmunized kids

We believe Oregon is ahead of most of the rest of the nation in having established a strong working coalition for preschool immunization. WE NEED THE VFC TO CONTINUE OUR EFFORT.

Please do everything in your power to fund this vital program It will save many millions of dollars in the long term.

Sincerely,

(Mrs) Mary Gonzales Lundy
Executive Director

HOOD RIVER COUNTY HEALTH DEPARTMENT
1108 JUNE STREET
HOOD RIVER, OREGON 97031

TELEPHONE 503-386-1115
FAX 503-386-6161

The Honorable Robert Packwood
295 Russell, Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood:

I am writing in regards to the Vaccines for Children program. I am in total support of making immunizations more available and more accessible. However, it appears that the compromises reached with the vaccine manufacturers have erected as many barriers as the program sought to eliminate.

Family Practice Physicians in our area are very reluctant to sign up for a program that requires them to purchase vaccine at "retail" for their fully insured families, and accept "free" vaccine for uninsured, underinsured, Native American and Alaska Native patients, and those with Medicaid coverage. The record keeping, the sorting of patients into one of the two groups, and the separation of the vaccine storage appears to them to be much more trouble than it is worth.

Our health department has been doing most of the immunizations for this community for a very long time. We would much prefer that children receive immunizations from their family physician. Our rates would improve immediately.

I believe that the motivation behind this program was sincere. I know that the vaccine manufacturers risk liability and want to cover the potential cost. However, it is also true that the vaccine manufacturers are making very healthy profits that they want to protect.

As unpopular as my opinion is with the current majority in Congress, I believe that the federal government should buy and distribute all vaccine for childhood immunizations. The vaccine should be available to all health care providers at no or minimal cost, and the necessary "paperwork" should be automated, so that busy physician offices and clinics can focus on giving health care. If the "best health care system in the world" can't protect our children from preventable diseases, what is our claim to fame?

Sincerely,

Anne R. Cathey

Anne R. Cathey, Director

May 2, 1995

The Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood;

I strongly urge you to support the continuation of the Vaccines for Children Program, and other related legislation that will protect the health of our children and the general population against diseases that are capable of disabling and sometimes killing a child or adult. Strong local and federal efforts, teamed for complete coverage of children's immunizations, are necessary for the current and future health and welfare of our people.

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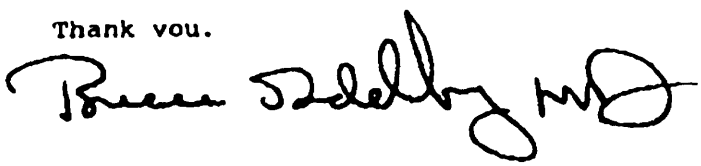
Thank you.



OREGON
HEALTH SCIENCES UNIVERSITY
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(503) 494-8382, Fax (503) 494-3878

School of Nursing
Department of Family Nursing

May 2, 1995

The Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood:

I strongly urge you to support the continuation of the Vaccines for Children Program, and other related legislation that will protect the health of our children and the general population against diseases that are capable of disabling and sometimes killing a child or adult. Strong local and federal efforts, teamed for complete coverage of children's immunizations, are necessary for the current and future health and welfare of our people.

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Thank you.
Sincerely, Marsha L Heims

Marsha L. Heims, RN
Member, Oregon Preschool Immunization Consortium
Portland, Oregon

Senator Packwood —
Wire counting on your support! Thank you
Marsha
Pediatric & Child Health & Family Health Nurse

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Schools of Dentistry, Medicine, Nursing

Clinical Facilities
University Hospital,
Doernbecher Children's Hospital,
Child Development and Rehabilitation Center,
University Clinics

Special Research Divisions
Biomedical Information Communication Center
Center for Research on Occupational and Environmental Toxicology
Vollum Institute for

State of Kansas

Bill Graves Governor

Department of Health and Environment
James J. O'Connell, Secretary

May 2, 1995

The Honorable Bob Dole
Office of Republican Leader
United States Senate
Capitol - Room S-230
Washington, D.C. 20510

Dear Senator Dole:

It is my understanding that the Senate Finance Committee will be conducting a hearing on the Vaccine for Children Program. The Vaccine for Children Program has been beneficial for Kansas because of the following:

1. It enhances accessibility for timely childhood immunizations which we know is a beneficial and cost-saving prevention activity.

2. It strengthens the private/public partnership and encourages state and local health departments to work closely with private providers to assure that children are maintained in their medical homes for comprehensive, continuous health care.

3. It saves the State of Kansas substantial dollars on vaccine purchases which enabled the state to increase the vaccine administration fee to encourage physicians to give the vaccines in their private offices.

Enclosed is the Kansas Fact Sheet on the Vaccine for Children Program which, hopefully, will help you in your deliberations. Please do not hesitate to contact me should you need any additional information. As always, we appreciate your support and assistance.

Sincerely,

Steven R. Potsic, MD, MPH
Director of Health

c: James J. O'Connell, Secretary

Office of the Director of Health
900 SW Jackson, Rm 665, Topeka, KS 66612-1290

Telephone: (913) 296
Fax: (913) 296

State of Kansas

Bill Graves Governor

Department of Health and Environment
James J. O'Connell, Secretary

VACCINE FOR CHILDREN PROGRAM AND FUNDING

FACT SHEET

The Omnibus Budget Reconciliation Act of 1993 created the Vaccines for Children entitlement program for all States and Territories to assist with vaccine purchase and to expand the health care provider base for comprehensive health care. As of this date, the State of Kansas has 144 Public Provider Sites (Local Health Departments, - there are 105 counties - Rural Health Clinics and Federally Qualified Health Centers) and 150 private Provider Sites (single and group practices).

VFC serves 4 classifications of children in the 0-18 age range:

1) Medicaid (*125,320 children estimated)

2) Children with no insurance whatsoever (*112,758 children estimated)

3) Native Americans, which includes Eskimos but not Hawaiians, (*7704 children estimated)

4) Children who have insurance but the insurance does not include vaccine, may receive VFC vaccine at a Federally Qualified Health Center or a Rural Health Center or a designate. (*15,408 children estimated)

*As of 1995, 261,190 children qualify for VFC in Kansas.

VFC totally replaced the existing Physicians Vaccine Replacement Program (Medicaid - Kansas SRS program). All Medicaid SRS health providers were invited to participate in VFC. With the savings on vaccine purchase, SRS increased the administration fees from $3 to $8 per administration in order to encourage physicians to give the vaccines in their private practices.

The Kansas Immunization Program ships vaccine to all VFC public and private providers. A third party vaccine distributor is being considered because of in-house vaccine storage liability. If the State should have to pay for distribution of State purchased vaccine, additional State funding would be a problem.

CDC is developing Vaccine Accountability Reporting Forms which are currently being piloted in 6 states which should help assess program effectiveness.

1995 VFC Direct Assistance (vaccine funding) award is $2,735,946. Total doses of vaccine provided in 1994: 399,235. Estimated total doses for 1995: 420,000.

In the event that 317 Basic Funds or VFC Funds are cut, the State will not be able to supplement with State funds, and immunizations could be severely jeopardized.

For additional information concerning any of the above, please contact Monica Mayer, Immunization Program Director at 913 296-5593.

*VFC Population Estimates and Projected Vaccine Needs, Fiscal Year 1996, Survey.

Office of the Director of Health
900 SW Jackson, Rm 665, Topeka, KS 66612-1290

Telephone: (913) 296-10(
Fax: (913) 296-12)

May 2, 1995

The Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood:

I strongly urge you to support the continuation of the Vaccines for Children Program, and other related legislation that will protect the health of our children and the general population against diseases that are capable of disabling and sometimes killing a child or adult. Strong local and federal efforts, teamed for complete coverage of children's immunizations, are necessary for the current and future health and welfare of our people.

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Thank you.

Teri Reese, SN

Illinois Department of
Public Health

John R. Lumpkin, M.D., M.P.H., Director

525-535 West Jefferson Street • Springfield, Illinois 62761-0001

May 1, 1995

The Honorable Carol Moseley-Braun
United States Senator
320 Hart Senate Office Building
Washington, D.C. 20510-1303

Carol

Dear Senator Moseley-Braun:

I would like to request your support in opposing any legislation that may be introduced that would eliminate or reduce federal funding for the national "Vaccines for Children" (VFC) program. The elimination or significant reduction in funding for the national VFC program would have considerable long-term adverse effects on immunization efforts currently underway in Illinois, including our efforts to immunize the vulnerable preschool-age population.

The importance of maintaining appropriate funding levels for the national Vaccines for Children (VFC) program cannot be overly emphasized. As you know, the VFC program was implemented just last October 1, 1994, after considerable effort by federal and state health agencies, private health provider associations, local voluntary interest groups, etc. Any elimination or significant reductions in Congressional support of the VFC program would place Illinois and other states in a precarious position, and could jeopardize children's health if federal funding cuts could not be made up by states. To illustrate the problems Illinois health officials would encounter if VFC funding is reduced, it is important to point out the following:

1) In anticipation of the national VFC program, the Illinois Department of Public Health terminated its interagency agreement with the state Medicaid program for vaccine replacement to Medicaid providers, as part of the state's "Healthy Kids" program. If the VFC Program is eliminated (or substantially reduced), Illinois' Medicaid eligible children now covered by the VFC program may be without free vaccine (or it could be in short supply), because no alternative to VFC currently exists for serving this population.

2) Approximately 60% of Illinois' children are eligible for the VFC program. Without the VFC program (or an alternative infusion of vaccines), it would be impossible to achieve the national FY 96 goal of 90% immunization coverage among two-year olds. Unless other state or federal resources could be identified to supplement the budget for vaccines, it will jeopardize the progress made in increasing immunization levels in the two-year old population. Inevitably, children would fall out of the vaccine delivery system, and the result will be a decrease in immunization levels throughout the state.

3) As a state health officer, I appreciate the flexibility that the federal VFC program affords me in implementation. In Illinois, we have been very successful in working with the private medical community throughout the development and implementation of the program, resulting in Illinois' VFC *Plus* Program. This program, an expansion of the

national VFC program, makes vaccine available to physicians to serve all underinsured children in their offices. Unlike the national base VFC Program, Illinois' VFC *Plus* Program eliminates the need for referral of underinsured children to federally qualified health centers, and thereby keeps them in their primary medical home. If funding for the national VFC program is eliminated or reduced to a public entitlement program (Medicaid enrolled only), Illinois health officials will have to curtail the VFC *Plus* Program and will lose the hard earned trust of the private medical community.

4) Parents of many children in Illinois have come to expect and depend upon immunization services at no cost or at a minimal cost through the public vaccine delivery system. Since the national VFC program became operational, many public vaccine providers have begun working more closely with the private health care providers in their community to ensure continuity in immunization services. This has resulted in the establishment, for the first time, of effective public/private partnerships in many communities. If availability of these services is interrupted by lack of funding to purchase vaccines, due to political issues, the loss of public confidence in government funded health programs will be dramatic.

In closing, I would like to emphasize that Illinois has the reputation of being very successful in accomplishing immunization-related projects. If our state is to be successful in achieving the national immunization goals of the Childhood Immunization Initiative, it is essential that the national VFC program not be repealed or drastically reduced.

Your support in opposing any legislation that would repeal this most worthy childhood program, or reduce its funding, would be appreciated.

Sincerely,

John R. Lumpkin, M.D.
Director of Public Health

cc: Michelle Gentry-Wiseman

May 2, 1995

The Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood;

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Thank vou.

I know that you will give this matter your attention as I am aware you care greatly about children's issues.

Sara Eide

May 2, 1995

The Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood:

I strongly urge you to support the continuation of the Vaccines for Children Program, and other related legislation that will protect the health of our children and the general population against diseases that are capable of disabling and sometimes killing a child or adult. Strong local and federal efforts, teamed for complete coverage of children's immunizations, are necessary for the current and future health and welfare of our people.

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Thank you.

Doreen Dittle CMA

Lane County

May 2, 1995

The Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, D.C. 20501

Dear Senator Packwood:

This letter is in support of the Vaccine For Children Program (VFC). As a public health nurse with twenty-five plus years of experience in both promoting and providing children's immunizations, I was very excited when this program was developed. I am now very concerned that a program which has the potential of helping the United States achieve its goal of having 90% of its children immunized by age two is in serious danger of being derailed before there is a chance to demonstrate its effectiveness.

In my opinion, there are two significant factors that the VFC program will address. Cost is a significant barrier to many families and few insurance programs cover this expense. Therefore, families will choose to defer the immunizations until a time that better fits their budget. Second, many health care providers do not make immunizations a major focus of office visits unless they are a part of the well child check. If physicians had the low cost vaccine in their offices, there would be fewer parents waiting until a better time according to the pocketbook to immunize their children. Also, with health care providers agreeing to participate in the VFC program, children's immunizations could play a larger part in their practices, because program participation should serve to raise the consciousness of immunizations in those practices.

I hope that the U.S. Senate will approve continuation of this program. Currently, immunization levels for children in the U.S. fall behind those of many third world countries. With all our resources, we should be among the world leaders, and Vaccines For Children will help us achieve that goal.

Sincerely,

Sandra L. Nowter, R.N., MPH
Public Health Nurse

SM:ag

LANE COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICES
(503) 687-4013 135 East Sixth Avenue, Eugene, OR 97401 TDD (503) 687-4345

OPCA
OREGON PRIMARY CARE ASSOCIATION

321 SW 6th Ave., Fifth Floor • Portland, Oregon 97204 • Tel (503) 228-8852 • Fax (503) 228-9687

May 1, 1995

The Honorable Robert Packwood
295 Russell, Senate Office Building
Washington, D C 20510

RE: Vaccines for Children Program

Dear Senator Packwood:

It has come to my attention that the House and Senate Budget committees are considering recommending the repeal of the Vaccines for Children (VFC) program. I am asking you to protect the VFC program from any attempts at repeal.

VFC is an invaluable program for Oregon as well as the nation. The VFC program is particularly effective in removing identified barriers to care for children and their families. Immunizations are not always available through the primary care provider. VFC promotes continuity of care and the ability to receive immunizations and well child care in the same setting. Ultimately, this is more convenient for the parent and assures the child will be better immunized. A second barrier to care is cost. VFC addresses this barrier by providing vaccine free of charge to vaccine eligible children. It is estimated that more than 60% of U.S. infants and children will be eligible for immunization through the VFC program. For the first time, private providers will be able to receive publically purchased vaccine in support of the national intent to significantly improve the immunization coverage level among children.

The state of Oregon is committed to the VFC program. VFC is a critical component necessary to increase the immunization coverage of Oregon's children as well as a major step to having 90% of two year olds fully immunized.

It is my belief that affordable, quality health care should be available to all Americans. Preventative care cannot begin too early, and the Vaccines for Children program assures parents that their children will be adequately protected despite their parents' income level. This is a vital service and in the current climate of spending cuts, I am requesting your full support for the VFC program.

Sincerely,

Sarah Vogel
Program Coordinator

(503) 731-4000
FAX (503) 731-4078
TDD-Nonvoice (503) 731-4031

Oregon

DEPARTMENT OF
HUMAN
RESOURCES

HEALTH DIVISION

May 2, 1995

The Honorable Senator Bob Packwood
Chair, Senate Finance Committee
259 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood:

The Oregon Health Division strongly supports the Vaccines For Children (VFC) Program as a critical piece of the Immunization Program in Oregon. The Division, which coordinates all publicly funded immunization efforts in the state, believes VFC promotes a unique partnership between private health care providers and federal, state and county governments to immunize approximately 60 percent of young Oregonians. The Vaccines For Children Program has been endorsed by the Oregon Preschool Immunization Consortium, a private/public partnership of over 40 organizations dedicated to achieving the Oregon Benchmark Goal of age-appropriately immunizing 90 percent of Oregon children by the year 2000.

One key strategy for improving immunizations rates is to ensure that all children are immunized as part of their routine medical care. A major benefit of VFC is that it allows children to receive immunizations in their private physician's office, and eliminates the need for referral to a county health department for vaccination. We know that such referrals mean parents often delay care for several months and sometimes they do not return for care at all. We are in the final stages of implementing VFC in the private sector, and Oregon providers are excited about how the program facilitates comprehensive well child care and reduces the need for referral to public clinics.

While many VFC-eligible children could receive immunizations at county health departments through the 317 program, there are thousands of other Oregon children immunized through VFC who would not be eligible for state-supplied vaccine any other way. The Division, working through the Immunization Consortium, is attempting to increase the capacity of private sector immunization services. Our concern is that a repeal of VFC would be a substantial blow to that working public/private partnership.

We respectfully request your consideration of these facts in your deliberations, and we hope you will support the Vaccines For Children Program as it assists the Division in our mission to improve the health of Oregon's children and adolescents.

Sincerely,

Grant Higginson, M.D.
Acting State Health Officer

David Fleming, M.D.
State Epidemiologist

John A. Kitzhaber
Governor

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Emergency

26-66 (Rev. 12-94)

MULTNOMAH COUNTY OREGON

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May 2, 1995

Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, DC 20510

Dear Senator Packwood:

I wanted to take this opportunity to express my concern about any possibility of modifying or repealing the VFC Program. Though public clinics are the only current VFC members in Oregon, Multnomah County Health Department has been appreciative of the vaccines and the targeted populations of the VFC program. In a recent campaign, private physicians were asked to provide free immunizations on the Saturday as well as the public sector. The state agreed to provide free replacement vaccine for any children served on that Saturday. There were 48 private providers interested in participating and signed up for the program.

I believe that the "bugs" in the system can be adequately worked out and the potential success of having more and more of our two-year-olds up to date will be greatly enhanced. The public sector can not provide immunizations alone. Another benefit to the VFC program is the improved communication with the private providers. In a recent survey, clients of private providers were twice as likely as clients of public providers to erroneously believe their child was up to date with their immunizations when they were not. VFC would enhance the system's ability to keep private providers up-to-date regarding current immunization schedules.

Please do what you can to continue to support this important program.

Sincerely,

Peggy Lou Hillman

Peggy Lou Hillman
Immunization Coordinator

AN EQUAL OPPORTUNITY EMPLOYER

ISBN 0-16-047425-6