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DEBBIE

Impact of a Large-Scale Immunization Initiative in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

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Context.—Inner-city immunization rates have lagged behind those in other areas of the country.

Objective.—To evaluate the impact of an initiative linking immunization with distribution of food vouchers in the inner city.

Design.—Retrospective analysis of immunization data gathered in 1996 and 1997.

Setting.—Nineteen Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) sites serving 30% of the Chicago, Ill, birth cohort.

Participants.—A total of 16 581 children 24 months old or younger.

Interventions.—Voucher incentives (varying frequency of food voucher issuance based on immunization status) and assessment of immunization status and referral to immunization provider.

Main Outcome Measures.—Age-appropriate immunization rates and WIC enrollment rates.

Results.—During the 15-month period of evaluation, immunization rates increased from 56% to 89% at sites performing voucher incentives. The proportion of children needing voucher incentives declined from 51% to 12%. Sites performing assessment and referral, but not providing voucher incentives, showed no evidence of improvement in immunization coverage. No difference was observed in enrollment rates between sites performing voucher incentives and those that did not.

Conclusion.—Applied in a large-scale, programmatic fashion, voucher incentives in WIC can rapidly increase and sustain high childhood immunization rates in an inner-city population.

JAMA. 1998;280:1143-1147

AFTER THE MEASLES resurgence of 1989-1991, public and private investment in immunization increased dramatically, and immunization rates have risen across the nation.¹⁻³ However, approximately 80% of unvaccinated measles cases dur-

ing the resurgence occurred among urban preschoolers,^{4,5} and immunization rates in inner cities have often lagged behind the rest of the country.^{3,6} This raised concerns that high-risk urban children might lack the minimum level of population immunity necessary to prevent outbreaks.⁷

A 6-month randomized trial in 1991 showed that varying the frequency of food voucher issuance (voucher incentives) in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) could increase measles vaccination rates among preschoolers enrolled in 6 of New York City's more than 100 WIC sites.^{8,9} These findings have been confirmed by preliminary re-

sults from 2 randomized trials elsewhere.^{10,11} Since 44% of the US birth cohort is enrolled in WIC (US Department of Agriculture, unpublished data, 1995), with age and demographic characteristics that match immunization needs, a nationwide initiative to promote activities that raise immunization coverage in WIC began in 1995, with the endorsement of the Advisory Committee on Immunization Practices (ACIP).¹² States and localities now must spend a minimum of 10% of all federal immunization funds on WIC linkages (1996 Senate Appropriations Committee Report language). A recent survey suggested that 75% of all states have already established WIC immunization linkages.¹³

For editorial comment see p 1182.

This national WIC initiative represents the most sweeping effort to link immunization to a public program since the school law campaigns of the 1970s. But can interventions, which were successful in relatively small, time-limited, and intensively monitored studies, actually raise coverage when they are applied programmatically to whole populations, particularly in inner cities where infrastructure problems are intense? Questions have also been raised as to whether some immunization interventions in WIC might have an adverse effect on enrollment.

Chicago, Ill, was a major source of cases during the measles resurgence,^{4,14-16} with data indicating that city-wide vaccination coverage was 16% to 25% over 8 years, despite the epidemic.¹⁷ A 1994 survey of children residing in public housing suggested that immunization series completion rates were 23% by 2 years of age.¹⁸ In 1995, the Chicago Department of

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	Immunization Activities*		Sites	Sites With Immunization Services, %†			Children Aged <12 mo		Racial/Ethnic Proportions, %‡				
	Incentives	Monitoring		RN	Clinic	None	N	% Birth Cohort	B	H	W	A	O
Birth cohort 1996§	...	...	...	...	...	...	54 694	...	42	34	21	...	4
Preschool measles cases 1989-1990	...	...	...	...	...	...	2091	...	73	23	3	...	<1
WIC enrollment 1996¶	...	...	44	...	...	...	37 871	69	50	25	6	3	17
Contract	...	...	25	...	...	...	20 290	37	47	23	7	3	20
CDPH#	...	...	19	16	58	26	16 581	30	53	27	4	3	13
Group A	Y	Y	4	25	75	0	4014	8	50	31	5	4	10
Group B	Y	N	10	0	50	50	9746	18	52	32	3	1	12
Group C	N	Y	3	0	100	0	1912	4	72	5	7	6	11
Group D	N	N	2	100	0	0	909	2	48	44	1	2	1

*All sites performed assessment and referral and had been doing so for 4 months or more prior to the start of evaluation. Monitoring indicates immunization process measures collected from each WIC site each month. Incentives indicate voucher incentives provided for age-appropriate immunization. Ellipses indicate data not applicable.

†The preexisting immunization services available at each site that were not changed during the course of the initiative. RN indicates nurse regularly presents 2 or more times per week to vaccinate children on-site; clinic, public health clinic in same location as WIC site; and none, no immunization services available through WIC site.

‡Mutually exclusive racial/ethnic categories: B, non-Hispanic black; H, Hispanic; W, non-Hispanic white; A, Asian; and O, other. WIC allows self-designation of racial/ethnic category. Chicago Department of Public Health (CDPH) data do not include a discreet category for Asian children, and they are included with "other" children.

§Live births in Chicago in 1996 according to provisional CDPH data.

||Confirmed measles cases 0 to 59 months of age, or 73% of the total 2857 cases, for 1989-1990, according to CDPH measles surveillance data.

¶WIC enrollment in Chicago as of April 1, 1996, according to Illinois WIC.

#Three additional CDPH sites were located in schools and served pregnant teenagers. After the child's birth, the family was transferred to the site serving the area where the family resided. These sites were not subject to the immunization initiative and were excluded from analysis.

Public Health (CDPH) began implementation of immunization interventions in WIC, a supplemental food voucher program in which approximately 70% of the Chicago birth cohort is enrolled. We present the first evaluation of the impact of a large-scale immunization initiative through WIC.

METHODS

Chicago WIC Immunization Initiative

The Chicago WIC is administered through 47 sites, at which about 37 000 infants are enrolled (Table). Approximately 45% of these clients are served by 22 sites under the direct administration of the CDPH, while the rest are served by 25 sites administered by contract agencies. In December 1995, CDPH required its sites to begin the following: (1) to ask all families with children 24 months of age or younger to bring vaccination documentation to WIC visits; (2) to assess the vaccination status of these children; and (3) to refer children in need of vaccinations to a provider. In May 1996, CDPH began the progressive implementation of voucher incentives for immunization (see below). By June 1997 (the end of the evaluation period), 14 sites were providing voucher incentives. To implement this ongoing initiative, 11 clerks were hired, under the supervision of a coordinator, at an annual cost of \$271 000.

Interventions

Assessment and Referral.—At each WIC certification and recertification visit (which occur every 6 months), the clerk reviewed the vaccination status of each child 24 months of age or younger. Where documentation of vaccination was provided (eg, vaccination card), the vaccination dates for each antigen were

entered into a software program on the WIC computer. The program determined if the child was age-appropriately vaccinated by ACIP standards. If the child was not age-appropriately vaccinated, the family was referred to a provider for vaccination.

Voucher Incentive.—In Chicago, a 3-month supply of food vouchers is usually issued by WIC to enrolled families. When a child is designated as being at high risk for illness (eg, anemic), only a 1-month supply of vouchers is issued at a time, to ensure frequent contact with the family regarding the high-risk condition. In the immunization initiative, children who were not age-appropriately vaccinated were treated as high-risk clients. A 1-month supply of vouchers was issued until the child was age-appropriately vaccinated, at which time the issuance of a 3-month supply was resumed. Only voucher frequency was varied; no voucher was ever withheld from a child because of immunization status.

Evaluation Approach

We retrospectively evaluated the impact of the initiative using existing data generated for the period April 1996 (by which date all sites had been performing assessment and referral for 4 months or longer, but none had started voucher incentives) through June 1997 (when the majority of sites had been performing voucher incentives for more than 12 months). From these data, we identified groups of sites (Table) whose different immunization activities provided comparisons to help distinguish the effects of voucher incentives from the impact of other immunization-related activities.

Group A (+ Incentives; + Monitoring).—Four CDPH sites serving about

4000 infants (8% of the Chicago birth cohort) had been prospectively selected by initiative staff as sentinel sites for intensive monitoring of the initiative from its inception (see process measures below). Selection was based on inner-city location and on the program staff's perception of the population's risk for low vaccination coverage.

Group B (+ Incentives; - Monitoring).—Ten CDPH sites serving about 9000 infants (18% of the Chicago birth cohort) began voucher incentives at the same time as group A (May 1996) but were not intensively monitored. Monthly immunization rates were not collected until September 1996.

Group C (- Incentives; + Monitoring).—Three CDPH sites serving about 2000 infants (4% of the Chicago birth cohort) did not begin providing voucher incentives during the evaluation period but collected immunization rate data, starting in February 1996, in preparation for the subsequent implementation of voucher incentives. Implementation did not take place at these sites during the study period because of administrative delays in hiring and assigning staff.

Group D (- Incentives; - Monitoring).—Two CDPH sites serving about 1000 infants (2% of the Chicago birth cohort) did not implement voucher incentives and were not monitored during the evaluation period, although they reported having performed assessment and referral.

Data Collected

Population Characteristics.—The 1996 Chicago birth cohort, the children of Chicago with reported preschool measles during the 1989-1990 epidemic, and the infants enrolled in WIC in Chi-

cago in April 1996 were compared for population size and race/ethnicity.

Immunization Services Available at WIC Sites.—One of 3 levels of immunization services was available at each WIC site: an on-site nurse, a colocated clinic, or no immunization services whatsoever (Table). The availability of these services at each site predated the initiative and did not change during the evaluation period. We examined the availability of these services as a potential cofactor in the impact of the initiative.

Process Measures.—From the group A (+ incentives; + monitoring) sites, the following data were collected: documentation rates—the monthly proportion of children for whom vaccination status could be documented; voucher incentive eligibility rates—the monthly proportion of children seen who were eligible for a voucher incentive because they needed a vaccination; and voucher incentive delivery rates—the monthly proportion of children eligible for a voucher incentive who actually received the incentive.

Age-Appropriate Vaccination Rates.—This rate is the proportion of children 24 months of age or younger who were documented to be age-appropriately vaccinated based on the series currently recommended by the ACIP (including hepatitis B and *Haemophilus influenzae* type b). Since the group D (– incentives; – monitoring) sites did not report immunization rates during the evaluation period, records of all children 24 months of age or younger seen at these sites for WIC certification or recertification during June 1997 (the last month of evaluation) were checked against computerized immunization files, and age-appropriate immunization rates for these sites were calculated. These results were compared to rates obtained by identical methods from the group A (+ incentives; + monitoring) sites.

WIC Enrollment Rates.—Monthly enrollment data for each site were obtained from Illinois WIC to evaluate the impact of the initiative on WIC enrollment.

Statistics

Statistical tests were not applied since this is a description of a large-scale programmatic initiative rather than a report of the results of a formal scientific trial.

RESULTS

Population Characteristics

The WIC clients served by CDPH were comparable to WIC clients in Chicago as a whole (Table). Each of the 4 groups of CDPH sites served a predominantly minority population, although the racial/ethnic composition differed among groups.

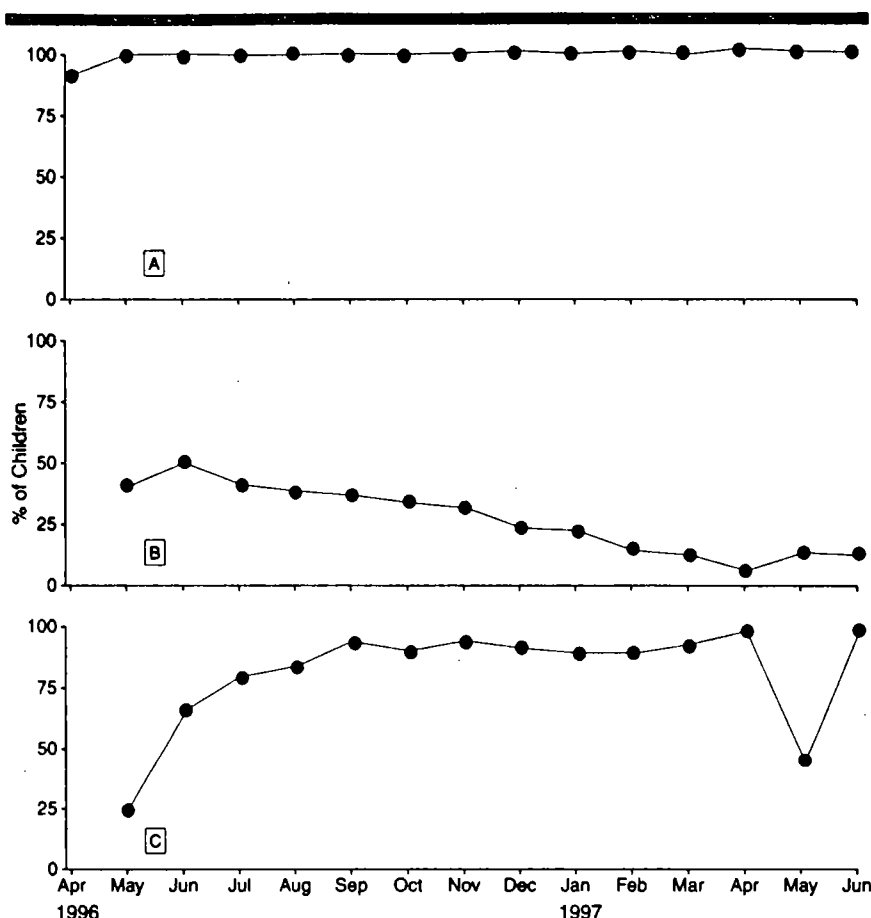


Figure 1.—Program implementation process measures for the 4 group A (+ incentives; + monitoring) Special Supplemental Nutrition Program for Women, Infants, and Children sites, showing the percentage of children whose vaccination status could be documented (A), the percentage of children eligible for the voucher incentive (B), and the percentage of incentive-eligible children who actually received the incentive (C).

Immunization Services Available Through WIC Sites

Preexisting immunization services were not comparably distributed among groups of sites, but the distribution did not appear to favor immunization at voucher incentive sites (Table). Among the 14 sites performing voucher incentives, 5 (36%) lacked any services, 1 (7%) had an on-site nurse, and 8 (57%) were colocated with a clinic. In contrast, all 5 sites not performing voucher incentives had available services: 2 (40%) with on-site nurses and 3 (60%) with colocated clinics.

Process Measures

Documentation Rates.—The proportion of children whose immunization status could be documented at the certification visit started at a high level (range, 87%-100%), reflecting the effect of previous assessment and referral activities. Thereafter, it improved to the point where documentation was almost universal (range, 98%-100%) (Figure 1, A).

Voucher Incentive Eligibility Rates.—The proportion of children seen who were eligible to receive a voucher incentive

fell from a high of 51% in June 1996 to a low of 5% in April 1997. It rose to 12% in the 2 succeeding months because computer problems prevented voucher incentive delivery in May 1997 (Figure 1, B).

Voucher Incentive Delivery Rates.—The proportion of incentive-eligible children who actually received the incentive began at a low level but after 4 months was consistently more than 80%, except for May 1997, during which month WIC computer problems caused a transient drop (Figure 1, C).

Age-Appropriate Vaccination Rates

Among the 4 group A (+ incentives; + monitoring) sites, immunization rates rose from 56% to 89% during the 15 months of evaluation (Figure 2). Among the 10 group B (+ incentives; – monitoring) sites, data are absent for the early phases of incentive implementation, but the final immunization rate was identical to that of the group A sites (89%). In contrast, the 3 group C (– incentives; + monitoring) sites showed no improvement, despite the monitored implementation of assessment and

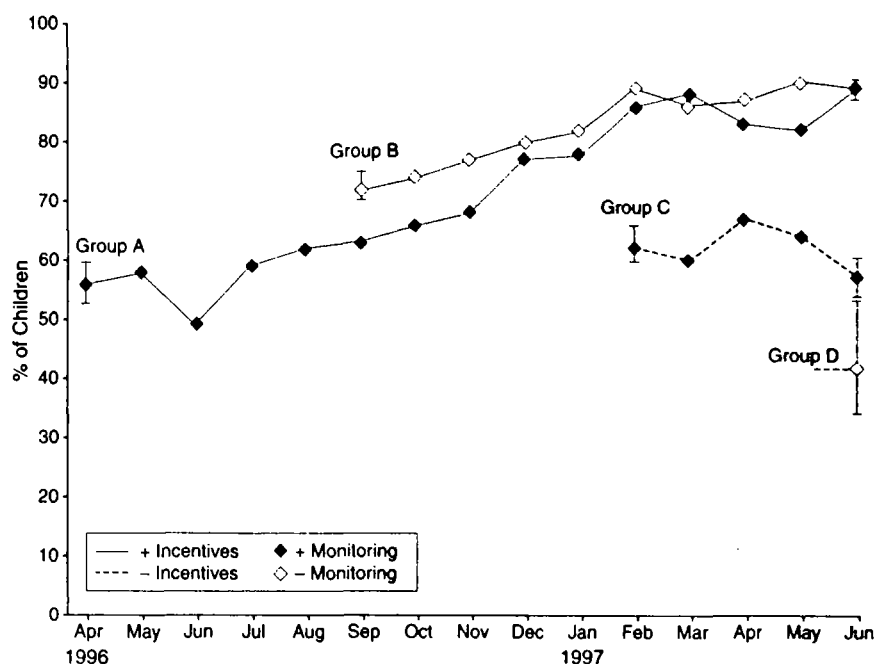


Figure 2.—Percentage, by study month, of children 24 months of age or younger who were age-appropriately vaccinated at the time of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) visit at 19 Chicago, Ill, WIC sites (95% confidence intervals shown).

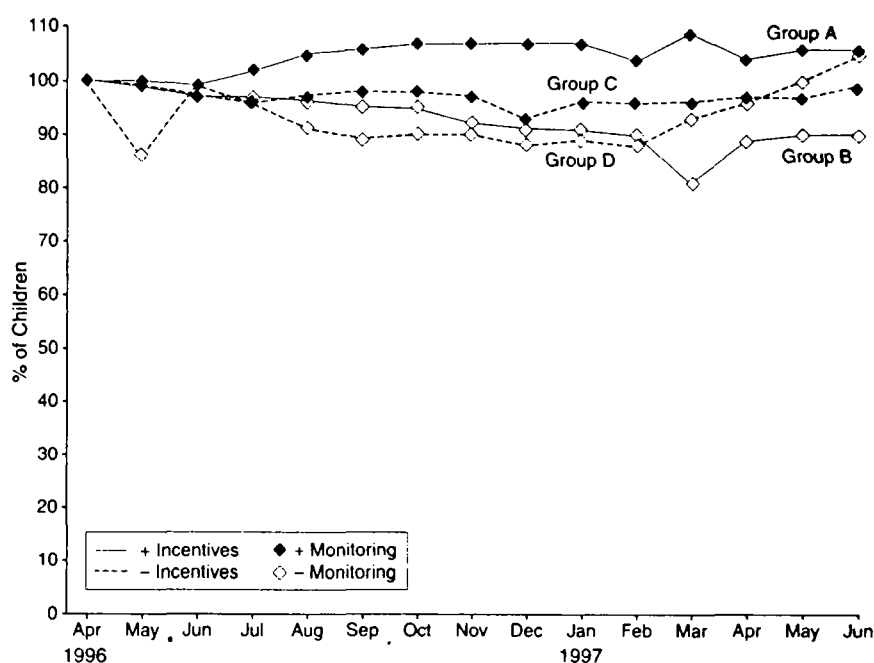


Figure 3.—Change in monthly Special Supplemental Nutrition Program for Women, Infants, and Children enrollment at 19 Chicago, Ill, Department of Public Health sites for the study period, with April 1996 enrollment as 100%.

referral; their final vaccination rate was almost identical to the starting rate of the group A sites (57% vs 58%). The 2 group D (- incentives; - monitoring) sites, which had been performing unmonitored assessment and referral, had a coverage rate at the end of the evaluation period of 42% (42/99). Using the same computer-record sur-

vey method, coverage at the 4 group A sites for the same month was 80% (312/391).

Immunization Services and Initiative Impact

Differences in the availability of immunization services did not account for the

initiative's impact. Among the sites performing voucher incentives, the final vaccination coverage at the 8 sites that were colocated with clinics was 87% (1876/2145), slightly lower than the 91% (331/362) coverage at the 5 that had no immunization delivery services available. Among the sites not performing voucher incentives, final coverage at the 3 sites that were colocated with clinics was 57% (352/622) compared to 42% (42/99) at the 2 that had an on-site nurse for vaccinations.

Race/Ethnicity and Initiative Impact

Differences in the race/ethnicity composition among sites did not account for the initiative's impact. Among the sites performing voucher incentives, the final coverage in the 8 sites with majority black populations was 93% (808/873), slightly higher than the 86% (464/538) coverage in the 2 sites serving majority Hispanic populations. Among the sites not performing voucher incentives, the final coverage in the 3 sites serving majority black populations was 48% (260/540), slightly lower than the 55% (21/38) in the 1 site serving a majority Hispanic population.

Changes in WIC Enrollment

Enrollment at the 14 sites providing voucher incentives was 13 874 in April 1996 and 13 066 in June 1997, while the 5 sites not providing incentives had an enrollment of 2742 in April 1996 and 2765 in June 1997 (Figure 3). Over the evaluation period, average net monthly enrollment (reflecting both attrition and addition of new clients and expressed as a fraction of starting enrollment) was the same at the incentive and nonincentive sites. Several large group B (+ incentives; - monitoring) sites instituted computerization for WIC eligibility processing, which created increased waiting periods for clients. Since WIC clients are permitted to transfer their care to a site of their choice, the increased waits apparently caused a loss of enrollment at these sites, from which some of the nearby group A (+ incentives; + monitoring) sites were beneficiaries.

COMMENT

This study was designed to answer a question that is often neglected in health services research: can an intervention that has been demonstrated to be efficacious in the controlled environment of relatively small, time-limited intervention trials actually prove effective in the "real world"? The population targeted by the Chicago WIC immunization initiative appears appropriate for answering such a question, since this population comprises almost one third of the birth cohort of the third largest city in the nation, all with family incomes of 185% or less of the de-

defined poverty level, and 80% black or Hispanic. The results suggest that the programmatic implementation of voucher incentives was associated with a marked rise in immunization rates in this population and did not appear to be associated with a decline in WIC enrollment.

Prior to the evaluation period, CDPH sites had been assessing the immunization status of enrolled children and referring those in need of vaccination to a provider. This produced a high level of immunization documentation, a result that is consistent with previous studies,^{8,9} but there was no apparent impact of assessment and referral on immunization rates. In our study, 5 sites provided only assessment and referral during the evaluation period. Of these, the 3 group C (- incentives; + monitoring) sites showed no improvement in coverage during a 5-month period of monitoring (62% to 57%), and the 2 group D (- incentives; - monitoring) sites had 42% coverage at the end of the evaluation period.

In contrast, voucher incentives appeared to have a marked effect on immunization rates, raising coverage to 89%. This final high rate is remarkable, given the inclusion of all ACIP-recommended antigens. The impact did not appear to be attributable to any other identifiable factor: project monitoring (the intensively monitored group A and relatively unmonitored group B voucher incentive sites reached the same 89% final coverage); the availability of immunization services at the WIC site (final coverage at voucher incentive sites with no immunization services was 91% compared to 87% for those colocated with a clinic that administered vaccinations); or the racial/ethnic composition of the population served (final coverage for voucher incentive sites serving majority black populations was 93% compared to 86% for those serving majority Hispanic populations). At the 5 sites not performing voucher incentives, final coverage was low (42%-57%), regardless of whether the site was monitored, was colocated with a clinic or had a nurse administering vaccinations on-site, or was serving a majority black or Hispanic population.

Changes occurred in enrollment rates but were of small magnitude, and average enrollment was the same for incentive and nonincentive sites. Trends among groups were apparently attributable to WIC changes (eg, computerization delays causing clients to seek transfers) rather than immunization activities. This is consistent with the results of a recent focus group study, in which mothers enrolled in WIC did not mention voucher incentives as a reason to drop out of WIC,¹⁹ as well as with intervention trials that did not show an impact of voucher incentives on enrollment.^{8,11}

This evaluation was limited by the use of existing data and by the potential confounders that may be present when subject populations have not been highly characterized. The immunization rates in this study (based on age-appropriate receipt of all recommended antigens) are lower than would be produced by a provider-verified survey of the same population based on 4:3:1 series completion by 24 months of age.

The annual labor cost of providing voucher incentives in Chicago was relatively modest (\$271 000), but of the 65 federal immunization grantees (50 states plus 15 cities), only 7 are known by the Centers for Disease Control and Prevention to be providing immunization voucher incentives as a part of WIC. The rest mainly offer assessment and referral, although no study to date has established any impact for this intervention.^{8,9,11}

The Chicago experience illustrates the potential value of using the results of intervention trials to formulate strategies for public health problems. But beyond science, Chicago made several management decisions that may have been responsible for the initiative's success: dedicated staff were hired; these staff were provided with dedicated supervision; the intervention was phased in site by site rather than begun abruptly at all sites; a small number of sentinel sites were intensively monitored to detect implementation problems; and vaccination rates were obtained monthly from all intervention sites to assess outcome. In addition, the Chicago WIC staff were highly cooperative with the initiative. A different impact might have resulted had the initiative's funds been used instead to reimburse a reluctant WIC for generalized but unmonitored immunization activities by existing hardworking WIC staff, with outcomes that were never measured. The applicability of Chicago's scientifically based and carefully managed approach needs to be explored for a wide range of inner-city health problems.

Since the manuscript was accepted for publication, all 19 CDPH sites have begun providing voucher incentives. By March 1998, coverage for the 5 sites that did not provide incentives during the study period had risen to 89% (694/777). Coverage in the other 14 sites, which continued providing voucher incentives, was 91% (3746/4111). WIC enrollment at all 19 sites was stable: 16 001 in March 1998, compared to 16 616 in April 1996, the month before the initiative began.

We would like to thank Lance Rodewald, MD, Michael Matuck, MPA, Pat Stein, BA, Edward Brink, MD, Abigail Shefer, MD, John Stevenson, MA, and particularly all Chicago WIC and Catholic Charities personnel.

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Children must be immunized

A late arrival in the mail from Wayne and Karen Beeks of Farmington wanted publishing this past Sunday, at the start of National Immunization Week, but any time is a good time to run this couple's caution.

"Almost two months ago," they wrote, "we were blessed with a third son, Nathan. In 1992, when Justin, our firstborn, was 6 weeks old, we went to Tulsa for the day. As new parents, we were thrilled to head out on our first family trip. Now, three years later, we are fearful to take Nathan out of the house. We are afraid to show off our precious newborn.

"Why? Because in 1994 our second son, Marcus, died at 3 weeks of age from pertussis, or whooping cough.

"We asked ourselves then, as you too might question, how could a child die of this age-old childhood disease with today's medicine?

"It was a shock to find out that there is no wonder antibiotic available today that can cure this disease. In fact, the only difference between today and when it was the No. 1 cause of death of infants in the 1960s is the supportive measures now available such as respirators, intravenous fluids, suction devices, etc., that can only make a body more comfortable while it fights this bacteria.

"Marcus did not have the chance to receive even his first round of immunizations given at 2 months of age, and he was far too young to win the horrific battle that we could only stand by helplessly and watch.

"The pain that he suffered in his short time on earth is forever embedded in the hearts of those he touched. While it has been two years, we can describe every detail of those three weeks and the hell that our precious baby was put through—a hell that crossed his path by an unknown adult carrier of this disease that ultimately had to

Meredith Oakley



originate from an unimmunized child.

"Parents who neglect to have their children immunized not only place their child at risk, but are also endangering other children with whom their child comes in contact.

"The week of April 21-27 is National Immunization Week. Let our loss serve as a reminder to take time out of your busy schedule to ensure that the children in your life have an A+ in health by being age-appropriately immunized.

"By the age of 18 months, all children should have received four DTP (diphtheria, tetanus and pertussis), three polio, one MMR (measles, mumps, rubella), three Hepatitis B and three Hib (*Haemophilus influenzae* type b) shots.

"Immunizations are the only protection against these childhood illnesses. We must all work together to ensure that what happened to Marcus does not happen to another child. With all the unavoidable tragedies in this world, we must protect ourselves where we can.

"Let's prevent tragedies where possible. Don't wait. Vaccinate!"

I wanted more information on National Immunization Week to share with you, but the operator at the state Health Department advised me that everyone is attending some convention in Hot Springs this week.

Never mind. When in need of information, turn to the information superhighway, which I did and found reports from the National Centers for Disease Control and Prevention that expanded my knowledge of

pertussis and its "problematic" treatment nature.

According to the reports, the nation as a whole is improving its childhood immunization rate every year. That's little comfort to those who have lost children to any of the so-called childhood diseases.

Science has brought us so many wonderful things, among them the opportunity to avoid certain illnesses, some of them life-threatening, through vaccinations. That's real preventive health care.

When I was a child, a vaccination meant smallpox immunization and polio immunization and little else. Everything else was "just something every child gets." In earlier days, some parents intentionally exposed their healthy offspring to their ailing siblings in an attempt to "get it over with all at once."

Wrong, wrong, wrong.

A "childhood disease" is not something every child should expect to get. It is no less menacing an affliction because it strikes infants and children more readily than it strikes adults; many times, it's a serious threat to future health, even life, made dangerous by the mere fact that it strikes such young lives.

Do your part. Get your children immunized at the appropriate stages in their development. Your physician can advise you, and if you cannot afford private care, contact your local health agency. The honchos may be away at a convention, but the agency's health care providers will be on hand, and the cost may be minimal or possibly non-existent.

As the Beeks said, don't wait. Vaccinate!



Associate Editor Meredith Oakley's column appears every Monday, Wednesday, Friday and Sunday.

PHOTOCOPY
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LETTERS TO THE EDITOR

Need for immunizations in children often ignored

Do you know if your child is properly immunized? Many parents don't — and that's a big danger for their children.

In Arkansas, 31 percent of 2-year-olds have not received the full series of vaccines they need to protect them from life-threatening diseases like measles and pertussis.

The good news is that we've made real progress in the last few years.

Today, infant immunization rates are at their highest levels in history, and vaccine-preventable childhood diseases are at an all-time low.

But our work is far from done.

There are still more than one million pre-schoolers in this country who don't have all their shots — and your child could be one of them.

This week — National Infant Immunization Week — communities across the country are joining hands to ensure that all children get the shots they need, when they need them.

But we need your help. Parents need to check their children's immunization records to make sure they're up to date — and bring them in for their shots if they're not.

Doctors need to take every opportunity to vaccinate children during office visits. It's up to all of us to ensure that every child gets an equal shot at a

healthy life.

For information on where you can go to get shots, call 1-800-232-2522.

Donna E. Shalala
Secretary of Health and
Human Services

The Times (Arkansas), April 25, 1996

Tampa Trib.; 4-22-96

Immunization Week

Do you know if your child is properly immunized? Many parents don't — and that's a big danger for their children. In Florida, 21 percent of 2-year-olds have not received the full series of vaccines they need to protect them from life-threatening diseases, such as measles and pertussis.

The good news is that we've made real progress in the last few years. Today, infant immunization rates are at their highest levels in history, and vaccine-preventable childhood diseases are at an all-time low. But our work is far from done. There are still more than 1 million preschoolers in this country who don't have all their shots; your child could be one of them.

This week is National Infant Immunization Week. Parents need to check their children's immunization records to make sure they're up to date — and bring them in for their shots if they're not. Doctors need to take every opportunity to vaccinate children during office visits.

For information on where to go for shots, call 1 (800) 232-2522.

DONNA E. SHALALA
Washington, D.C.

The writer is the U.S. secretary of health and human services.

LOVELAND REPORTER HERALD (COLORADO) April 26, 1996

As concerned citizens, our neighborhood opposes the development of Registry Ridge on the southwest corner of Shields and Trilby Road in Fort Collins. In approving this development, the Fort Collins city staff, Planning and Zoning Board and City Council arbitrarily applied criteria to meet the needs of the developer, not the citizens.

We feel the development of 700 houses, town homes and a mini-mall in the wheat strips, next to the proposed corridor is wrong for our neighborhood and the Fort Collins/Loveland greater community because:

- It is not in conformance with Fort Collins' Comprehensive Plan and is not consistent with the Plan for the Region Between Fort Collins and Loveland.

- It is not within 3,000 feet of a major employment center; or 1,000 feet of a child-care center; or 2,500 feet of an existing school; nor is it contiguous to existing urban development as required by the city's Land Use Development Guidance System.

- It will produce more congestion and an increase in traffic that cannot be safely accommodated by existing roads and suggested road improvements.

- It will strain existing services such as police, fire, water, and power. Children will be bused to Loveland schools.

- It will not "pay its way" and taxpayers will burden the costs.

- It violates the intentions of voters who approved an open space tax to protect the corridor between Loveland and Fort Collins.

We took these concerns to the Fort Collins Planning and Zoning Board. But we were disillusioned as we listened to city staff vehemently defend the project and Planning and Zoning pass it.

We appealed to City Council only to hear city planning and legal staff defend it. Our requests and needs were drowned out by those of the developer — and, according to one council member, his threat of lawsuit.

After nearly one hour in secret executive session, the City Council approved the project. For the reasons stated above, we were left with no choice but to file suit against the City of Fort Collins, City Council, and the developer.

LoAnn Thleman
Fort Collins

A 'perfect' officer, father and husband

To the editor:

I had the good fortune to work with Capt. Dave Davison for 11 1/2 years. In that time, I also had the opportunity to become his friend. In the time I knew Dave, I can say that I have never met an officer more committed to his work and the people of this community. In all these years, I don't think I ever called him Dave to his face, it was always "captain" out of the great respect I had for him.

Dave always signed his letters and memos with his initials D.A.D., which seemed very appropriate because I think he was much like a dad and the Loveland P.D. was his child. When things went well, he was proud as a father was of his child. When things bad, he was unhappy and

Sometimes I would come to work a little depressed about something, and Dave would arrive and his positive attitude would inspire me to feel better and pull through the day. I was always amazed when we went to lunch or a meeting, at how many people knew him and at how he greeted everyone so positively, especially children.

My favorite times with Dave were golfing and going to lunch. Dave was very competitive and enjoyed sports. I would teach him about his golfing and bet him lunch and end up buying every time. Dave was a hardcore Nebraska fan and I would bet him lunch on many of the games and would end up buying every time.

I looked at it as I was the winner because not only did I get to spend this time with him but I was able to go to many lunches with Dave and spend even more time with him.

Dave Davison was the "perfect" police officer, a devoted husband and father and I will always be proud that I could call him my friend.

Steve Cobbo
Gunnison

Make sure your child is immunized

To the editor:

Do you know if your child is properly immunized? Many parents don't and that's a big danger for their children. In Colorado, 24 percent of 2-year-olds have not received the full series of vaccines they need to protect them from life-threatening diseases such as measles, whooping cough or pertussis.

The good news is that we've made real progress in the last few years. Today, infant immunization rates are at their highest levels in history, and vaccine-preventable childhood diseases are at an all-time low. Our work is far from done. We still have more than one million preschoolers in this country who don't have all their shots — and your child could be one of them.

This week, during National Infant Immunization Week, communities across the country are joining hands to ensure that all children get the shots they need, when they need them. We need your help. Parents need to check their children's immunization records to make sure they're up to date — and bring them in for their shots if they're not. As a physician with a background in public health, I encourage other physicians to take every opportunity to vaccinate children during office visits. It's up to all of us to make certain that every child gets an equal shot at a healthy life.

For information on where to go for shots, call 1-800-832-2522.

Dr. Margaret Cory
Loveland

Please, just let him rest in peace

To the editor:

Peace, peace, peace.

I knew him, respected him, liked him, and grieved this past week.

I said to myself that I hope no one tries to

Sure enough, it was done this 23rd day of April in the first column in the Open Forum, in my opinion.

I believe that there is a time and a place for most everything and this extreme misfortune should be able to rest in peace.

Capt. Dave you have touched my heart and I will not forget you.

Tom Behnk
Milliken

Read this and then you can decide

To the editor:

Does this sound familiar?

"Because individuals with Paranoid Personality Disorder lack trust in others, they have an excessive need to be self-sufficient and a strong sense of autonomy. They also need to have a high degree of control over those around them. They are often rigid, critical of others, and unable to collaborate, although they have great difficulty accepting criticism themselves. They may blame others for their own shortcomings. Because of their quickness to counterattack in response to threats they perceive around them, they may be litigious and frequently become involved in legal disputes. Individuals with this disorder seek to confirm their preconceived negative notions regarding people or situations they encounter, attributing malevolent motivations to other than are projections of their own fears. They may exhibit thinly hidden, unrealistic grandiose fantasies, are often attuned to issues of power and rank, and tend to develop negative stereotypes of others, particularly those from population groups distinct from their own. Attracted by simplistic formulations of the world, they are often wary of ambiguous situations. They may be perceived as 'fanatics' and form tightly knit 'cults' or groups with others who share their paranoid belief systems."

Taken from: pg. 635, 301.0 "Paranoid Personality Disorder Diagnostic and Statistical Manual of Mental Disorders," Loveland Public Library.

Data Peter:
Lovels

Letters policy

The Reporter-Herald welcomes letters to the editor. They should be addressed to Open Forum, P.O. Box 27, Loveland, Colo., 80501. Letters may be dropped off at the Reporter-Herald, 101 N. Fifth St. Loveland. The newspaper's e-mail address is rh@rnhil.com. Letters must be signed. Each letter verified with the author before publication. For 100 words or verification, the writer's address and telephone number where he or she can be reached during working hours must be furnished. This information won't be published but must be submitted with all letters to the Open Forum. Letters submitted without address and daytime telephone number will be delayed or not published. Maximum acceptable length of non-election letters is 250 words but the Reporter-Herald reserves the right to edit letters for purposes of clarity, redundancy and length but that limit. The newspaper will publish no more than one election letter from any writer in month. Election letters will be limited to 250 words with no more than one letter from any writer published in any month.

Well done on immunization levels

Hartford Courant 4/18/96

For those who get tired hearing about what's going wrong in Connecticut, here's an antidote:

This state is among the five national leaders in the immunization of children.

In fact, Connecticut is a close second only to top-ranked Vermont in the percentage of preschoolers receiving the principal vaccines against 10 dreaded diseases. The immunization levels in these two New England states are 87 and 86 percent respectively.

Nationally, the level has improved significantly. According to figures released last week by the federal Department of Health and Human Services, only 56 percent of America's young children were immunized four years ago. Today, that number is 75 percent — the highest level in history, said HHS Secretary Donna E. Shalala. As a result, childhood infectious diseases are at an all-time low, she reported.

Widespread immunization isn't cost-free. Over four years, the federal government has nearly doubled — to \$938 million today — the budget for vaccine purchases and immunizations. The Clinton administration has requested \$1 billion

for the next fiscal year.

But the benefits outweigh the costs. Society will pay a far higher price if children are unprotected from infectious diseases such as polio, measles, diphtheria, whooping cough, mumps, tetanus, rubella and chicken pox.

Although the improvement in immunization levels is cause for cheer, the loudest hurrahs will come when America reaches its goal by the year 2000. That goal is to have 90 percent of 2-year-olds immunized.

To get there, attention must focus on urban and rural poverty areas, where motivating parents to bring their children for rounds of disease-preventing shots is a problem.

Thirteen states plan to require parents to immunize their children as a condition of receiving welfare. Massachusetts is the only New England state among the 13.

Connecticut should be part of this list. If the national goal is 90 percent immunization by 2000, we ought to set our sights at 100 percent coverage by then. We can get there. Connecticut has already shown that it can be a leader.

RD-Region #3

TEL No.215-596-0328

Apr 26,96 13:16 No.005 P.06

VITAL IMMUNIZATIONS

Too many children don't get vaccines to prevent illness

According to the Department of Health and Human Services, 19 percent of Delaware 2-year-olds haven't received the full series of vaccines needed to protect them from serious, often life-threatening diseases such as polio, mumps, whooping cough, chicken pox, measles and pertussis.

Many of these children will get their shots by the time they go to school because the state requires them for enrollment. But that may be too late for many kids.

WHERE WE STAND

Parents and guardians should check records and make sure that children are properly immunized.

On a national basis, immunization against these childhood diseases has steadily improved. A couple of weeks ago, federal health secretary Donna Shalala said that immunization of children has grown from 55 percent to 75 percent since 1992. The Clinton ad-

ministration has made an exceptional effort to make sure immunization is available to all. The goal is to have all children immunized by age 2.

This is a good time for parents and others charged with the welfare of young children to check records. If youngsters have not completed a series of vaccinations, they should see that they are given quickly.

In Delaware and throughout the nation this week, public health officials are conducting information programs on childhood immunizations. People should act on it.

The News Journal April 23, 1996

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P. 02

MILWAUKEE JOURNAL SENTINEL (WI)

APRIL 22, 1996



A good week to immunize

This is National Infant Immunization Week. Unfortunately, many parents simply do not know whether their children are properly immunized against a wide range of childhood illnesses.

The U.S. Department of Health and Human Services reports that in Wisconsin, 24% of 2-year-olds have not received all of the vaccinations they need to avoid life-threatening diseases such as measles and whooping cough.

The challenge is clear: Parents need to examine their children's immunization records. Make certain they are up to date. Then make arrangements to get any vaccinations that have not been administered.

The message will be publicized in a number of ways this week. But for instant information on where to go for shots, there's a number to call: It's (800) 232-2522.

Significant progress has been made in recent years in infant immunization rates. There can be no justification for retreat.

SENT BY:

4-24-96 ; 7:30AM ;

DHHS/ORD/ORHA-

THE MIAMI HERALD

4/17/96

: 9

A shot in the arm

At last the state of Florida surpasses most of the nation in something other than crime and poverty. Immunizations of children by their second year have soared to 75 percent nationwide. However,

80 percent of Florida's children are now immunized against a range of preventable disabling diseases. That's great news reflecting fantastic strides.

It is a result of the sorts of partnerships that could be a balm to a host of social problems, if applied as thoughtfully and purposefully.

Indeed, a host of Florida players preceded — by a number of years — the Clinton administration's push to immunize 90 percent of U.S. kids by age 2.

Education and access barriers are falling, especially in poor urban areas. Public and private health-care providers are armed with a new awareness of the need to ensure that children do not fall through the cracks and become vulnerable to measles, mumps, diphtheria, spinal meningitis, and other ailments.

Federal initiatives are providing huge quantities of vaccine to the states, which in turn funnel it to health-care providers. Doctors are not allowed to charge for the vaccines, other than a small

IMMUNIZING CHILDREN

Florida, surpassing the national rate, continues to make strides in quelling diseases in children.

administrative fee. Additionally, federal funds are helping communities obtain the resources that they deem most useful, be it a mobile van or another clinic staffer.

At the state level, Florida's comprehen-

sive Healthy Start program plays a major role in making sure that children are born healthy and stay that way. Immunizations clearly are vital to that.

The third component of Florida's success remains the private, volunteer efforts of civic organizations, most specifically in this case the Kiwanis Clubs of Florida. Nine years ago, under the leadership of Dr. Wil Blechman of North Miami Beach, the clubs forged a partnership with the state and provided equipment and volunteers with commitments to clinics. Dr. Blechman last year was appointed state health officer.

The measurable progress in Florida, and around the nation, is all the evidence needed to keep these efforts funded. As recently as last year, Congress attempted to disable the vaccine-purchase program, but common sense ultimately prevailed. If the quality of children's lives is to mean anything at all, then this most basic of life-enhancing aid will continue unimpeded.

Children's immunizations get a shot in the arm in Philadelphia

The city doubled its vaccination rate in four years. The push is part of a nationwide effort.

By Huntly Collins
INQUIRER STAFF WRITER

In a major public-health victory, Philadelphia has more than doubled the immunization rate among 2-year-olds since a deadly measles epidemic swept the city in 1991.

At that time, only about 34 percent of the city's 2-year-olds had received vaccines to prevent such childhood diseases as polio, diphtheria and measles. By last year, the figure had shot up to 71 percent.

The gains here are part of a national effort that has put the incidence of preventable childhood diseases at an all-time low across the

country.

Still, health officials aim to boost the national immunization rate to 90 percent by 2000.

"This is going to be one of the great public-health successes of the century," predicted Health and Human Services Secretary Donna E. Shalala, as she toured the Maria de los Santos Health Center at Fifth and Allegheny Streets yesterday.

The federally funded center is one of more than a dozen sites in the city now linked by computer to a new centralized database at the city Health Department that is keeping track of the immunization his-

tory of all newborns who live in Philadelphia.

The computerized system will track children from birth to age 6, making it easier for health providers to know whether a child's shots are up to date.

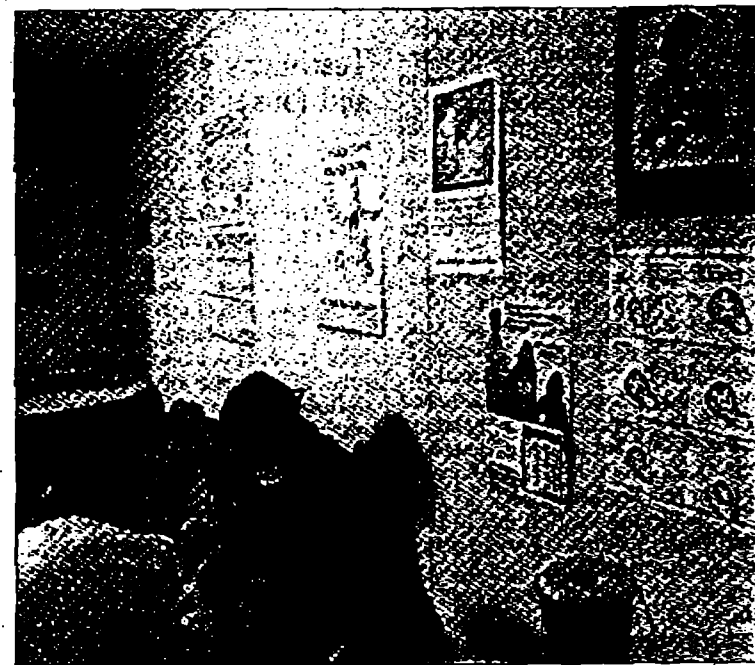
This type of tracking system is the newest wrinkle in the all-out national immunization effort.

The campaign, launched by the Clinton administration in 1992, boosted federal funding for immunizations and, for the first time, allowed the money to be used for such things as additional nurses in public clinics and community-outreach workers to round up children who need to be vaccinated.

In Philadelphia, federal funding for the program went from \$142,000

See VACCINES on B4

Philadelphia Inquirer
4-26-96



The Philadelphia Inquirer / PETER TOBIN

In the arms of his mother, Reina Gonzalez, 5-month-old Jerry Herrera gets his immunization shot from nurse-practitioner Dionne Line.

Philadelphia shines in U.S. effort to step up children's vaccinations

VACCINES from B1
in 1991 to \$440,000 in 1992. Last year, the city received nearly \$600,000.

"We've made a major investment in infrastructure, and we've tried to get the word out," said city Health Commissioner Estelle Richman as she joined Shalala at the North Philadelphia health center where young mothers cradled babies waiting to get their shots.

As part of the effort, the city has targeted neighborhoods in North Philadelphia, West Philadelphia and parts of South Philadelphia where immunization rates are typically lower than the citywide average.

In these areas, the city has enlisted the help of community organizations to put out the word and to help get babies into nearby clinics. The city's eight district health centers have also begun offering immunizations without appointments.

If families cannot make it to clinics, the city even sends public health nurses into the home.

"It's not what we want to do," said Robert Levenson, director of infectious disease in the Health Department. "But if nothing else works, we will immunize in the home."

The impetus for the crash program was the nationwide measles epidemic in 1990-91. More than

50,000 children came down with measles, including 1,559 in Philadelphia. More than 130 died, including nine children here.

As a result of the stepped-up vaccination program, the incidence of measles is at its lowest since reporting began in 1912, the federal Centers for Disease Control and Prevention reported yesterday.

In 1995, there were 301 measles cases across the country — down 69 percent from the number of cases in 1994, the CDC said.

Not a single case of measles was reported in Philadelphia last year.

"Vaccines work. They are superb, cost-effective tools to prevent disease," said Shalala.

Still, Shalala said, the country — and Pennsylvania — have a way to go. "There are more cows immunized in Pennsylvania than kids," said the blunt-speaking Cabinet official as she talked with workers at Maria de los Santos.

Shalala knelt in front of Iveliss Laboy, 23, as a nurse practitioner squirted a dose of oral polio vaccine into the mouth of Laboy's 3-month-old daughter, Katelyn.

"Do you know you have a Cabinet officer kneeling at your feet — and the President sent me?" Shalala asked the pink-cheeked baby.

The child's mother said she moved to Philadelphia just three weeks ago from New York and had learned about the clinic's vaccination program from a friend.

Shalala said the mother illustrated the need for the kind of computerized system that Philadelphia and 13 other cities across the country are now putting in place.

Many families, especially those in low-income neighborhoods, move around a lot. Their children go from one medical provider to another. Often, their medical records don't go with them, making it difficult to track their immunizations.

In a joint venture with the Robert Wood Johnson Foundation, which provided \$580,000, and Mercy Health Plan, which gave \$650,000, Philadelphia is attempting to put vaccination records of resident children born after August 1992 on line.

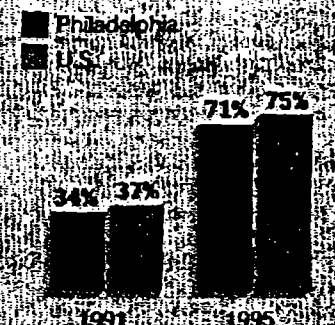
There are 80,000 names in the database, about 40,000 of whom have received one or more of their vaccinations, city officials said.

Philadelphia's major pediatric-hospital programs are linked to the database, as are the city's eight district health centers and other federally funded health centers such as Maria de los Santos.

Soon, WIC sites — which provide federally subsidized nutrition for

Immunization Rates

For children age 2



SOURCE: Phila. Health Dept., CDC
The Philadelphia Inquirer

low-income mothers and infants — are to be plugged into the system.

Providers for the state's Medicaid program are also coming on line, as are the major Medicaid HMOs.

Eventually, the system will be able to spit out what census tracts lag in immunization rates. The data might also be broken out on the basis of councilmanic districts, which could put political pressure on City Council members to insure that their constituents get children vaccinated.

The measles vaccine, typically given at 15 months and again at 4 to 6 years, is one of the six vaccines recommended by pediatricians.

The others are for Hepatitis B, diphtheria, tetanus, pertussis, bacterial meningitis, polio, mumps, rubella and chicken pox.

The Topeka Capital-Jrnl; 9-25-95

Free vaccine program lauded

By MARK SOMMER
The Capital-Journal

Vaccines for Children, the Clinton administration's distribution of free vaccine for children and others without medical insurance, is drawing high marks from the University of Kansas Children's Center in Kansas City, Kan.

Dr. Pamela Shaw, director of ambulatory pediatrics, said the free vaccine program has complemented the state program, Operation Immunize, by providing free vaccine to people who would have trouble affording it, especially those without insurance.

"I really think having it available for free has really made a difference," Shaw said. "This has been especially true for people who are working and not eligible for Medicaid, people caught between the cracks. We see an indigent population of 20 percent here, and all of them are children. These people have no way to pay for any of their health care, let alone vaccina-

tions."

Clinton's plan to distribute free vaccine was roundly criticized by pharmaceutical companies and some lawmakers when first proposed, and it was criticized by the General Accounting Office in a report released in June. All of the vaccine used in the government-run program is stored in a huge depot in New Jersey.

Shaw said that while there were start-up problems in the government program in ordering and availability, she has found those kinks to have been worked out. She said the program's effectiveness has allayed fears over government red tape and bureaucracy.

"In our experience here we haven't had problems with vaccine availability or problems with ordering. Frankly, (the program) has made it possible for us to give vaccines to people who before would have had to go to public health departments. When you see a kid and tell the mom to go to the health department to get shots, you don't know when they're going to go."

She said 7,500 children are attended to each year at the KU Children's Center.

"Wyandotte County is one of the lowest immunized counties (in Kansas)," said Shaw. "Two of the biggest barriers have always been availability and the cost of vaccines. So, Vaccines for Children folded into (Operation Immunize) because we were able to get vaccine for free."

Shaw said an administrative fee is charged, but it is waived if the person is unable to afford it.

She said she added up the cost of the battery of vaccinations needed by age 2, and the cost came to between \$300 and \$400. "And that doesn't include Hepatitis B or chicken pox vaccine that are recommended but not required by the schools yet," she said.

Despite some congressional opposition, Shaw said, she hopes the free vaccine program continues.

"I really think it's been a good program. It could be a wonderful national model for how we care for our children," Shaw said.

IMMUNIZATION SCHEDULE

Recommended childhood immunization schedule for United States, as of September 1995:

Vaccine: Age:

■ **Hepatitis B-1:** birth to 2 months

■ **Hepatitis B-2:** 2 months to 4 months

■ **Hepatitis B-3:** 6 months to 18 months

■ **Diphtheria, Tetanus and Pertussis:** 2 months, 4 months, 6 months, between 12 and 18 months and between 4 and 6 years. Also, tetanus booster between 11 and 16 years

■ **H. Influenzae type b:** 2 months, 4 months, 6 months and between 12 and 15 months

■ **Polio:** 2 months, 4 months, between 6 and 18 months and 4 to 6 years

■ **Measles, Mumps and Rubella:** Between 12 and 15 months and 4 to 6 years or 11 to 12 years

Sources: Kansas Department of Health and Environment

Cont'd from previous page

Alfano's husband, Leonard Alfano, an advertising instructor at the University of Kansas in Lawrence, had his students design pamphlets, flyers and folders. Their work was donated and done for college class credit.

"We kept our costs down," Alfano said. "Other states that have done this kind of project have spent far more money."

"I think this was our biggest plus in Kansas," she said. "People really were committed to it."

Alfano acknowledged that the work begun by Operation Immunize is far from over.

To assist with the ongoing nature of the program, Alfano said, doctor's offices and medical clinics across the state are being encouraged to remind mothers of the need for childhood immunizations. The state has the overall responsibility for immunizations, while county health departments provide the immunizations.

Public health officials said disease outbreaks in the late 1980s and early 1990s may have resulted from parents who had become complacent about childhood diseases.

Since the parents hadn't experienced large outbreaks of childhood diseases when they were young, many didn't place a high priority on getting their children immunized.

However, the reason there hadn't been any large outbreaks of childhood diseases was largely the result of high immunization levels in preceding generations. Public

health officials knew a generation of unimmunized children could mark a return of the diseases.

As a result, the door was thrown open to diseases that could have been prevented through proper immunizations.

Diseases for which vaccines were available — measles, mumps, rubella, Hepatitis B, polio and diphtheria — were looming increasingly large on the public health horizon.

That's when Operation Immunize was implemented. Its original goal was to get 100 percent of all children properly immunized by age 2. Later, a more realistic goal of 90 percent was adopted.

State officials are guarding against resting on their laurels, based on the increased immunization levels for the state's children.

Alfano said there are new mothers every day and that health officials must continue their efforts to inform them of the need for immunizing their children.

"With immunization, it's constant awareness and promotion," Alfano said. "We can't let up."

Based on the increased immunization rate in Kansas, the federal government has provided a grant that will enable county health departments to have a computerized automatic telephone dialing system to remind parents when their children need their next round of immunizations.

Former Kansas Department of Health and Environment Secretary Bob Harder, who served as health and environment secretary from October 1992 to January 1995 under then-Gov. Joan Finney, credited Alfano with much of the program's success.

"She was the energy behind the project," said Harder. "She was relentless in her moving of the whole project and program."



Six-month-old Sara Jane Price received the oral polio vaccine at the Topeka-Shawnee County Health Agency.

She had a good staff, there's no question about that ... But she's the one who never became discouraged. She's the one who gave it heart and momentum."

Harder said the improvement in the state's childhood immunization rate seems even greater when one remembers that the top state in the nation has an 88 percent immunization rate for children 19 to 35 months old.

Harder also credited the Kansas State Nurses Association, which provided 750 to 1,000 nurses to assist with Operation Immunize, as well as the Wichita-based Kansas Health Foundation, which has instituted a

statewide registry to help keep track of children's immunization records.

For her work on Operation Immunize, Alfano will be presented on Tuesday with the Kansas Public Health Association's Samuel Crumrine Award for 1995 during the organization's annual meeting in Great Bend.

The Crumrine award is the highest honor given by the Kansas Public Health Association and recognizes service that improves public health in the state, region and nation.

State health and environment officials say Operation Immunize will continue to promote immunizations, but could take different forms, as it has done in the past, said Kansas Department of Health and Environment spokesman Greg Crawford.

"It's a constantly evolving effort," Crawford said. "In that sense, it doesn't become dormant. A lot of good campaigns sometimes become stagnant because they become 'institutionalized' and they're not open to modifications."

"We don't want to see that happen here."

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- **Hepatitis B-3:** 6 months to 18 months
- **Diphtheria, Tetanus and Pertussis:** 2 months, 4 months, 6 months, between 12 and 18 months and between 4 and 6 years. Also, tetanus booster between 11 and 16 years
- **H. influenzae type b:** 2 months, 4 months, 6 months and between 12 and 15 months
- **Polio:** 2 months, 4 months, between 6 and 18 months and 4 to 6 years
- **Measles, Mumps and Rubella:** Between 12 and 15 months and 4 to 6 years or 11 to 12 years

Source: Kansas Department of Health and Environment

58 THE GREEN SHEET

Wednesday, September 20, 1995 The Kansas City Star

Immunization helps children lead quality lives

Considering that in the long run parents can't ensure their children's welfare regardless of how great their hopes or meticulous their management, it's encouraging that at least one thing they can do is almost perfectly effective in keeping children safe.



JEAN Haley

Immunizing them against the so-called childhood diseases is prevention that works. In this matter, efficacy doesn't depend on odds or circumstances, what genes the child has inherited, or how he uses them. Regard-

less of how the family's fortune changes before the child is ready for college or which oddball accident turns the course of her life, immunization will prevent her from getting sick.

It will keep her safe. It will keep him safe. It will keep every child from every family safe.

How many things in life do we do that have such a rate of success?

Why, then, do so many families let this opportunity dissolve into the sunset, or slide into the dregs of Brush Creek, or otherwise put off the job until the little boy or girl is ready to start to school and the state whacks the parent over the head by

threatening to refuse the child admittance to first grade?

■ People simply put it off. Their doctors don't remind them, the insurance company doesn't remind them, the day care center doesn't require it. So they procrastinate.

■ We figure it's silly to worry much about childhood diseases. After all, when was the last time anyone heard of a measles outbreak or a child dying from whooping cough? And probably the only iron lung we can identify with is one in a museum or history book.

■ We thought we had taken care of the baby's shots. Or we knew we had taken care of most of them. Or we forgot.

■ It was difficult to get to the public health clinic because of one or both parents' work schedule.

Set beside a child's health or a child's life, though, none of them are meaningful reasons at all.

Public health authorities say that every child should be fully immunized against: polio, diphtheria, pertussis, tetanus, Hepatitis B, measles, mumps and rubella. Fully immunized means one dose of vaccine against measles, mumps and rubella and three doses against the other diseases. Two years is considered the optimal age to finish immunization.

Once upon a time, because children were mostly at home before they entered public school, tying completion of the vaccination regime to admission to the first grade made sense. It was about the first occasion children were thrown together with a lot of others their age on a regular basis — a

group situation in which disease sharing and epidemics flourish.

Now most children are old hands at group activities long before they start elementary school: day care, nursery school, kindergarten. The risks are the same as they were and are in the first grade. Conditions are dangerously perfect for disease to spread. If anything, because the children are younger and more vulnerable to some conditions than older youngsters, parents of day care or nursery school participants ought to be even more worried than their parents or grandparents about letting them go unprotected to school and "catching something."

But we don't. We're trying to play by yesteryear's rules in a speeded-up childhood. It's dangerous.

In the United States, only about 56 percent of children are immunized by the age of two, behind the immunization rate of 69 other countries. Less than half of Missouri's children in the two-year-old under age group are fully immunized. Only a little more than half of the group are fully immunized in Kansas.

One of the most popular issues to fight about now is the basics — in education, in family values, in government.

A lot of that energy would be much better placed concentrating on this even more essential basic: Get all children immunized by the time they are two years old, so they can grow up to create families, so they can use the schools and government services and enjoy the freedoms we're agonizing over.

Haley is a member of The Star's Editorial Board.

THE GREEN SHEET 69

The State Columbia, SC
8/29/95

Free vaccines: Big boost for preventive health care

By DEE C. BREEDEN

I was saddened to see yet another published mischaracterization of the federal Vaccines for Children (VFC) program in *The State* July 10. Unlike the picture painted by your editorial, we've experienced excellent results from this vital program in South Carolina through a strong partnership between the public and private medical communities.

Ironically, only days later you reported on South Carolina's No. one national ranking in childhood immunization following Governor Beasley's announcement that 90 percent of the state's 2-year-olds are fully immunized. While the use of VFC funds in South Carolina is not the only reason we reached a 90 percent immunization level, it is a significant contributor to our success.

This underscores the failure to get to the real story in South Carolina. You relied largely on paraphrases from an Executive Summary of the General Accounting Office report with no input from the S.C. Department of Health and Environmental Control, the S.C. Chapter of the American Academy of Pediatrics and the Association of State and Territorial Health Of-



Breeden

ficers. Like the GAO, local sources went unchecked: the people who actually are implementing VFC and seeing the good it is doing.

Beginning Oct. 1, 1994, S.C. DHEC and VFC, under a program called S.C. Vaccine Assurance For All Children, made free vaccine available to enrolled public and private immunization providers for children whose insurance does not cover vaccine. Where private insurance covers vaccines, all enrolled immunization providers are required to obtain vaccine from manufacturers and bill private insurance.

Private physicians joined with private service organizations, DHEC and other state agencies to form S.C. VAFAC. DHEC has been the major provider of vaccines to children because younger families cannot afford the approximately \$400 per-child cost of vaccines.

By the Oct. 1 start date, 172 providers had enrolled and were supplied with vaccine. Enrollment in VAFAC totals 376 immunization provider practices. About 90 percent, or 330 private physician practices, participate in VAFAC and receive no profit.

VAFAC supports the one medical home for all children concept, serves as a drawing card for families to seek other important preventive services for children, allows the public sector to put more focus on outreach to children at risk, and establishes a successful public-private partnership. It also assures ability to sustain high levels of immunization in South Car-

olina's children and puts children and their families first in South Carolina.

Who supports VAFAC? Gov. David Beasley and former Gov. Carroll Campbell, state health agencies, four state medical association chapters, and major alliances for children, to name only a few.

This country has had a policy of providing free vaccines for all children since Eisenhower days. The issue should not be whether all children will be given free vaccines, but how we can reduce all other barriers to timely immunization.

Had the GAO talked with us on the front lines and to parents, they would have learned what VAFAC means in South Carolina and put accountability questions in the correct perspective. Parents are the only ones who can answer the question about cost being a barrier to immunizations. Immunization providers are the ones who can answer the questions about program efficiency, effectiveness, and the crucial balance between effective accountability and provider participation.

Immunization is one of the most cost-effective public health interventions. When children are put unnecessarily at risk for vaccine-preventable diseases, society pays.

Never again should epidemics be the primary motivation to renew immunization efforts.

Dr. Breeden is chief of S.C. DHEC's Bureau of Preventive Health Services.

JUL 17 1995

THE WASHINGTON POST
SUNDAY, JUNE 25, 1995

PRESIDENT HAS SEEN *Plates*

when away on our now

Be

Donna E. Shalala

Cheap Shot at the Vaccine Program

A few critics of the Clinton administration's Childhood Immunization Initiative (CII) have resorted to using errors and distortion to attack our efforts. The most recent example is Robert M. Goldberg's piece, "Made in Washington: The Great Vaccine Scare" [Outlook, June 18]. I would like to set the record straight.

First, the Clinton administration did not "invent" this country's longstanding infant immunization problem. Let's look at the reality.

It is in the two years before President Clinton took office, about 50 percent of America's 2-year-olds were not properly vaccinated.

Historically, we have witnessed repeated outbreaks of preventable infectious diseases, including the 1989-91 measles epidemic that struck more than 55,000 people and took more than 130 lives, many of them young children.

Today, while our immunization rates are the highest ever, there are almost 8 million children who have not received all the shots they need by their second birthday.

There are the facts, and, as Aldous Huxley once wrote, "Facts do not cease to exist because they are ignored."

Goldberg also errs by ignoring the true scope of the Childhood Immunization Initiative, which is the most comprehensive vaccination effort in American history. Our approach is to increase immunization rates right now, while also building a permanent system to sustain high rates in the future. This means addressing all the different barriers that prevent immunization—and we are doing that.

We have increased funds and flexibility for state and local communities, so they can create new clinics in

underserved areas, lengthen clinic hours, hire additional staff and expand other key services.

We are working to develop more effective systems for detecting disease before outbreaks occur and measuring vaccination coverage levels.

We are conducting research to improve vaccine use and, one day, to immunize children against more diseases with fewer shots.

To ensure that parents and health professionals understand the importance of proper immunizations, we have initiated a national and community-based outreach effort the likes of which this country has never seen.

Taking Exception

Goldberg says nothing about these efforts. Instead he focuses on only one of the CII's five elements, which is the Vaccines for Children Program (VFC).

Under VFC, poor and uninsured children are eligible to receive government-purchased vaccines right in their doctors' offices. Under the old system, the only way uninsured children of working families could get government-purchased vaccines was to leave their private doctors and make a number of trips to public clinics—which contributed to fragmented care, overcrowding at the clinics, and missed opportunities to vaccinate.

Numerous studies show that private doctors end up referring patients to public health clinics because of the high cost of vaccinations. That's why state health officials and private doctors overwhelmingly support VFC: It means more children will receive care in their "medical homes" and will be immunized on time. In just eight months since VFC became operational, more than

23,000 private health providers, including doctors, clinics and hospitals, have enrolled in the program.

Goldberg incorrectly claims that VFC increases federal vaccine purchase expenditures by \$587 million between 1993 and 1996. In fact, the increase in public vaccine purchases is just \$78 million—and we're buying a few types of vaccine we didn't buy in 1993. This is a wise investment.

Goldberg falsely accuses me of using 1996 data at a 1993 hearing when 1992 data were available. This is not so: I used 1991 data because 1992 data were not yet available. By the way, one year ago, Goldberg made the same erroneous charge in the pages of the Wall Street Journal. We corrected him then and do so again now.

And he suggests that the administration does not support efforts in Dallas, Chicago and Maryland to increase immunization rates in families receiving WIC and AFDC. In fact, we have aggressively promoted these innovations and are evaluating their results.

Instead of distortion, we need a stronger national commitment to protecting our youngest and most vulnerable children with all the shots they need—when they need them, and that means we all must do our part. Health professionals must take every opportunity to vaccinate children during office visits. Parents must take responsibility for bringing in their children for shots. Community leaders and the private sector must spread the message about the importance of proper immunizations. And we who are public servants must continue to fight for children and families.

The writer is secretary of health and human services.

Samuelson and Wilk may be right that wide income disparities in the United States offer a powerful inducement for Americans to work, save and invest (though it is difficult to find evidence for this in U.S. saving or investment rates, which tend to languish near the bottom of the industrialized world). They may also be correct in believing large and rising disparities contribute to U.S. economic growth, though evidence for this is also weak. Recent studies on the relationship between inequality and growth in fact suggest that advanced countries with more equal distributions grow faster than countries that are less equal. Whatever the advantages of faster growth, they are purely theoretical for many low-income Americans. These Americans have not shared the general prosperity. Their after-tax incomes have slipped even though national output has increased.

Even more depressing is the fact that the absolute incomes of low- and even middle-income Americans are below those of residents in industrialized countries that are poorer than the United States. A comparison of Canada and the United States, based on 1991 income statistics, is particularly striking. In 1991, gross domestic product per person was 13 percent lower in Canada than in the United States. Because the Canadian income distribution is more equal than our own, however, Canadians in the bottom 56 percent of the distribution enjoyed higher after-tax incomes than they would have received in the United States at a comparable position in our income distribution. Of course, Americans in the top 43 percent of the U.S. income distribution received higher incomes than their Canadian counterparts. But for a majority of poorer and middle-class Canadians, the higher average income of the United States has little practical significance. These Canadians enjoy more comfortable incomes in Canada than they would be likely to receive in the United States.

The United States enjoys a high rank in one international contest, however. Americans near the top of our income distribution tend to receive much larger incomes than people with a similar position in other industrialized countries.

It is probably safe to assume that Wilk, Glasman and Samuelson are closer to the upper tier than the bottom tier of the income distribution. From their perch, U.S. economic performance undoubtedly looks quite satisfying. People further down the economic scale can be forgiven, however, if they doubt their economic good fortune as Americans. If wide income disparities have big advantages for the U.S. economy, low-income Americans are right to think the advantages should eventually show up in a tangible way—in larger paychecks and higher incomes. Whatever the virtues of our economic system, one conclusion is certain: Our fatter paychecks have not gone to the poor.

*Jen
Carol would
like to think
about a memo
to POTUS for
when she returns
—Julie*

Diana

Who keeps you
in the loop?

Health Insurance and Preventive Care Sources of Children at Public Immunization Clinics

Tracy A. Lieu, MD, MPH*; Mark D. Smith, MD, MBA†; Paul W. Newacheck, DrPH§;
Dottie Langthorn, PHN¶; Pravina Venkatesh, BS; and Ruth Herradora

ABSTRACT. *Background.* Recent proposals to reform immunization financing aim to help more children receive vaccines at their sources of primary care. Under the current system, referrals of children from the private sector may strain public immunization clinics, but scant information exists on what proportions of public clinic patients actually have insurance or primary care sources.

Objective. To describe the health insurance, usual sources of health care, and referral patterns of children at low-cost public immunization clinics.

Design. Cross-sectional study based on face-to-face, structured interviews.

Setting. Public immunization clinics at three sites in Contra Costa County.

Participants. Five hundred thirty-eight parents of children awaiting immunizations.

Results. Thirty-four percent of families at these public immunization clinics had Medicaid alone, whereas 24% had private insurance. Of those with private insurance, almost one third had at least partial coverage for vaccines. Sixty-two percent of families had sources of preventive care other than the immunization clinic, and most would have preferred to receive their vaccines at these sources. Most in this group named cost as the main barrier to immunizations at primary care sources; but one third of this group, including almost all the families insured by health maintenance organizations, named the wait for appointments at their usual source of care as the main barrier to receiving vaccines there. Two thirds of Medicaid patients and at least one third of privately insured patients were either uninformed or mistaken about whether their insurance covered vaccines.

Conclusions. Financing reform may improve immunization delivery and reduce the load on public clinics. However, legislation to improve immunization financing will not achieve optimal results unless parent education is improved and organizational barriers are also removed. *Pediatrics* 1994;93:373-378; immunization, health insurance, primary care, clinic, Medi-Cal, private insurance.

ABBREVIATION. HMO, health maintenance organization.

More than one third of all 2-year-olds in the United States have not received all recommended vaccinations.^{1,2} The patchwork nature of the public and pri-

vate systems responsible for vaccine purchasing and administration may hamper efficient immunization delivery.^{3,4} President Clinton's call for increased federal funding of immunization programs aims to improve delivery as well as reduce cost to parents (*New York Times*, February 1, 1993:1,10).⁵

One disadvantage of the present system is that patients who already have health insurance or sources of comprehensive preventive care services may seek vaccines at low-cost public immunization clinics due to inadequate insurance coverage or nonfinancial barriers. Increasing vaccine costs and lagging reimbursement from Medicaid and private insurance have led growing numbers of physicians to refer children to public clinics for immunizations in recent years.⁶⁻⁸ Referrals from the private sector may create additional strains for public clinics, which are already dealing with funding cutbacks and vaccine shortages.⁹ Further, because immunization-only clinics do not offer other preventive services, their use increases fragmentation of health supervision.

Scant information exists on how much shifting of private sector patients to public immunization clinics actually occurs.⁹ The extent of such shifting, and the reasons for it, will determine whether current proposals for reform will be effective. In this study, we surveyed families seeking immunizations at public clinics: (1) to determine the proportions of children with Medicaid or private insurance; (2) to evaluate their reasons for choosing the public clinic for immunizations; and (3) to describe their usual sources of health care and the barriers to obtaining immunizations at these sources.

We chose Contra Costa County in northern California as the setting for this study because its immunization clinics offered all recommended childhood vaccines at minimal cost, without appointments or physical examinations, and without financial screening. The county had a population of approximately 803 000 in the 1990 census and a per capita income of \$24 308 in 1989.^{10,11} The county's population was 70% white, 11% Latino, 9% black, and 9% Asian.¹² Approximately 13% of the county's children were Medi-Cal-eligible. At the time of the study, California Medicaid reimbursed private physicians for vaccines and administration, at rates ranging from 49% to 76% of usual fees.³

METHODS

Face-to-face interviews were conducted with parents of children attending public immunization clinics in Contra Costa

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Received for publication Jun 14, 1993; accepted Jul 29, 1993.

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County in northern California, during 5 weeks in August through September 1992. The county health department operated immunization clinics at three public health centers during four weekly afternoon sessions: in Pittsburg on Mondays from 1:30 to 4:00 PM, in Richmond on Mondays and Wednesdays from 2:00 to 4:00 PM, and in Concord on Fridays from 2:00 to 4:00 PM. There was a fee for vaccines of \$2 per child, up to a maximum of \$5 per family; this fee was waived in cases of need. The advertising for these clinics consisted of information flyers distributed in school registration packets and a press release sent to local newspapers. The public health department delivered most of its vaccines through immunization clinics, but also delivered vaccines to patients already enrolled in its comprehensive health screening clinics.

Study interviews were conducted at three of the four afternoon clinic sessions each week. Each parent waiting in line was approached by one of two research assistants. All parents were eligible for interviews because there was uniformly at least a 10-minute wait. Interviews were conducted in English, Spanish, and Hindi using a structured, closed-ended survey format. This closed-ended interview was developed based on open-ended pilot interviews with clinic parents prior to the start of the study. (Copies of the interview instrument are available from the authors on request). The study protocol was approved by the University of California, San Francisco Committee on Human Research.

The interview focused on the oldest child brought for immunizations in each family. It included one question about Medi-Cal (Medicaid) coverage and another about private insurance coverage at the time of the interview. Two questions covered whether the child's insurance or Medi-Cal paid for any part of his or her vaccines. The interview also covered sources of preventive and sick care, source of referral to the immunization clinic, reason for choosing the public clinic, source of child's last immunization, willingness to accept immunizations at potential alternative outreach sites, and demographic information. Questions on insurance coverage and health care sources were modified from the National Health Interview Survey.

The χ^2 test was used for comparisons of categorical data, with Yates' continuity correction for 2×2 tables.

RESULTS

Study population

A total of 582 families attending the county's public immunization clinics were approached for interviews. Of this total, 538 families (92%) agreed to par-

ticipate and were included in the study sample. Twenty-eight parents (5%) declined to be interviewed, and 16 (3%) were excluded due to language barriers or other reasons. Table 1 shows the demographic characteristics of the 538 respondents included in this survey. Most respondents (74%) were mothers. Of note, >30% of respondents had attended at least some college. Latinos comprised a higher proportion (39%) of the study group than of the county's general population (11%).

Most families (76%) brought one child for immunizations, whereas 17% brought two children, and 7% brought three or more. We asked the age of the oldest child brought for immunization by each family; 26% were 5 years old and 11% were 4 years old. Fifteen percent were <12 months old.

Health Insurance Coverage

We asked about the health insurance coverage and health care sources of the oldest child being seen for immunizations in each family (Table 1). Most children had Medi-Cal alone (34%) or private insurance with or without Medi-Cal (24%). The rest (42%) were uninsured.

Of the 128 families with private insurance, 25% named one health maintenance organization (HMO), 15% named a second HMO, and 9% named one indemnity plan as their insurer. The remaining 51% of the privately insured families named 1 of 29 other health insurers.

We asked each family with private insurance or Medi-Cal, "Does the child's health insurance, health plan, or Medi-Cal pay for any part of the child's vaccines?" Among privately insured families, a plurality (43%) said their insurance did not cover vaccines, whereas 28% said they did not know. However, of the privately insured families, 28% said their insurance

TABLE 1. Demographic Characteristics and Insurance Sources of Families at Public Immunization Clinics, Contra Costa County, 1992

	% (n)
Education of respondent (N = 532)	
Less than high school graduate	32 (170)
High school graduate	36 (192)
Some college or more	32 (170)
Ethnicity of respondent (N = 535)	
Latino	39 (209)
White	36 (192)
Black	11 (61)
Asian	9 (48)
Other	5 (25)
Health insurance coverage (N = 538)	
Medi-Cal only	34 (183)
Private only	22 (117)
Medi-Cal and private	2 (11)
None	42 (227)
Does insurance or Medi-Cal pay for any part of child's vaccines?	
Medi-Cal insured patients (N = 184)	
Yes	36 (67)
No	30 (56)
Don't know	33 (61)
Privately insured patients (N = 127)	
Yes	28 (36)
No	43 (55)
Don't know	28 (36)

paid for at least part of the child's vaccines; half of these said it covered the cost of vaccines entirely. Surprisingly, although all HMOs cover immunizations, 29 (57%) of 51 HMO-insured families either mistakenly believed that their insurance did not cover vaccines or did not know.

By comparison, approximately one third of the parents of Medi-Cal-insured children mistakenly believed it did not cover vaccines and another one-third did not know. The remaining one-third of Medi-Cal parents correctly said it paid for at least part of the child's vaccines.

Reasons for Use of the Public Clinic for Immunizations

During our pilot interviews, parents usually named four factors—cost, location, not needing an appointment, and having recently moved—as reasons for choosing the public clinic for immunizations. To evaluate the relative importance of these reasons for use of the public immunization clinic, parents were asked to select the most important reason for their choice (Table 2). Most parents (55%) chose cost. However, substantial minorities chose location (20%) and not needing an appointment (17%).

Both privately insured families ($P < .001$) and uninsured families ($P < .001$) were more likely than Medi-Cal-insured families to name cost as the most important reason for choosing the public clinic. Privately insured ($P < .05$) and Medi-Cal-insured respondents ($P < .01$) were more likely than uninsured respondents to name not needing an appointment as the main reason for their choice. Privately insured families were less likely than other families to name location as the main reason for using the public clinic ($P < .01$).

Because multiple reasons may contribute to the use of public health clinics for immunizations, we asked respondents to rate each of the four factors above as important or not important (Table 2). Cost was rated important by the highest proportion of parents (79%), although convenience of location and not needing an appointment were also rated important by more than half of parents. In addition, parents were asked whether they had any other important reasons for choosing the public clinic for vaccines. Twenty-two parents (5%) cited other difficulties with health care access: most commonly, difficulty finding a doctor who would accept Medi-Cal coverage for immunizations.

Sources of Care and Barriers to Immunizations

Sources of primary care and acute are shown in Table 3. Most parents (62%) said their child had a source of primary care, and most of these named a doctor's office, private clinic, or HMO as the source. We asked those patients with a source of primary care, except those who were already public clinic patients, whether they would have preferred to have their child vaccinated at their place of primary care if cost were not an issue. Sixty-three percent said they would have preferred that their child be immunized at the primary care source. We asked this group of parents to name the main difficulty with obtaining vaccines at that source. Among this group, 53% cited cost, but 33% cited the waiting period for appointments as the main difficulty. Seven parents (4%) said that the vaccines they needed were not being offered at their source of routine care; six of these were private doctor's offices. Transportation difficulties were cited by seven parents as the main difficulty with getting shots at their usual source of primary care.

Overall, 228 (42%) of the 538 children in the study group had health insurance as well as a source of preventive care. Predictably, insurance status was significantly associated with having a source of primary care ($P < .001$): 80% of privately insured children, 69% of Medi-Cal-insured children, and 47% of uninsured children had a regular source of preventive care. When the families who had a source of primary care were stratified by insurance status, similar proportions of privately insured (68%), Medi-Cal (59%), and uninsured families (64%) said they would have preferred to receive vaccines at their primary care source ($P = \text{NS}$). However, there were significant differences by insurance status in perceived barriers to being vaccinated at their primary care source. Although almost half of families with Medi-Cal (46%) or private insurance (48%) cited cost as the main barrier, a significantly higher proportion of uninsured families (77%) named cost as the main barrier ($P < .001$). Conversely, families with Medi-Cal (41%) or private insurance (47%) were more likely than uninsured families (17%) to cite waits for appointments as the main difficulty with being immunized at their primary care source ($P < .001$).

Referral Sources and Potential Outreach Sites

Most parents were either self-referred or had been referred to the public immunization clinic by a friend or relative (Table 3). Many were referred by schools.

TABLE 2. Parents' Reasons for Choosing the Public Clinic for Immunizations, Contra Costa County, 1992

	Families in This Insurance Category Naming This as the Most Important Reason for Their Choice, % (n)*				Families Who Rated This Reason Important, % (n)
	All Families	Medi-Cal	Private	Uninsured	
It costs less than other places	55 (250)	40 (62)	66 (70)	60 (118)	79 (424)
The location is convenient for me	20 (91)	27 (41)	9 (10)	20 (40)	74 (396)
No appointment is needed	17 (78)	23 (35)	21 (22)	11 (21)	59 (318)
We recently moved to the area	5 (24)	4 (6)	3 (3)	8 (15)	39 (210)
Other access problems†	3 (13)	7 (10)	1 (1)	2 (1)	5 (22)

* Based on these totals for valid responses: 456 families, including 154 Medi-Cal, 106 privately insured, and 196 uninsured families.

† Twenty-two parents cited other problems with access to immunizations in response to an open-ended question asking them to name any other important reasons for choosing the public clinic; 13 named this as the most important reason.

TABLE 3. Health Care and Referral Sources of Children at Public Immunization Clinics, Contra Costa County, 1992

	% (n)
Source of primary care (N = 534)	
Doctor's office, private clinic, or HMO*	34 (180)
Public health clinic, hospital clinic, or other	28 (151)
No source of routine care	38 (203)
Source of acute care (N = 516)	
Doctor's office, private clinic, or HMO	40 (204)
Public health clinic, hospital clinic, or other	31 (167)
No source of acute care	28 (145)
Would you have preferred to get child's vaccines at source of primary care? (N = 322)	
Yes	63 (204)
No	16 (51)
No preference	21 (67)
Main difficulty with receiving vaccine there (N = 189)	
Cost	57 (108)
Waiting period for appointments	35 (67)
Other access problems	7 (14)
Referral source (N = 531)	
Friend, relative, or school	44 (236)
No one	28 (149)
Private or HMO health professional	12 (65)
Public health professional	9 (49)
Other	6 (32)
Place last vaccine was received (N = 512)	
Public health or community clinic	45 (230)
Doctor's office, private clinic, or HMO	30 (153)
Other country	18 (94)

* HMO, health maintenance organization.

Approximately 12% of families said they had been referred by private health professionals (including private doctors, nurses, and clerks and HMO professionals). Among families with Medi-Cal, a higher proportion (21%) had been referred by health professionals outside the public health system than families with private (12%, $P = \text{NS}$) or no insurance (5%, $P < .001$).

We also asked where each child in the sample had received his last vaccine. Most children had received their last vaccines at places other than the public health clinic, including doctor's offices, HMOs, and other countries.

When asked about potential outreach sites for immunizations, most parents said they would have their children receive vaccines at school (89%, or 477) or church (73%, or 391) if they were offered there. However, most parents (55%, or 295) said they would not have their children vaccinated at a shopping mall. We did not ask parents whether they would have preferred these alternative sites to the public clinic or to primary care providers as their source of immunizations.

Subgroup Analysis by Age

This study was conducted in late summer, when children need immunizations to start school, and 69% of children in our sample were aged 4 years or older. The study's timing could have led families who do not routinely use the public immunization clinic, but who had school-aged children, to be overrepresented in our sample. To evaluate how the study's timing may have affected our results, we performed analyses stratified by age, assuming that families of toddlers and infants might be more representative of families who use public clinics at other times of the year.

In general, the results of the age-stratified analyses do not support the concern that the study's timing at the start of the school year caused an overestimate of the importance of appointment waits as a barrier at primary care sources or an overestimate of the proportion of patients with insurance and sources of primary care. There were no significant differences between school-aged and younger children in reasons for using the public health clinic, whether insurance paid for any part of the child's vaccines, whether the family would have preferred to receive vaccines at the child's primary care source, or the main barrier to being immunized at the primary care source. Toddlers and infants were actually more likely than school-aged children to have sources of preventive care ($P < .001$) and sick care ($P < .01$). Although the younger children and school-aged children in this study group were equally likely to have private insurance (24% vs 24%), the younger children were less likely to be uninsured (35% vs 45%, $P < .05$) and more likely to have Medi-Cal (40% vs 31%, $P < .05$). Among those families with private insurance in this study group, younger children were less likely to have HMOs as their insurance sources than older children (28% vs 51%, $P < .05$).

COMMENT

This study's results suggest that improving immunization delivery will require reform of both the financing and the organization of vaccine services. Ideally, immunizations should be readily accessible at usual health care sources. In our study, 42% of families had both health insurance and a source of primary care. Their presence at the public immunization clinic

signifies financial and organizational barriers to vaccination at primary care sources.

Financial Reform

Cost was the most commonly cited reason for choosing the public clinic for immunizations, despite the fact that 36% of families in this study had Medi-Cal and 24% had private insurance. Universal vaccine distribution systems in which the federal or state governments buy all needed vaccines and distribute them free to providers would reduce costs to parents. Our findings suggest that these systems may enable more children to be vaccinated at their usual sources of preventive care. Eleven states already have universal distribution systems that provide all vaccines for all children (Sam Flint, personal communication, May 1993).⁴ However, there is mixed evidence about whether such programs are associated with increased immunization rates (AAP News, May 1993:16-19).⁴

Financial reform may need to include more than vaccine purchasing alone. Even if vaccines were made available free to all providers, families might still face charges to obtain immunizations. In one survey, charges for vaccine administration accounted for 30% to 40% of charges for vaccines.¹³ Further, the American Academy of Pediatrics recommends that immunizations be provided during periodic preventive visits. In 1991, before the hepatitis B vaccine was added to the childhood vaccination schedule, the estimated charges for services recommended by the American Academy of Pediatrics during the first year of life included \$213 for immunizations and \$276 for physician visits and other primary services.¹⁴ Thus, reforms which only pay for vaccines may have limited effects on increasing access at primary health care sources unless vaccine administration and other preventive services are also covered.

An alternative financing option is for state governments to mandate that private insurers cover vaccines as part of minimum benefit packages. Twelve states have such mandates; one was passed in California and took effect January 1, 1993. Approximately one fourth of the families in our study had private insurance; some of these families may benefit from mandated private insurance coverage of vaccines. However, the effects of mandated private coverage will be limited because self-insured employers, which now cover more than half of the nation's employees, are exempt from these regulations (Flint, personal communication).

Some public clinics have implemented financial screening and prorated fee schedules to obtain more payment from patients who have other resources. The Contra Costa County clinics where this study was conducted had to raise fees for vaccine administration from \$2 per child to \$5 per child due to funding cutbacks in the fall of 1992. Alternatively, public clinics could attempt to reduce their financial burden from privately insured patients by seeking reimbursement from private insurers. However, because privately insured patients whose insurance covered at least part of the cost of vaccines comprised only 7% of this public clinic population, the impact of such interventions at the public clinics in this study would be limited.

Organizational Reform

This study further suggests that financial reform alone will not achieve optimal immunization rates. Many privately insured parents in our study did not know whether their insurance covered vaccines. Only one third of the parents who had Medi-Cal were aware that it paid for any part of the cost of immunizations. These findings are not surprising, given previous studies which found a lack of consumer understanding of health insurance.^{15,16} Parent education about the timetable for childhood vaccines, as well as about insurance coverage, needs to be improved to capitalize fully on a cost-effective preventive service.

Our results show that organizational barriers to vaccination, especially waits for appointments, play an important role. Compared with uninsured patients, insured patients were more likely to cite convenience factors—location or not needing an appointment—as reasons for their use of the public clinics. Almost all the HMO patients at the public immunization clinics who would have preferred to use the HMO cited appointment waits as the main barrier. As more states shift to managed care for Medicaid patients, the effects of appointment waits on the accessibility of immunizations and other preventive services will need careful scrutiny.

Finally, there may be a tradeoff between optimal immunization rates and the comprehensiveness of children's health care delivery. Immunizations have traditionally been linked with other services in health supervision visits, but this requirement may present yet another barrier to vaccine delivery. One third of the children in this study had no source of preventive care. Even if all vaccines are distributed free to providers, access problems will persist if preventive visits are required for vaccines and access to primary care providers is inadequate. At a minimum, access to vaccines could be improved by using alternative outreach sites. Parents in this study seemed quite willing to accept schools and churches, but not shopping malls, as sites for vaccine delivery.

Limitations

Several limitations of these findings should be noted. Most important, the geographic scope of the study population was limited. Similar evaluations in other sites would help to determine whether these findings are typical. Compared with other states, California has a larger representation of HMO patients. Based on this study's findings, the families using public immunization clinics who were insured by the larger HMO in Contra Costa County would actually have accounted for <0.5% of the children in that HMO's population.

Although the public clinic population is traditionally viewed as high-risk, we could not include the highest risk group of children who never received immunizations at all. This study evaluated barriers to immunization at primary care sources, but it did not evaluate barriers to immunization at the public clinic itself; this question was addressed by a previous study.¹⁷ Because the study included only public clinic users, we have not attempted to compare the health

care access and opinions of these families with those of families who received immunizations in other sectors.

The timing of this study at the start of the school year most likely caused families of school-aged children who did not use services at other times of the year to be overrepresented. We could not directly evaluate differences between families who used the public clinics at this time of year and those who used them at other times. The age-stratified analysis suggested that the study's timing did not cause overestimates of the importance of appointment waits as barriers or of the proportions of public immunization clinic users with health insurance and sources of primary care. However, it did suggest that HMO-insured children may have been overrepresented during this study period compared with the rest of the year.

Information on children's insurance status relied on parent recall. Bias in responses to insurance questions should have been reduced by the interview introduction, which made clear that all responses were confidential and would not affect children's care at the public clinics in any way. However, errors in insurance status could still have been introduced by faulty recall or embarrassment at lack of insurance coverage.

CONCLUSIONS

This study provides one baseline point for evaluating the effects of future reforms in immunization financing. When reforms are introduced, studies should examine whether the reforms decrease the shifting of privately insured children to public immunization clinics, and improve financial as well as nonfinancial access to vaccines. Centralized tracking systems for immunization records, already under development in certain regions, will enable such evaluations to be performed.

In conclusion, our study shows that most children receiving vaccines at public immunization clinics in Contra Costa County, California, have either Medicaid or private insurance. The main barriers to receiving immunizations at the usual preventive care sources were cost and waiting times for appointments. If these findings are replicated elsewhere, they would suggest that financing reform has the potential to improve vaccination rates, but only if it is combined

with improved parent education and reduced nonfinancial barriers to immunizations.

ACKNOWLEDGMENTS

This work was supported by a grant from the Kaiser Family Foundation. Dr Lieu was supported by the Robert Wood Johnson Clinical Scholars Program.

We are indebted to Thomas Newman, MD, MPH, Bernard Lo, MD, George Rutherford, MD, Loring Dales, MD, Jan Eldred, the Robert Wood Johnson Clinical Scholars of University of California, San Francisco, and members of the Association of Bay Area Health Officials for suggestions on study design. We thank Sam Flint, PhD, Walter Orenstein, MD, and Drs Newman and Lo for thoughtful reviews of the manuscript. We are grateful to Lisa Gates and Mary Rose for their administrative assistance on this study, and to Lyn Wender for editorial assistance.

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Jordan LeMoine, 13 months, receives an oral polio vaccine.

Denver Post; 8-1-95

Free for all

Kids' vaccine program in legislative limbo

By Carol Kreck
Denver Post Staff Writer

With little more than 60 percent of its 2-year-olds fully immunized, the state of Colorado is planning to implement President Clinton's Vaccines for Children program even as Congress threatens to kill it.

"We're moving ahead without knowing what the future holds," said Judy Connor, director of immunization for the Colorado Department of Public Health and the Environment. "We just have to do what we think is necessary."

The children's vaccine program was born in 1993 when the president accused pharmaceutical companies of "pursuing profits at the expense of our children."

Using recommendations from University of Colorado Health Sciences chancellor Vincent Fulginiti, who chaired the presidential advisory commission, Clinton proposed making vaccines a public utility purchased by the federal government and distributed to all children for free.

Congress scaled back the president's idea, but established the program as an entitlement that allows free vaccines for children who are uninsured, on Medicaid or whose insurance doesn't cover vaccinations — about 60 percent of American children.

What's more, VFC gave private doctors access to free vaccines for the low-income patients they treated so children could get all their care in one medical "home."

Despite this seemingly win-win situation, the program is playing to widely mixed reviews.

A group called Taxpayers Against Government Waste distributed tracts claiming VFC is ill-conceived and "grossly mismanaged." In a recent report, the Government Accounting Office declared that the program is based on a faulty premise. The report found that cost is not a barrier to vaccination and concluded the program was unnecessary.

Meanwhile the majority of state officials, whose states have fully implemented the program, endorse it.

David Smith, Texas commissioner of health, calls VFC successful and credits the program and the money it saved with helping to double immunization rates in his state.

Smith said the GAO's assessment is absurd. "In a state like Texas where we have 1.5 million children on Medicaid and another 1.5 million uninsured, let me tell you that cost is a barrier."

Before the program was implemented, poor children in Colorado, as well as in the rest of



The Denver Post / Lyn /

OUCH! Ashley Mueña gets a shot but her brother Arturo starts crying while their mom, Marcela Rodriguez, looks on.

the country, could (and still can) get free shots at public health clinics, a fact the GAO used to excoriate the program.

But when you ask families with few resources to jump through more hoops, kids will fall between the cracks, argues the American Academy of Pediatrics and the Children's Defense Fund.

"I see families every day, five days a week, who cannot afford the cost of these vaccines," said pediatrician Lee Thompson of Au-

rore Pediatric Associates. Having to refer families to public clinics "presents a series of additional obstacles."

"What has happened in the last 10 years before Vaccines for Children is that as the price of vaccines rose, the income of young families went down and the number of kids with private insurance went down," said Jim Weill, general counsel for the Children's Defense Fund in Washington.

Nationwide, the number of uninsured is ris-

ing by 1.1 million annually, to 40.9 million early 1994, according to the Employee Benefit Research Institute in Washington.

The employers added 2 million workers to the insured rolls when the economy revved up year, 4.5 million spouses and children were dropped, mostly by small businesses.

"So doctors started to refer children already in their offices to public health clinics."

Cont'd on next

THE GREEN

from previous page

fordable shots by the tens and hundreds of thousands," Weill said. He considers each referral a missed opportunity for vaccination.

"Many of those kids got down to public clinics; many did not. There was a huge attraction between the doctors' offices and the clinic. Maybe some of those parents were working one or two jobs.

"Maybe it was risky taking time from work for the doctor's appointment, and maybe taking off a second time to go to the clinic was riskier. It's rough for parents these days."

Not in Colorado

The crucial aspect of VFC that Weill extols was never available in Colorado.

In Colorado, the transition in 1993 from state-purchased to VFC vaccine went smoothly for public health clinics. But to distribute the vaccine to private doctors, public health officials planned to use a system set up by the Centers for Disease Control, which was to have been implemented in October 1994, according to Judy Connor at the state department of public health.

The GAO shot down that plan and the CDC tried for a different system in which vaccines were distributed by manufacturers. That too fell through, Connor said.

"We in Colorado decided we couldn't wait another year," she said. As many states already have done, Colorado is creating its own plan to get low-cost vaccine to private physicians by the beginning of next year.

But because VFC vaccine is still unavailable to private practitioners now, uninsured children cared for in

INFORMATION

For the clinic nearest you, call the Family Health Line at 692-2229 in the Denver metro area; in the rest of Colorado, call 1-800-688-7777.

doctors' offices still have to be referred to public clinics for immunization.

There are some 170,000 uninsured kids in Colorado and the number is growing.

Another 150,000 children are covered by Medicaid and some of the private practitioners who treat them also are referring to clinics because, they say, Medicaid reimbursement rates for vaccines are too low.

Currently, private doctors in Colorado can offer Medicaid children no-cost vaccines, though each shot costs the doctor \$5 or \$6 to administer.

And, as of January 1994, a new state law requires all insurers who cover children to include such well-child preventive services as immunizations at no extra cost to families.

Little will change

Because Colorado was slow to extend VFC to private practitioners, if Congress kills Vaccines for Children, little will change here, except vaccines administered in public clinics will cost taxpayers more because each state will have to negotiate a separate contract with manufacturers.

Around the country, more than 23,000 private practices or clinics are enrolled nationwide, according to Barbara Heynolds at the CDC. The majority of state health officials from those states endorse the program.

Texas Health Commissioner David Smith, for example, said, "Like any other program from Washington, VFC has warts, but it's working. It's been very successful."

But, Smith warned, "If we continue to change, the greatest barrier for private doctors will be uncertainty. The rules are going to change again."

Smith is miffed the GAO never asked him how he felt about VFC's implementation in Texas. In 1999, a survey of parents and pediatricians by Texas A&M indicated cost was a barrier to children getting immunized 90 percent of the time, Smith said.

Talk to real people

"What upsets me about the GAO report is, if you don't talk to state officials, fine. But at least talk to parents. That's the problem with government — we don't talk to the real people."

No one really knows how many children fall through the cracks when their private doctors send them to public clinics for shots.

But Smith's numbers give a hint: in 1993, 21 percent of 4 million state-purchased vaccine doses were delivered by private doctors; last year, 5.2 million doses were administered, 32 percent by private docs — "a bigger percentage against a larger number," Smith said.

And, because VFC is an entitlement, he is able to offer the latest and greatest vaccines to his state's poorest children. Texas immunization rates for 2-year-olds have almost doubled, from 30 percent to 54 percent, Smith credits VFC, but says his efforts didn't stop there.

With money saved by using VFC in place of state-purchased vaccine, Smith bought a tracking system to

pick up unimmunized, malnourished toddlers. He hired visiting public health nurses. He put nurses and vaccinators in public health clinics. He made immunization a requirement for pre-school.

He bought hepatitis vaccines for his population — odd.

But there is a larger Smith said. "We into doctors' offices," especially those with chronic asthma or diabetes. Forcing parents to bring their children to the doctor's office.

Might help kids

Steve Berman, policy at the University of Texas Health Sciences Center, said the same thing could have been done in 1993. He could have been able to see 100 rooms.

GREEN SHEET 25

pick up unimmunized and under-immunized toddlers. He bought vans and hired visiting nurses to take public health to the kids who needed it. He put nurses and vaccine in WIC (Special Supplemental Food Program for Women, Infants and Children) offices and made immunization a requirement for access to the aid.

He bought hepatitis and influenza vaccines for his most underimmunized population — adults.

But there is a larger issue here, Smith said. "We want to get kids back into doctors' offices." All children, especially those with chronic problems like asthma or diabetes, need medical homes. Forcing families to make appointments all over town "makes families make bad choices."

Might help kids

Steve Berman, director of health policy at the University of Colorado Health Sciences Center, says the same thing could happen here. VFC could mean more Medicaid kids will be able to see private pediatricians instead of getting care in emergency rooms.

"One of the big issues that surrounds Medicaid is that we don't have enough primary care physicians to take Medicaid patients. The primary reason is poor reimbursement. Providing adequate reimbursement for giving shots removes one barrier to getting physicians to participate," Berman said.

Financial barriers to immunization exist, he said. "Removing financial barriers in and of itself won't do it but it is an important step that has to be taken with other steps."

Why is VFC so much much trouble? A lot of finger-pointing is going on. The GAO says cost of vaccines is no problem; the fault must lie with parents.

But counselor Weill at the Children's Defense Fund says, "The GAO had a large budget cut last year and, is fighting for its life. They decided to come down on this issue, to cover their rear end by telling congressional members what they wanted to hear."

Families and children win because with VFC, they get one-stop medical care, said Jackie Noves of the Acad-

emy of Pediatrics. Taxpayers win because they are paying less for vaccine when the federal government negotiates one low price for 50 states rather than making each state fend for itself in negotiations.

Only the pharmaceutical companies, which would like to see their profits increased, are losing, said Noves. She would like to see some middle ground in manufacturer profits — more than under VFC but less than with each state negotiating a separate contract.

Several barriers

Speaking for the vaccine manufacturer Merck and Co., Isabelle Claxton said the real barriers to immunization for children are bad clinic hours, uneducated parents and uneducated pediatricians.

"If they were good doctors, they would just give vaccine at cost," Claxton said. Further, "doctors aren't immunizing these kids. They don't keep their records properly and they aren't educated enough to give the vaccine when the kid has the antibodies."

ANOTHER POINT OF VIEW

The writer is director of the Nebraska Department of Health.

'Federal Vaccine Program Needed'

BY MARK B. MORTON, M.D.

I would like to offer some considerations regarding the June 28 editorial: "Failed Vaccination Program Should End." I think that it is perhaps premature to deem the federal Vaccines for Children Program a "failed program." It is still in the early stages of its effort to make vaccines available through physicians' offices for four categories of children for whom the cost of vaccines might be a barrier to being appropriately immunized.

These are children who do not have insurance coverage for immunizations, Native American and Eskimo children, and children who are Medicaid-eligible.

The program's implementation has encountered its share of challenges. I think that difficulties in establishing a distribution system for vaccine can be expected when dealing with more than 60 state and territorial programs.

The recent report from the General Accounting Office has caused critics to call for an end to the program. It

RESPONSE
TO JUNE 28
EDITORIAL:
"FAILED
VACCINATION
PROGRAM
SHOULD END"

criticizes the program for its difficulties in implementation and expresses concern about accounting mechanisms. There are problems that can be overcome. In my opinion, the report does not adequately recognize the benefits that Vaccines for Children has to offer.

As a nation, we have been successful recently in increasing our childhood immunization rates, yet we should not forget that millions of children are born each year in this country who will need immunizations. Our immunization strategy should be a long-term and continuous effort, not sporadic and crisis-oriented.

The goal of immunizing 90 percent of our country's 2-year-olds is something we will have to continuously and tirelessly work to achieve.

Another benefit of the VFC program is that it strengthens the public-private partnership by providing free vaccines for eligible children to be given in the child's medical home. This reinforces the importance of a primary care provider and strengthens the link to other medical services.

Public clinics are invaluable, of course, but making free vaccine available in a child's own doctor's office will reduce the chance of "missed opportunities" for immunization.

Some opponents of the program have

argued that the price of vaccines is not the true impediment to achieving high childhood immunization rates. Studies have shown that for poor families, cost is one issue that needs to be addressed.

There are other barriers that we must also surmount, such as parental lack of knowledge about the need for immunizations, insufficient clinic hours that do not give consideration to parental convenience, and lack of a tracking system to remind parents that immunizations are due.

At Governor Nelson's behest, the 1994 Nebraska Legislature appropriated \$300,000 for the purchase of vaccine to be supplied to physicians' offices. With this funding, more than 200 physicians' offices have received free vaccine for their needy patients.

This act shows our commitment on the state level to immunizations for children. Commitment to immunizations on the federal level is equally important.

While the federal VFC program has had some start-up problems, it is nevertheless a very valuable tool for many states and promises to be of even greater value as implementation proceeds.

Now is not the time to give it up. Support for this program should not be scaled back.

MEMORANDUM

TO: Jennifer Klein
FROM: Jim Weill 
DATE: August 14, 1995
RE: V.F.C. Press

Attached are some of the better recent articles, op-eds, and letters to the editor.

It was good seeing you.

Attachment

July 8, 1995, Saturday, SOONER EDITION

SECTION: EDITORIAL, Pg. A6

LENGTH: 462 words

HEADLINE: Shots in the dark;
The immunization crisis is partly an attitude problem

BODY:

The health of American children will be in the hands of Congress when members decide whether to provide free immunization for needy youngsters.

The current program was established by Congress in 1993 at the urging of President Clinton. It provides free vaccine against such diseases as measles, mumps, polio and whooping cough to children 18 and younger who are eligible for Medicaid, have no health insurance or have private insurance that doesn't cover vaccine.

The Government Accounting Office recently issued a report saying that the current program is mismanaged and poorly planned, and should be scrapped.

The GAO report suggested that the Clinton administration had underestimated the complexity of delivering vaccine to doctors and clinics, and had based the program on the notion that vaccine costs were the major barrier to immunization.

Congressional Republicans have said -- and continue to say -- that they are quite willing to do away with the current program, but there is no indication exactly what they would propose instead.

Rather than discarding the entire program, it make more sense to make corrections and adjustments. First, the kinds of problems attributed to the immunization program -- delivery difficulties, poor record keeping, imprecise data on whether the vaccines are reaching target populations, and computer problems -- can certainly be corrected after thorough analysis.

Other factors may be hampering the effectiveness of the program that have nothing to do with the program itself -- inconvenient doctor's office hours, for instance. In some poor areas of the country, the relationship between patient and physician is marked by suspicion and misunderstanding. There also is an element of fear concerning the side effects of vaccines on children.

In some poor neighborhoods, there's a lack of information about the need to get children immunized, the threat that some diseases pose to personal health, and the fact that financial help is available for those who can't afford shots.

The need for the program is indisputable: Between 40 percent and 60 percent of 2-year-olds are not fully vaccinated, a figure that rises to 90 percent in some inner-city neighborhoods. Before the federal effort is abandoned, changes should be implemented and a better information campaign should be undertaken.

Meanwhile, one argument that does not justify scuttling the program is cost. An annual expenditure of \$ 457 million may seem like a lot of money. But consider that during just one health crisis alone -- the measles epidemic of 1989-91 -- 55,000 cases were reported causing 44,000 days of hospitalization and \$ 165 million in direct health-care costs. By comparison, an effective immunization effort is a bargain.

FIX IT, DON'T KILL IT

Miami Herald (MH) - TUE July 18, 1995

By: Herald Staff

Edition: FINAL Section: EDITORIAL Page: 6A

Word Count: 450

MEMO:

VACCINES FOR CHILDREN

TEXT:

While some states have problems, Florida and others are getting more kids immunized on time.

If there are problems within the Vaccines for Children program, Congress should fix them, not scrap the program. Some states, Florida among them, are doing what the program intended: getting vaccines to doctors -- and into kids.

Lumping this program into that cure-all, the block grant, won't solve the issues here. Worse for Florida, block grants are hazardous to the health of high growth states because they won't meet the rising need.

Most children are vaccinated against diseases such as measles by the time they enter school, but only 40 percent of children in some states are vaccinated in infancy. This leaves them exposed to disability or death.

This program was a priority for President Clinton. But as it moved through Congress in 1993, it was criticized as a government takeover of the vaccine supply, as providing vaccines to well-off children, and as focusing on cost, not other barriers to immunization.

The program started last October. It offers free vaccines to families that are indigent, uninsured, or not insured for vaccinations. Last week the General Accounting Office reported that the program has too few controls and should focus on poor families and areas where outbreaks of disease are likely.

But how has the program worked here? Dr. John Curran, president of the Florida Pediatric Society/Florida Chapter of the American Academy of Pediatrics, rates the program highly. In the past, pediatricians treating children on Medicaid would have to pay for vaccines out of pocket and wait for reimbursement. Because Medicaid can pay slowly or deny coverage, they lost money.

Often, doctors would refer families to public health clinics. These families and those pressed to find the \$300 or so for the full course of shots delayed getting them. Now Florida doctors order vaccines through the state, so there is no reason for referrals to clinics or delay.

Al Sulkes, who heads the state program, says that because Florida already had systems in place, it started the program promptly. It now serves more than 1,600 doctors as well. In Dade, for example, the state counts providers in 65 zip codes.

In 1991 some 62 percent of Florida's 2-year-olds were immunized. In 1994, before the vaccine program started, an aggressive drive by the state and groups such as Kiwanis brought this to 76 percent. No new figures are available. Dr. Louis St. Petery Jr. of the pediatric society says that a recent Tallahassee survey showed that 98 percent of toddlers had received their shots.

That's the point -- getting kids vaccinated. So if there are problems, fix 'em. But don't kill the program.

July 2, 1995, Sunday, Final Edition

SECTION: EDITORIAL; Pg. B8

LENGTH: 320 words

HEADLINE: VACCINATIONS THE GOAL

BODY:

REPUBLICANS keen on undoing President Clinton's bold plan to immunize millions of children from a host of preventable diseases need to stay focused on the goal.

Congressional critics, including the Government Accounting Office, have found the administration's approach too expensive and poorly managed.

The president wanted the federal government to be the primary provider of vaccines through bulk purchases that could be provided at no cost to family doctors as well as public health clinics. Drug companies, worried about their profit margins, complained that Vaccines for America tampered with a distribution system that was working.

The GOP is right in one regard - the issue is broader than vaccine price and availability. Laws that require children to have current immunizations to enter school or day care have had a salutary impact on health statistics. But many children under two do not get basic and follow-up immunizations.

The GOP alternative is to scuttle Clinton's plan and turn the responsibility over to the states. This is a potential trap for two reasons. One danger is Congress will cap the money for immunization programs at a fixed level that is not adequate to future needs. Second, there is a role for the federal government to assure that a broad public health goal is met. Spotty performance by states got the federal government involved in the first place.

Leadership and innovation is needed for the delivery of information and immunization campaigns targeted to parents and families with language barriers and irregular work hours. Everything from record-keeping to follow-up visits have to be simplified to encourage participation.

This all costs money, but a dollar spent on immunizations saves another \$ 10 in medical care not provided. That savings is worth protecting, and Republicans need to be mindful of the bargain that comes with protecting our children's health.

August 1, 1995 Tuesday 2D EDITION

SECTION: LIVING; Pg. E-01

LENGTH: 1791 words

HEADLINE: Free for all Kid's vaccine program in legislative limbo

BYLINE: Carol Kreck, Denver Post Staff Writer

BODY:

With little more than 60 percent of its 2-year-olds fully immunized, the state of Colorado is planning to implement President Clinton's Vaccines for Children program even as Congress threatens to kill it.

"We're moving ahead without knowing what the future holds," said Judy Connor, director of immunization for the Colorado Department of Public Health and the Environment. "We just have to do what we think is necessary."

The children's vaccine program was born in 1993 when the president accused pharmaceutical companies of "pursuing profits at the expense of our children."

Using recommendations from University of Colorado Health Sciences chancellor Vincent Fulginiti, who chaired the presidential advisory commission, Clinton proposed making vaccines a public utility purchased by the federal government and distributed to all children for free.

Congress scaled back the president's idea, but established the program as an entitlement that allows free vaccines for children who are uninsured, on Medicaid or whose insurance doesn't cover vaccinations - about 60 percent of American children.

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Despite this seemingly win-win situation, the program is playing to widely mixed reviews.

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Meanwhile the majority of state officials whose states have fully implemented the program endorse it.

David Smith, Texas commissioner of health, calls VFC successful and credits the program and the money it saved with helping to double immunization rates in his state.

Smith said the GAO's assessment is absurd. "In a state like Texas where we have 1.5 million children on Medicaid and another 1.5 million uninsured, let me tell you that cost is a barrier."

Before the program was implemented, poor children in Colorado, as well as in the rest of the country, could (and still can) get free shots at public health clinics, a fact the GAO used to excoriate the program.

But when you ask families with few resources to jump through more hoops, kids will fall between the cracks, argues the American Academy of Pediatrics and the Children's Defense Fund.

"I see families every day, five days a week who cannot afford the cost of these vaccines," said pediatrician Lee Thompson of Aurora Pediatric Associates. Having to refer families to public clinics "presents a series of additional obstacles."

"What has happened in the last 10 years before Vaccines for Children is that as the price of vaccines rose, the income of young families went down and the number of kids with private insurance went down," said Jim Weill, general counsel for the Children's Defense Fund in Washington.

Nationwide, the number of uninsured is rising by 1.1 million annually, to 40.9 million in early 1994, according to the Employee Benefit Research Institute in Washington. Though employers added 2 million workers to the insured rolls when the economy revved up last year, 4.5 million spouses and children were dropped, mostly by small businesses.

"So doctors started to refer children already in their offices to public clinics for affordable shots by the tens and hundreds of thousands," Weill said. He considers each referral a missed opportunity for vaccination.

"Many of those kids got down to public clinics; many did not. There was a huge attrition between the doctors' offices and the clinic. Maybe some of those parents were working one or two jobs.

"Maybe it was risky taking time from work for the doctor's appointment, and maybe taking off a second time to go to the clinic was riskier. It's rough for parents these days."

Not in Colorado

The crucial aspect of VFC that Weill extols was never available in Colorado.

In Colorado, the transition in 1993 from state-purchased to VFC vaccine went smoothly for public health clinics. But to distribute the vaccine to private doctors, public health officials planned to use a system set up by the Centers for Disease Control, which was to have been implemented in October 1994, according to Judy Connor at the state department of public health.

The GAO shot down that plan and the CDC tried for a different system in which vaccines were distributed by manufacturers. That too fell through, Connor said.

"We in Colorado decided we couldn't wait another year," she said. As many states already have done, Colorado is creating its own plan to get low-cost vaccine to private physicians by the beginning of next year.

But because VFC vaccine is still unavailable to private practitioners now, uninsured children cared for in doctors' offices still have to be referred to public clinics for immunization.

There are some 170,000 uninsured kids in Colorado and the number is growing.

Another 150,000 children are covered by Medicaid and some of the private practitioners who treat them also are referring to clinics because, they say, Medicaid reimbursement rates for vaccines are too low.

Currently, private doctors in Colorado can offer Medicaid children no-cost vaccines, though each shot costs the doctor \$ 5 or \$ 6 to administer.

And, as of January 1996, a new state law requires all insurers who cover children to include such well-child preventive services as immunizations at no extra cost to families.

Little will change

Because Colorado was slow to extend VFC to private practitioners, if Congress kills Vaccines for Children, little will change here, except vaccines administered in public clinics will cost taxpayers more because each state will have to negotiate a separate contract with manufacturers.

Around the country, more than 23,000 private practices or clinics are enrolled nationwide, according to Barbara Reynolds at the CDC. The majority of state health officials from those states endorse the program.

Texas Health Commissioner David Smith, for example, said, "like any other program from Washington, VFC has warts, but it's working. It's been very successful."

But, Smith warned, "if we continue to change, the greatest barrier for private doctors will be uncertainty. The rules are going to change again."

Smith is miffed the GAO never asked him how he felt about VFC's implementation in Texas. In 1989, a survey of parents and pediatricians by Texas A&M indicated cost was a barrier to children getting immunized 90 percent of the time, Smith said.

'Talk to real people'

"What upsets me about the GAO report is, if you don't talk to state officials, fine. But at least talk to parents. That's the problem with government - we don't talk to the real people."

No one really knows how many children fall through the cracks when their private doctors send them to public clinics for shots.

But Smith's numbers give a hint: in 1993, 21 percent of 4 million state-purchased vaccine doses were delivered by private doctors; last year, 5.2 million doses were administered, 32 percent by private docs - "a bigger percentage against a larger number," Smith said.

And, because VFC is an entitlement, he is able to offer the latest and greatest vaccines to his state's poorest children. Texas immunization rates for 2-year-olds have almost doubled, from 30 percent to 56 percent. Smith credits VFC, but says his efforts didn't stop there.

With money saved by using VFC in place of state-purchased vaccine, Smith bought a tracking system to pick up unimmunized and under-immunized toddlers. He bought vans and hired visiting nurses to take public health to the kids who needed it. He put nurses and vaccine in WIC (Special Supplemental Food Program for Women, Infants and Children) offices and made immunization a requirement for access to the aid.

He bought hepatitis and influenza vaccines for his most underimmunized population - adults.

But there is a larger issue here, Smith said. "We want to get kids back into doctors' offices." All children, especially those with chronic problems like asthma or diabetes, need medical homes. Forcing families to make appointments all over town "makes families make bad choices."

Might help kids

Steve Berman, director of health policy at the University of Colorado Health Sciences Center, says the same thing could happen here. VFC could mean more Medicaid kids will be able to see private pediatricians instead of getting care in emergency rooms.

"One of the big issues that surrounds Medicaid is that we don't have enough primary care physicians to take Medicaid patients. The primary reason is poor reimbursement. Providing adequate reimbursement for giving shots removes one barrier to getting physicians to participate," Berman said.

Financial barriers to immunization exist, he said. "Removing financial barriers in and of itself won't do it, but it's an important step that has to be taken with other steps."

Why is VFC in so much trouble? A lot of finger-pointing is going on. The GAO says cost of vaccines is no problem; the fault must lie with parents.

But counselor Weill at the Children's Defense Fund says, "the GAO had a large budget cut last year and is fighting for its life. They decided to come down on this issue, to cover their rear end by telling congressional members what they wanted to hear."

Families and children win because with VFC, they get one-stop medical care, said Jackie Noyes of the Academy of Pediatrics. Taxpayers win because they are paying less for vaccine when the federal government negotiates one low price for 50 states rather than making each state fend for itself in negotiations.

Only the pharmaceutical companies, which would like to see their profits increased, are losing, said Noyes. She would like to see some middle ground in manufacturer profits - more than under VFC, but less than with each state negotiating a separate contract.

Several barriers

Speaking for the vaccine manufacturer Merck and Co., Isabelle Claxton said the real barriers to immunization for children are bad clinic hours, uneducated parents and uneducated pediatricians.

"If they were good doctors, they would just give vaccine at cost," Claxton said. Further, "doctors aren't immunizing these kids. They don't keep their records properly and they aren't educated enough to give the vaccine when the kid has the sniffles."

INFORMATION

For the clinic nearest you, call the Family Health Line at 692-2229 in the Denver metro area; in the rest of Colorado, call 1-800-688-7777.

GRAPHIC: PHOTOS: The Denver Post/Lyn Alweis OUCH! Ashley Muella gets a shot but her brother Arturo starts crying while their mom, Marsela Rodriguez, looks on. Jordan LeMoine, 13 months, receives an oral polio vaccine.

July 27, 1995, Thursday, ALL EDITIONS

SECTION: EXTRA, Pg. 10D
LENGTH: 583 words
HEADLINE: Readers' Letters;
TELL US WHAT YOU THINK;

Shots made easy
ECLEAMUS RICKS, Deputy Commissioner for Physical Health

A recent editorial, "Saving kids isn't such a long shot," mentioned several barriers to children receiving immunizations.

Generally, a trip to a Fulton County Health Department clinic for immunizations does not take all day; it probably takes no more than one hour or less in the clinic. Each of our 20 health centers offers immunizations by appointment Monday through Friday, 8:30 a.m. to 5 p.m., or on a walk-in basis on specific days.

We make every attempt to provide immunizations at any time a clinic requests the services. Additionally, six centers (Sandy Springs, Neighborhood Union, Aldredge, Lakewood, Adamsville and College Park) offer the service two Saturdays each month. In most situations, using these clinics will not involve loss of work time.

I agree that the immunization schedule is complex. Our nurses attempt to explain to each parent what is needed, have them read information about each schedule, answer questions and determine if there is any reason not to give the vaccine. We also tell the parent what vaccine is due next and when it is due. We make special attempts to educate all parents, especially teenage mothers about immunizations. Many of our centers attempt to remind parents when vaccines are due or to contact them if they fail to return for the next doses.

Cost is not a barrier in Fulton County because the vaccine is supplied by the state whether or not a child is eligible for the Vaccine for Children program. We do charge a small administration fee based on the family size and income, but we do not refuse vaccines to anyone if they cannot pay.

The Fulton County Health Department is doing everything possible to remove any barriers to immunizations. We are proud that we're making strides. Our immunization adequacy rate for children 21 to 23 months old increased from 56.6 percent to 73.7 percent from 1993 to 1994. Protecting our children from these preventable diseases is one of our highest priorities.

July 25, 1995, METRO FINAL

SECTION: EDITORIALS; Pg. B7

LENGTH: 1827 words

HEADLINE: LETTERS

BODY:

In his July 9 Forum article, "Clinton invents a vaccine crisis," Robert M. Goldberg takes the position that President Clinton's motives for proposing the federal Vaccines for Children program were purely political. While his premise may be valid, his conclusion that no vaccination crisis exists is one that must not go unanswered.

The true vaccine crisis is one of creating a demand for early immunization by educating parents and caregivers that shots are due by age 2, not by kindergarten. Preschool children are at risk for measles, meningitis, hepatitis, whooping cough, German measles and several other preventable diseases until the series of shots is completed.

Studies by the California Department of Health Services in 1994 revealed a one-time rate of only 40 percent in Sacramento County. While this year's figures are up to 52 percent, babies in this county still are not receiving baby shots by the age recommended. If these children received no other shots before school entry, nearly 115 school buses full of children would be turned away from Sacramento County schools on the first day of class.

A community in which nearly half of its toddlers are not immunized does, indeed, have a crisis, with the potential for outbreaks of diseases with serious consequences for infants and small children.

B.J. Ueltzen, Program Consultant
Sacramento Toddler Immunization
Coalition
Sacramento

July 20, 1995 Thursday, NORTH SPORTS FINAL EDITION

SECTION: PERSPECTIVE; Pg. 24; ZONE: N; Voice of the people (letter).

LENGTH: 480 words

HEADLINE: A PARTNERSHIP FOR IMMUNIZATION

BYLINE: David Satcher, Director, Centers for Disease Control and Prevention.

DATELINE: ATLANTA, Ga.

BODY:

I am very disappointed with your June 27 editorial criticizing the administration's efforts to ensure that all children are immunized against crippling diseases such as mumps, measles and polio.

The editorial misstates the premises and operations of the nine-month old Vaccines For Children Program (VFC), which enables poor or uninsured children to receive free immunizations in their private doctors' offices.

A substantial body of research shows that, prior to the creation of VFC, the high cost of vaccination caused children to be shunted from their private doctors to public clinics. This resulted in fragmented care, overcrowding at clinics and missed opportunities to immunize children. VFC is designed to prevent these unacceptable practices.

The program is neither a "government distribution system" nor a "takeover" of the private vaccine market, as you allege. Rather, it is a genuine partnership among individual states, the federal government and health professionals that provides accountability, improved public access and flexibility for states and physicians.

Through the program, the federal government purchases vaccine at reduced rates and helps states buy at a discount as well. The states distribute the vaccine to doctors' offices, clinics and hospitals. In addition, the states design their own accountability approaches. Health professionals ensure that eligible children get their shots and are not forced to leave their "medical homes."

This partnership reduced federal micromanagement--a worthy goal we all share.

Moreover, your editorial does not note that VFC is just one component of the administration's Childhood Immunization Initiative. Through this initiative, we are rebuilding our country's immunization services systems, educating the public and health professionals about proper vaccination, mobilizing communities and businesses, improving the monitoring of disease outbreaks and coverage rates, researching new vaccines and giving grants to states for local immunization projects.

The administration's initiative is designed to address all the barriers that prevent children from receiving their shots and to build a permanent system to sustain high coverage in the future.

I agree that all parents must take responsibility for their children's health and safety. That is why we have formed partnerships with the private sector to put immunization information on the packaging of diapers and infant cereals, developed effective public service announcements and a toll-free referral service for parents and why we help local communities build coalitions to raise awareness. In addition, we are working with established government programs to increase immunization awareness and levels.

We remain committed to working on all fronts to protect our youngest and most vulnerable children.

July 8, 1995 Saturday SUNRISE EDITION

SECTION: EDITORIAL; Pg. 9; ANOTHER POINT OF VIEW

LENGTH: 566 words

HEADLINE: 'Federal Vaccine Program Needed'

BYLINE: Mark B. Horton, M.D.

BODY:

I would like to offer some considerations regarding the June 28 editorial: "Failed Vaccination Program Should End." I think that it is perhaps premature to deem the federal Vaccines for Children Program a "failed program." It is still in the early stages of its effort to make vaccines available through physicians' offices for four categories of children for whom the cost of vaccines might be a barrier to being appropriately immunized.

These are children who do not have insurance coverage for immunizations, Native American and Eskimo children, and children who are Medicaid-eligible.

The program's implementation has encountered its share of challenges. I think that difficulties in establishing a distribution system for vaccine can be expected when dealing with more than 60 state and territorial programs.

The recent report from the General Accounting Office has caused critics to call for an end to the program. It criticizes the program for its difficulties in implementation and expresses concern about accounting mechanisms. These are problems that can be overcome. In my opinion, the report does not adequately recognize the benefits that Vaccines for Children has to offer.

As a nation, we have been successful recently in increasing our childhood immunization rates, yet we should not forget that millions of children are born each year in this country who will need immunizations. Our immunization strategy should be a long-term and continuous effort, not sporadic and crisis-oriented.

The goal of immunizing 90 percent of our country's 2-year-olds is something we will have to continuously and tirelessly work to achieve.

Another benefit of the VFC program is that it strengthens the public-private partnership by providing free vaccines for eligible children to be given in the child's medical home. This reinforces the importance of a primary care provider and strengthens the link to other medical services.

Public clinics are invaluable, of course, but making free vaccine available in a child's own doctor's office will reduce the chance of "missed opportunities" for immunization.

Some opponents of the program have argued that the price of vaccines is not the true impediment to achieving high childhood immunization rates.

Studies have shown that for poor families, cost is one issue that needs to be addressed.

There are other barriers that we must also surmount, such as parental lack of knowledge about the need for immunizations, insufficient clinic hours that do not give consideration to parental convenience, and lack of a tracking system to remind parents that immunizations are due.

At Governor Nelson's behest, the 1994 Nebraska Legislature appropriated \$ 300,000 for the purchase of vaccine to be supplied to physicians' offices. With this funding, more than 200 physicians' offices have received free vaccine for their needy patients.

This act shows our commitment on the state level to immunizations for children. Commitment to immunizations on the federal level is equally important.

While the federal VFC program has had some start-up problems, it is nevertheless a very valuable tool for many states and promises to be of even greater value as implementation proceeds.

Now is not the time to give it up. Support for this program should not be scaled back.

July 16, 1995, Sunday, ALL EDITIONS

SECTION: Opinion, Pg. 3B, GUEST COLUMN

LENGTH: 685 words

HEADLINE: VACCINE PROGRAM ATTACKS PROBLEM NOW, SETS UP PLAN FOR FUTURE

BYLINE: BY DONNA SHALALA

BODY:

Winston Churchill once said, "There is no finer investment than putting milk into babies." And, I would add, making sure they're fully immunized at the right age against crippling diseases such as polio, measles and mumps.

The fact is, in the two years before President Clinton came to office, about 50 percent of America's two-year-olds were not vaccinated on time.

The president believes our country must do better -- and he has implemented a comprehensive Children Immunization Initiative to help us do just that.

Unfortunately, some critics, including the State Journal's June 18 editorial, have misunderstood the true scope of the Childhood Immunization Initiative -- and focused on only one piece of the puzzle, the nine-month-old Vaccines for Children program, which enables poor or uninsured children to receive free immunization in their private doctors' offices.

In fact, we are doing much more. We are addressing all the different barriers that prevent immunization -- such as inconvenient clinic hours, high cost of vaccination, and lack of awareness among parents and health care professionals about the importance of infant immunizations. Our approach is designed to increase immunization rates right now, while also building a permanent system to sustain rates into the future.

To accomplish that, in addition to Vaccines for Children, we are educating the public and health professionals about proper vaccination, mobilizing communities and businesses, improving the monitoring of disease outbreaks and coverage rates, researching new vaccines, giving new grants to states for local immunization projects, and rebuilding our country's immunization services systems -- so that clinics can expand their services and lengthen their hours.

Not only did the editorial say nothing about these efforts, but what it did say about the Vaccines for Children Program was misleading. Rather than attempting a "take over" of all vaccination programs, as your editorial asserts, VFC is a genuine partnership among the federal government, health professionals, and individual states such as Wisconsin.

Under the old system, the only way uninsured children of working families could get government-purchased vaccines was to leave their private doctors and make a number of trips to public clinics -- which contributed to fragmented care, overcrowding at clinics, and missed opportunities to vaccinate. Not anymore.

With the Vaccines for Children program, we are working with doctors and other officials at the state and local levels to ensure that poor and uninsured children are eligible to receive vaccines right in their doctors' offices.

Here's how it works: The federal government purchases vaccine at reduced rates and helps states buy at a discount as well. The states then distribute the vaccine to doctors' offices, clinics and hospitals, and design their own approaches to guaranteeing accountability. Health professionals ensure that eligible children receive their shots and are not forced to leave their "medical leaves." This partnership provides accountability to the public, while reducing federal micro-management of states and physicians -- worthy goals we all share.

In the short time since Vaccines for Children has become operational, tens of thousands of private health providers have enrolled in the program. In fact, right here in Wisconsin, VFC is helping to deliver vaccines to hundreds of private and public sector sites -- as physicians, state and local health officials, parents and community leaders all join together to immunize our state's youngest and most vulnerable citizens.

That's a great start -- but, it is not enough. Because today, although immunization rates have now risen to their highest levels in history, almost 2 million of American's two-year-olds have still not received all the vaccinations they need.

Together, we can do better. Together, we can protect our children and triumph against diseases such as polio, mumps and measles -- but only if we tackle this problem comprehensively. And that's just what we're doing.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

06-Jul-1995 01:16pm

TO: (See Below)

FROM: Farooq A. Khan
Office of Mgmt and Budget, HD

SUBJECT: CHILDHOOD VACCINATION: AMA pushes for ERISA exemptions.

CHILDHOOD VACCINATION: AMA PUSHES FOR ERISA EXEMPTIONS

"Concerned that children and adults who are enrolled in self-insured health plans are missing out on immunizations," the AMA, at its annual meeting in Chicago last week, "agreed to 'strongly advocate' that all health plans cover immunizations recommended by the" CDC. While "some states have adopted regulations to mandate insurance coverage of vaccines and vaccine administration," self-insured plans are exempt under ERISA. Doctors from Michigan, where 70% of state residents are covered by self-insured plans, urged the AMA to "seek a legislative change to ERISA to require that self-insured entities comply with state regulations mandating coverage of vaccines." But "the current political atmosphere makes it 'exceedingly unlikely' that Congress would 'open up'" ERISA, given that "approach contradicts the anti-regulatory atmosphere" prevalent on Capitol Hill. Still, an AMA committee said it "supports action in this area and believes that ... the AMA can promote vaccination by self-insured ERISA plans through educational efforts." The AMA "voted to disseminate information on the cost-effectiveness of vaccines and to advocate that all health plans cover immunizations for all plan beneficiaries." Delegates also "agreed to broaden their consideration of ERISA-related policies." The Board of Trustees was directed with studying and reporting "on the advantages and disadvantages of state-mandated taxes, surcharges or other assessments on self-insured ERISA plans" (Kent, 7/3-10 issue).

EDITORIAL ROUND-UP ON VFC: COLUMBUS DISPATCH: "The Clinton administration's child-vaccination program has been badly mismanaged from the start. ... The most important component of a vaccine program is education. ... It would make more sense to aid local programs rather than set up a new, gargantuan national program that is too unwieldy to operate efficiently" (7/2). Balto. EVENING SUN: "Childhood immunization should be an easy issue to champion. Yet somehow the administration jumped to the wrong conclusions and set about spending money in all the wrong places" (6/30). SEATTLE POST-INTELLIGENCER: "Congress should fine-tune the program where necessary and require that the states perform more efficiently in exchange for the federal aid. But it would be a tragedy compounded if this nation fails ... to retain

a program that provides a relatively inexpensive means of safeguarding the health of its children" (7/1). WASH. POST: "No doubt the vaccine program can be improved and tightened up. It should be. But if you want the immunization rate to go up, it shouldn't be junked without a lot of careful thought about the alternative" (7/3).

===== FOCUS =====

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E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

06-Jul-1995 12:21pm

TO: (See Below)

FROM: Gordon P. Agress
 Office of Mgmt and Budget, HD

SUBJECT: Diane Rehm Show on VFC

This morning the Diane Rehm show on WAMU hosted a discussion of Vaccines For Children. Speaking against VFC was Robert Goldberg, speaking for it was James Wile (sp?) of the Children's Defense Fund. Dr. Goldberg's chief points were that the program does not target areas of need, and that evidence suggests that access to vaccination in doctor's offices does not affect immunization rates. Mr. Wile argued that access in doctors' offices is important, and that VFC has helped in those States where it is running well. The discussion did not bring up new arguments for or against the program, and both participants made statements Bonnie and I thought inaccurate.

Mr. Wile did say that Federal spending for vaccination had only increased by \$70 million since VFC started (similar to Secretary Shalala's comments in the Post) -- this is inaccurate, but Dr. Goldberg did not call him on it. At another point, Dr. Goldberg said that HHS "played fast and loose" with the numbers for this program. The discussion largely focussed on the relative importance of the availability of vaccination in doctors' offices as opposed to clinics.

One pediatrician called in to say that VFC helps with an important group, children with insurance that does not cover immunization, since these children go to the doctor but the cost of vaccination causes parents to delay. However, VFC does not cover these "underinsured" children in doctors' offices, causing us to wonder if this doctor (and others) was improperly vaccinating underinsured children under VFC.

Distribution:

TO: Nancy-Ann E. Min

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FAX TRANSMISSION

U.S. Department of Health and Human Services
Office of the Secretary

DATE: 6/29

TO: Jennifer Klau

FAX: 456-2878

PHONE: _____

FROM: DAN PORTERFIELD, DIRECTOR

OASPA, SPEECH DIVISION

Phone: (202) 690 7470

Fax: (202) 690-7318

TOTAL NUMBER OF PAGES TRANSMITTED: 11

COMMENTS: Attache is the final copy of the
NYT response, which was sent out today, and
other responses to the Washington Times and the Chicago
Tribune that have been cleared by almost all around here.



U.S. Dept. of Health and Human Services
Office of the Secretary

DANIEL R. PORTERFIELD
Director, Speech Division

Please call tomorrow
morning before ~~10:00~~ 10:00
if you have any revisions.

Thanks,

DP

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

JUN 29 1995



Ms. Shelly Belzer
Acting Letters Editor
The New York Times
229 West 43rd Street
New York, New York 10036

Dear Ms. Belzer:

I was very disappointed with Robert Pear's article, "Republicans Plan to Scrap Program for Free Vaccines" (New York Times [NYT], 6/25/95).

While it is true that a General Accounting Office (GAO) report has raised concerns about the Vaccines For Children Program (VFC), I testified on June 15, 1995, before a congressional subcommittee that the GAO report is "deeply flawed" because the GAO misunderstood the premise and the operation of the VFC program.

Let me set the record straight here as well.

First, a substantial body of research shows that, prior to the creation of VFC, the high cost of vaccination caused poor or uninsured children to be shunted from their private doctors to public clinics. This resulted in fragmented care, overcrowding at clinics and missed opportunities to immunize children. VFC is designed to prevent these unacceptable practices.

Second, the program, which is only 9 months old, has a huge reservoir of support that Mr. Pear inexcusably fails to acknowledge. Now up and running across the country, VFC has won strong endorsements from State health officials, the American Academy of Pediatrics, and many others.

Third, we have established partnerships with States and health care providers to ensure that VFC resources are used wisely. We could have developed a heavy-handed approach to accountability and required every doctor to fill out multiple forms per child, but instead, we are balancing the need for Federal accountability with the appropriate level of State flexibility by empowering States to develop their own accountability approaches. This is consistent not only with our goal of reducing Federal micro-management, but with our critics' stated goals, as well.

Page 2 - Ms. Shelly Balzer

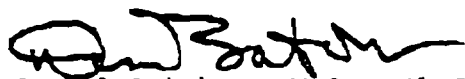
Fourth, neither the GAO nor Mr. Paar note that VFC is only one element of the larger Childhood Immunization Initiative (CII). This initiative is a comprehensive effort to address all the barriers that prevent children from receiving their shots and to build a permanent system to sustain high coverage in the future.

We are rebuilding our country's immunization services system, researching new vaccines, and educating parents and doctors about proper immunization.

Therein lies a supreme irony. Mr. Paar notes that one of VFC's critics would prefer to see program funds used to "buy vans to canvass poor neighborhoods, to hire nurses to knock on doors, to increase the operating hours of public health clinics, or to educate parents and doctors about the recommended schedule of childhood immunizations." With the CII, we are, in fact, already doing that and much more.

Unfortunately that fact was not included in the Times' article.

Sincerely,



David Satcher, M.D., Ph.D
Director

Letter to the Editor of
The Washington Times
David Satcher, M.D., Ph.D
Director of The CDC
June 29, 1995

I was disappointed with your 6/27/95 editorial on the Clinton administration's efforts to immunize our youngest and most vulnerable Americans against crippling diseases like mumps, measles, and polio.

While it is true that a General Accounting Office (GAO) report has raised concerns about the Vaccines For Children Program (VFC), I testified on June 15, 1995 before a congressional subcommittee that the report is "deeply flawed" because the GAO misunderstood the premise and operations of VFC.

Let me set the record straight here as well.

First, the GAO report and your editorial seriously misstate our national immunization problem by focusing on the fact that 95 percent of school-age children are properly immunized. That's not the issue. Proper pediatric practice requires that all children receive at least 11 shots *before their second birthdays*. Reaching and sustaining high *infant* immunization levels is the only way to prevent tragedies like the measles epidemic of 1989-

91, which struck more than 55,000 people -- many of them young children -- killing more than 130. That's especially true today, with many pre-schoolers going to group settings like day care centers well before their fifth birthdays.

Moreover, you are flat wrong with your allegation that in 1993 the Clinton administration relied on out-of-date immunization data supplied by an outside group. We used the most current figures available -- 1991 data provided by the Centers for Disease Control and Prevention.

Second, a substantial body of research shows that, prior to the creation of VFC, the high cost of vaccination caused poor or uninsured children to be shunted from their private doctors to public clinics. This resulted in fragmented care, overcrowding at clinics, and missed opportunities to immunize children. VFC is designed to prevent these unacceptable practices.

Third, VFC is not a "creaking federal bureaucracy." It is a genuine partnership among individual states, the federal government, and health professionals that provides accountability for the public and flexibility for states and physicians.

Here's how it works: The federal government purchases vaccine at reduced rates and helps states buy at a discount too. The states distribute the vaccine to doctors' offices, clinics,

and hospitals and design their own accountability approaches. Health professionals see to it that eligible children get their shots and are not forced to leave their "medical homes." This partnership reduces federal micromanagement -- a worthy goal we all share.

Fourth, VFC has enhanced vaccine delivery to doctors and hospitals. Now up and running across the country, VFC has won strong endorsements from state health officials, the American Academy of Pediatrics, and many others.

Fifth, neither the GAO report nor your editorial notes that VFC is only one element of the administration's larger Childhood Immunization Initiative. We are rebuilding our country's immunization services system, educating parents and doctors about proper immunization, mobilizing communities and businesses to help protect our children, improving the monitoring of disease outbreaks and coverage rates, researching new vaccines, and giving grants to states for local immunization activities.

With these strategies, we are working to knock down the many barriers that put children at risk -- including cost -- while building a permanent system to sustain high coverage rates in the future.

And we're making progress. That's the real story.

Wash. Times; 6-27-95

The vaccine boondoggle

For this, at least, we should be thankful: The Clinton administration's Vaccines for Children (VFC) program is the only plank of Clinton-Care that ever made it into law. Soon taxpayers will have paid over a billion dollars for the president's new bureaucracy, a disaster of a program that has utterly failed to increase immunization of low-income children — but by buying up much of the nation's supply of vaccine, has succeeded in disrupting distribution of vaccine to private doctors and hospitals.

There is almost no one outside the Clinton administration who can be found to say anything complimentary about the VFC program. The consensus is summed up in last week's General Accounting Office report on the program. The idea behind the VFC was that children were going without necessary immunization because their parents couldn't afford to pay for the vaccinations. The natural big-government solution favored by President and Mrs. Clinton was to have Washington buy vaccine and distribute it for free. Never mind that Medicaid already provided vaccine to poor children. Never mind that most states already had their own programs for providing vaccine to the disadvantaged. The GAO details these obvious problems, concluding flat-out that "the cost of vaccine for parents has not been a major barrier to children's immunization."

The Clintons knew this. After measles outbreaks in several cities in 1990, Congress gave the Centers for Disease Control some \$9 million to study why the children infected had not been inoculated. The CDC found that it wasn't for want of vaccine, nor even for lack of visits to the doctor. The average child who contracted measles was found to be on Medicaid, and to have been seeing a doctor about eight times a year. Instead, a number of easily solved problems had combined to create the mini-epidemics: Some doctors were not up to date on proper vaccination schedules; some failed to check their patients' records properly; others were overcautious about inoculated children suffering from colds or flu. A CDC study in New York City in 1992 had found a simple solution: Low-income mothers whose children were not up to date on their vaccinations were required to renew their WIC food vouchers once a month rather than every two months. The results were dramatic, with 40 percent to 80 percent increases in vaccination rates among the poor.

The Clintons had all these studies before them

when they cobbled together the VFC program. But they saw drug manufacturers as a target of opportunity in the opening skirmishes over nationalized health care. The Clintons demonized the makers of vaccine, calling them unconscionably greedy businessmen eager for "profits at the expense of our children." To make that case, Mr. and Mrs. Clinton relied on statistics prepared for them by Marian Wright Edelman and her staff at the Children's Defense Fund, statistics that showed a huge hike in the cost of vaccination. But as the Clintons and Mrs. Edelman knew, those price increases were not the result of business profiteering.

Two factors had boosted costs from 1980 to 1990. The first was the addition of two new vaccines to the basic set of inoculations given children, a shot for hepatitis B and one for haemophilus influenza type B. The second was a large excise tax imposed on the drugs by Congress. Several years ago, litigation costs drove all but three manufacturers out of the vaccine business. To protect the last few companies and maintain a supply of vaccines, Congress set up a fund to pay compensation for children injured by their inoculations. That fund is paid for by a tax built into the price of vaccines. But manufacturers were such a juicy target that the Clintons and their big-government allies were not willing to let the facts get in the way.

The administration also relied on bogus, out of date statistics about the number of children who go without full vaccination. Provided with figures by the Children's Defense Fund, the White House claims that the U.S. has shockingly high numbers of unprotected children. But those numbers were based on data from 1985. By contrast, the GAO confidently states, "More than 95 percent of the nation's children receive recommended vaccinations by the time they enter school." Nonetheless, amorphous claims about widespread under-immunization remain the White House line: "Isn't it troubling to see the United States way, way down the list of countries around the world in terms of vaccinating children against diseases?" Vice President Al Gore said on ABC's "This Week With David Brinkley." "That's something that cries out for a response."

What cries out for response is the creation of a creaking federal bureaucracy that does nothing to solve a simple problem except waste money. The appropriate response is the wholesale elimination of the Clintons' failed and futile immunization program.

1

Letter to the Editor of
The Chicago Tribune
David Satcher, M.D., Ph.D
Director of The CDC
June 29, 1995

I am writing to take exception to your June 27, 1995 editorial criticizing the Clinton administration's efforts to ensure that all children are immunized against crippling diseases like mumps, measles, and polio.

First, your editorial misunderstands the premises and operations of the our nine-month old Vaccines for Children Program (VFC), which enables poor or uninsured children to receive free immunizations in their private doctors' offices.

A substantial body of research shows that, prior to the creation of VFC, the high cost of vaccination caused children to be shunted from their private doctors to public clinics. This resulted in fragmented care, overcrowding at clinics, and missed opportunities to immunize children. VFC is designed to prevent these unacceptable practices.

The program is neither a "government distribution system" nor a "takeover" of the private vaccine market, as you wrongly allege. Rather, it is a genuine partnership among individual

states, the federal government, and health professionals that provides accountability for the public and flexibility for states and physicians.

Here's how it works: The federal government purchases vaccine at reduced rates and helps states buy at a discount too. The states distribute the vaccine to doctors' offices, clinics, and hospitals and design their own accountability approaches. Health professionals see to it that eligible children get their shots and are not forced to leave their "medical homes." This partnership reduces federal micromanagement -- a worthy goal we all share.

Moreover, your editorial fails to note that VFC is just one element of the administration's larger Childhood Immunization Initiative. Besides VFC, our activities include rebuilding our country's immunization services system, educating the public about proper immunization, mobilizing communities and businesses, improving the monitoring of disease outbreaks and coverage rates, researching new vaccines, and giving grants to states for local immunization projects.

With these strategies, we are working to knock down the many barriers that prevent timely immunization -- including cost -- while building a permanent system to sustain high coverage rates in the future.

However, on one point, I couldn't agree more: All parents must take responsibility for their children's health and safety.

That's why we have teamed up with the private sector to put immunization information on the packaging of diapers and infant cereals. That's why we have developed effective public service announcements and a toll-free referral service for parents. That's why we have helped local communities build coalitions to raise awareness. And that's why we are supporting innovative efforts in Maryland, Dallas, and right here in Chicago to expect families receiving WIC or AFDC to immunize their children.

To protect our youngest and most vulnerable Americans, we must work on all fronts -- and that's just what we're doing.

Chgo. Trib. / 6-27-95

The White House vaccine fiasco

The Clinton administration, unwilling to let reality intrude on its idealism, is rushing to save one of its most poorly conceived adventures.

In 1993 President Clinton offered an impossibly ambitious, \$1 billion plan in which the government would buy all of the nation's vaccine supply and distribute it at no cost to children.

He saw the problem: Many kids don't get the shots that can prevent deadly or debilitating diseases. But he was badly misguided about the solution.

There was no need to replace the private system that manufactured and distributed vaccines. In fact, there was considerable danger in doing so.

Congress scaled back spending on the program, but the Clinton team bulled ahead with its grand vision of a government distribution system. It has failed.

The first inkling of disaster came last year, when the White House dropped plans for a national vaccine warehouse after spending \$700,000 on equipment.

Now the General Accounting Office has detailed the scope of the failure. The administration didn't understand how difficult it would be to create a distribution system and mistakenly assumed that cost was the key

reason kids didn't get their shots. The government's system has "no way to insure" that vaccine is reaching the kids it is supposed to reach, the report says.

The administration should have recognized all that two years ago. The evidence was clear. Many of the states that already had "universal" vaccine programs had failed to reap better immunization rates than in other states. In the midst of the debate, a report from the Gordon Public Policy Center at Brandeis University laid out the problem clearly: Too many parents don't get their kids immunized, even when free shots are available. Other studies echoed those findings.

Rather than attempting a government takeover of a smoothly running private market, the administration should have concentrated on where vaccine delivery breaks down: with parental responsibility. The focus needs to be on encouraging, or compelling, parents to look after the basic health of their children.

The vaccine has been available at reasonable cost through private doctors or at no cost through public health clinics. The administration needs to work with the system that has been there all along and forget about reinventing it.



FAX TRANSMISSION

U.S. Department of Health and Human Services
Office of the Secretary

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6/30/95

TO:

Jean-F. Klein

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PHONE:

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FROM:

DAN PORTERFIELD, DIRECTOR

OASPA, SPEECH DIVISION

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TOTAL NUMBER OF PAGES TRANSMITTED:

5

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

M E M O R A N D U M

To: Jennifer Klein
From: Dan Porterfield *DP*
Subject: Draft letter from Dr. Satcher to New York
Newsday
Date: 6/30/95

This letter -- which is basically a cut and paste from other letters you have seen -- will be sent to New York Newsday later today. It has been cleared by everyone at HHS, but because of Dr. Satcher's schedule, it will have to be signed and sent rather quickly. Call by 4:00 if you have any revisions.

Thank you.

Mr. Ken Emerson
Viewpoints
New York Newsday
2 Park Avenue
New York, New York 10016

Dear Mr. Emerson:

I was disappointed with your June 28, 1995 editorial on the Clinton administration's efforts to immunize our youngest and most vulnerable Americans against crippling diseases like mumps, measles, and polio. Two major errors were made.

First, you misunderstood the premises of our nine-month old Vaccines for Children Program (VFC), which enables poor or uninsured children to receive free immunizations in their private doctors' offices.

While it is true that prior to the creation of VFC, free immunizations were available through federal and state programs, a substantial body of research shows that, to obtain free shots, poor or uninsured patients were forced to leave their private doctors and go to public clinics. This resulted in fragmented care, overcrowding at clinics, and missed opportunities to immunize children. VFC is designed to prevent these unacceptable practices -- and it's working.

Now up and running across the country, VFC has won strong endorsements from state health officials, the American Academy of Pediatrics, and many others. On May 4, 1995, Lloyd F. Novick, M.D., the First Deputy Commissioner of the New York State Department of Health, testified before Congress that VFC is a "major success" because it is an "important link" in the State's vaccination efforts. Dr. Novick cited preliminary data from 37 counties showing a 30 percent decrease in the number of children who had to leave their "medical homes" for immunizations.

The editorial also erred by suggesting that our approach fails to address the other factors besides cost that keep children from getting their shots.

In fact, VFC is only one element of our multi-faceted Childhood Immunization Initiative. We are rebuilding the country's immunization services system, educating the public and health professionals about proper vaccination, mobilizing communities and businesses, improving the monitoring of disease outbreaks and coverage rates, researching new vaccines, and giving grants to states for local immunization projects.

2

This is a comprehensive effort to knock down the many barriers that prevent timely immunization and to build a permanent system to sustain high coverage rates in the future.

Although the errors in the editorial were regrettable, I do share your sentiments on one crucial principle: This country should properly immunize every child by age two.

We can banish diseases like polio, mumps, and measles to the chronicles of history -- but only if we preserve our commitment to addressing the barriers that leave children at risk -- including cost.

Sincerely,

David Satcher, M.D., Ph.D
Director

NEW YORK NEWSPAPER, WEDNESDAY, JUNE 28, 1995

NEW YORK Newspaper

EDITORIALS

RAYMOND A. JAMON
Publisher, President and C.E.O.
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Publisher, New York Newspaper

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ERNEST TOLLERMAN, Editor, New York Editorial Pages
CAROL R. RICHARDS, Deputy Editor of Editorial Pages
JOSEPH H. C. FRIEDMAN, Deputy Editor, New York Editorial Pages

Liberal-itis

The Clinton administration's nationwide child immunization program could be viewed as good intentions gone awry. That would be charitable. Realistically, it is a political and administrative failure that's emblematic of a blockheaded commitment to liberal ideology that sometimes characterizes this administration, an example of why this White House still suffers from self-inflicted wounds.

Now, with a Republican-run Congress and even the best-targeted, best-run domestic programs on the chopping block, an immunization program aimed at a chronic, complex problem is unlikely to survive. That's too bad, especially since this could've been avoided.

President Bill Clinton and first lady Hillary Rodham Clinton started with the noble intent of having every American child properly immunized by age 2—a goal health professionals say is necessary to avoid outbreaks of preventable diseases. But the Clintons insisted that it was cost, driven by drug companies' price-gouging, that kept many poor and uninsured families from getting their kids shots.

In reality, free vaccines were available through federal and state programs. Other factors led to missed shots; those problems should have been addressed in other ways.

Still, Congress approved a scaled-back Clinton plan, designed to let federal and state governments buy more vaccine for distribution by private doctors. Now a highly critical General Accounting Office study has determined (to almost no one's surprise) that the vaccines' cost isn't a big problem and that the best solution may be an outreach program, increasing parental awareness of the need for immunization and making clinics more accessible.

Amazingly, the administration still clings to its program, saying only minor changes are necessary. Even Democrats want more; Republicans are likely to fold it into a Medicaid block grant that may or may not be used by states for shots. That's a sorry demise for a worthy goal, killed by zealotry and bureaucratic incompetence.



DEPARTMENT OF HEALTH & HUMAN SERVICES

A fax message from:

Melissa T. Skolfield

Deputy Assistant Secretary for Public Affairs

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To:

Jennifer KleckDPC

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Date:

8/29

Total number of pages sent:

5

Comments:

FYI - no action needed -
just updated some figures
to correspond to most
recent Satcher testimony.
Wanted you and Diana
to have current material.

Amy Busch

QUESTIONS AND ANSWERS ON THE VFC PROGRAM**6/29/95**

Q: The Vice President said that childhood immunization rates were less than 50 percent when the Clinton Administration took office. Is that true?

A: The Vice President was referring to immunization rates for two-year-olds, the focus of most public and private immunization campaigns. When this Administration came into office, the latest available information, a 1991 national health survey, showed that between 37 percent and 56 percent of the nation's toddlers were properly immunized. In September 1993, 1992 NHIS survey results, became available, and they showed that 55 percent of toddlers were immunized in 1992. This survey used a new set of interview questions that gave more definitive estimates of immunization levels, producing a single number rather than a range. However, even with 55 percent of the nation's children immunized against most diseases, the 1992 study did show that only 28 percent were immunized for HiB (Haemophilus influenzae Type B).

We have made progress since then, but even with immunization levels at 68 percent (2nd Quarter 1994 data), approximately two million two-year-old children are still not properly vaccinated against disease.

Q: The Vice President said that childhood immunization rates in the United States are lower than those in other countries. Is this true?

A: Although it is difficult to accurately compare immunization rates across countries, estimates do show the United States to be lagging behind other nations in protecting the health of our children through immunizations. For example, 1994 data reveal that 80 percent of this nation's children were immunized against polio, compared to 99 percent of children in Iran and 95 percent of children living in China. The United States is also behind Iran, China, Mexico, and Vietnam in its coverage of children for DTP.

While our childhood immunization rates have improved in the United States, increasing from 55 percent in 1992 to 68 percent according to the latest data (2nd Quarter 1994), we still haven't reached our goal for 1996: increasing vaccination levels for two-year-old children to 90 percent for the most critical vaccines (MMR, DTP and polio). Approximately two million two-year old children in the United States are still not properly vaccinated against disease.

Questions and Answers on the VFC Program
6/29/95

Q: The GAO has challenged CDC's assertion that the cost of vaccines is a barrier to childhood immunization. Is cost a barrier or not?

A: Cost is a barrier because it contributes to delays in achieving full immunization of preschool children with today's vaccines. The cost of the complete vaccine series has increased ten-fold in the past 12 years. Since parents must pay about \$270 in vaccine costs and an additional amount in administration fees for the series, those without adequate insurance may not seek immunizations from their private doctors, but from public health clinics where vaccine is free or available at nominal cost. Having to make extra visits to public clinics can result in delays and missed opportunities for immunization.

Numerous surveys of practitioners and health departments have also documented increased referrals of patients from their primary care providers to public clinics, with cost as the most important reason cited. A 1992 American Academy of Pediatrics study revealed that 55 percent of pediatricians refer some or all of their patients to a public provider for immunizations. A 1992 North Carolina survey showed that 93 percent of physicians referred patients to health departments for immunizations, and states such as New York have showed similar trends.

Q: The GAO has recommended that the VFC program should be targeted to certain population groups and areas referred to as "pockets of need." Doesn't this make sense?

A: We believe, and Congress has agreed, that the proper goal of Federal immunization efforts is to raise immunization levels throughout the nation, and to put in place a sustainable system that will ensure that immunization rates remain high. The GAO conclusion assumes that "general immunization rates" are not now a problem and will not be a problem in the future.

While child immunization rates have improved since the 1989-1991 measles epidemic, approximately two million children under age two in the United States are still not properly vaccinated against disease. VFC is a key part of our effort to reach our national goal for 1996: increasing vaccination levels for two-year-old children to 90 percent for the most critical vaccines (MMR, DTP and polio).

Talking points - Vaccines for Children
6/29/95

The Vaccines for Children program is an important part of the Administration's broader Child Immunization Initiative. The CII incorporates five key strategies to improve preschool vaccination rates. These include: increased funding to states and cities to improve the quality and quantity of vaccination delivery services; an aggressive outreach program designed to increase community participation, education and outreach; reduced vaccine costs; efforts to improve the monitoring of disease and vaccination coverage; and efforts to improve vaccines and vaccine use.

While child immunization rates have improved since the 1989-1991 measles epidemic, almost two million American children under two are still unvaccinated against one or more deadly diseases. Our childhood immunization rates have increased in the United States from 55 percent in 1992 to 68 percent, according to the latest data (2nd Quarter 1994). But we still haven't reached our goal for 1996: increasing vaccination levels for two-year-old children to 90 percent for the most critical vaccines (MMR, DTP and polio). VFC is a key part of our national strategy to reach this goal.

Improving child immunization rates is one of the Clinton Administration's highest priorities. Under previous administrations, budget requests for child immunization never exceeded \$257 million. In contrast, legislation to launch a new Child Immunization Initiative was introduced within 120 days of President Clinton's inauguration. Funding was tripled, and funds for new vaccines was guaranteed. The CII sets a specific goal for 1996: increasing vaccination levels for two-year-old children to 90 percent for the most critical doses.

While other aspects of the CII focus on increasing awareness and availability of vaccines, the Vaccines for Children program focuses on reducing costs for parents. In the past ten years, immunization costs have increased ten-fold: the private cost of a full series of immunizations increased from about \$15 in 1980 to \$280 in 1994. A Spring 1992 survey by the American Academy of Pediatrics showed that 43 percent of pediatricians had increased their referrals for vaccinations in the preceding ten years, primarily because of costs.

Under the VFC program, vaccines will be provided free to children who are eligible for Medicaid or uninsured. That means that physicians will no longer have to refer these children to public clinics, a common practice that means missed opportunities for immunizations and fragmented care. And parents can choose which provider makes the most sense for their child, because the difference in price between the two settings (\$270 and \$130) won't be a factor.

This will make a tremendous difference for nine million uninsured American children. While Medicaid recipients can receive free vaccines under current law, millions of working families have not had the same guarantee. Under VFC, more than one million infants and toddlers without insurance will now be guaranteed free vaccines, and their parents will pay only a modest administration fee. VFC will also help millions more older children who need follow-up vaccines at age four and fifteen.

Under VFC, providers must vaccinate every child, even if parents cannot afford to pay the administration fee. Private doctors will continue to serve their regular patients, immunizing them at no cost. Other children will have their administrative fees waived in public clinics.

In addition, VFC will provide free vaccines to children with limited insurance in rural health clinics and Federally Qualified Health Centers. In these settings, additional children whose insurance plans don't cover preventive care will continue to be eligible for free vaccines. Again, parents will only have to pay a modest administration fee.

States will be able to save money by ordering vaccines at the lower, government price. Because free vaccines will lower states' Medicaid costs, these savings can be used to keep clinics open longer, or take other measures to increase immunization rates. And more states will be guaranteed the lower CDC price for the vaccines they do purchase.

Funds for new vaccines will automatically be provided. Under VFC, new childhood vaccines recommended by a federal advisory committee will automatically be purchased by the federal government and provided free to eligible children -- and budget cuts will never again threaten children's health.

Immunization protects children and saves money. More than \$21 are saved for every \$1 spent on the MMR (measles/mumps/rubella) vaccine; more than \$30 are saved for every \$1 spent on the DPT (diphtheria/tetanus/pertussis) vaccine; and more than \$6 are saved for every \$1 spent on polio vaccine.



FAX TRANSMISSION

U.S. Department of Health and Human Services
Office of the Secretary

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TOTAL NUMBER OF PAGES TRANSMITTED: 5

COMMENTS:

Everyone here has signed off -
Please call tomorrow by 10:00 a.m.
If you have any questions or
problems -



U.S. Dept. of Health and Human Services
Office of the Secretary

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Director, Speech Division

Thank you

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Tom Still
Letters to the Editor
Wisconsin State Journal
P.O. Box 8058
Madison, WI 53708

Dear Mr. Still:

I was disappointed that your June 18, 1995 editorial about the Clinton Administration's immunization efforts missed the main point of our work: ensuring that all children are immunized against crippling diseases like mumps, measles, and polio.

The fact is, in the two years before President Clinton took office, about 50 percent of America's 2-year-olds were not properly vaccinated.

Today, while our immunization rates are at their highest levels in history, there are still almost 2 million children under the age of two who have not received all the shots they need.

The President's Childhood Immunization Initiative (CII), the most comprehensive vaccination effort in American history, is designed to help stop this public health menace. Our approach is to increase immunization rates right now, while also building a permanent system to sustain rates into the future. That means addressing all the different barriers that prevent immunization - and we are doing that.

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We are educating the public and health professionals about proper vaccination, mobilizing communities and businesses, improving the monitoring of disease outbreaks and coverage rates, researching new vaccines, giving grants to states for local immunization projects, and rebuilding our country's immunization services systems -- so that clinics can expand their services and lengthen their hours.

Unfortunately, your editorial ignored the true scope of the CII - - and focused only on our nine-month-old Vaccines for Children program (VFC), which enables poor or uninsured children to receive free immunizations in their private doctors' offices.

Moreover, what you did say about VFC was misleading. Rather than attempting a "take over" of all vaccination programs, as your editorial asserts, VFC is a genuine partnership among the federal government, health professionals, and individual states like Wisconsin.

Here's how it works: The federal government purchases vaccine at reduced rates and helps states buy at a discount as well. The states distribute the vaccine to doctors' offices, clinics, and hospitals and design their own approaches to guaranteeing accountability. Health professionals ensure that eligible children receive their shots and are not forced to leave their "medical homes." This partnership provides accountability to the

public, while reducing federal micromanagement of states and physicians -- worthy goals we all share.

Right here in Wisconsin, VFC is helping to deliver vaccines to more than 550 private and public sector sites -- as physicians, state and local health officials, parents, and community leaders all join together to immunize this State's youngest and most vulnerable citizens.

Together, we can build on that success. Together, we can protect our children and triumph against diseases like polio, mumps, and measles -- but only if we tackle this problem on all fronts. And that's just what we're doing.

Sincerely,

Donna E. Shalala

64 THE GREEN SHEET

Wisconsin State Journal, Sunday, June 18, 1995

Vaccine for overspending needed

Looking at the mess the Clinton administration has made of the childhood vaccination program puts one in mind of the late, great Casey Stengel's famous lament "Can't anybody here play this game?"

The latest blunder came to light Thursday at a hearing chaired by U.S. Rep. Scott Klug, R-Wis., who heads the Health and Environment Subcommittee. Under questioning from Klug, the director of the federal Centers for Disease Control admitted the agency spent more than \$1 million to send 238 employees in May to a "National Immunization Conference" at the posh Century Plaza Hotel, right outside Beverly Hills.

That \$1 million could have immunized 13,500 children under the age of one, Klug charged.

CDC Director David Satcher replied lamely that the Century Plaza is "not a resort, not a beachfront hotel . . . There's not a lot to do there but attend the conference." But Satcher could not explain how the 238 employees managed to spend more than \$400 apiece in expenses if all they were doing was riding the hotel elevator to the seminar rooms.

The CDC employees who attended the conference comprised 78 percent of the staff of the National Immunization Program, the Clinton administration's continuing misadventure in micromanaging the nation's childhood vaccination efforts. Noting that three out of every four federal immunization program workers attended the conference, Rep. Jim Greenwood, R-Pa., said incredulously "You sent everybody who wasn't a typist." Not to mention the fact that there must be cheaper places in which to gather three-quarters of your staff together to talk about their jobs — the company cafeteria, for instance.

The revelation comes at a particularly bad time for the CDC, which has been capitalizing on the outbreak of publicity about the deadly Ebola Fever virus to beg Congress for more money. It also comes at a bad time for the Clinton administration, which has botched every attempt so far to improve the nation's immunization rate.

Mistake No. 1 came in February 1993, when President Clinton launched his ill-fated drive for national health care reform by attacking the U.S. pharmaceutical industry. Clinton said that industry greed made the cost of childhood vaccinations rise from \$20 from 1982 to \$180 in '92, and blamed the cost of the vaccines for the nation's lagging vaccination rate.

But Clinton's diagnosis was wrong. It turned out that federal taxes and new vaccines not available in 1982 — not industry greed — accounted for 70 percent of the price increase.

If Clinton were a doctor, we might have heard him say "Oops." But this is politics, not brain surgery. Without missing a beat, the administration committed Mistake No. 2, a proposal for the government to take over all vaccination programs. Congress tossed out that idea like than a used band-aid, authorizing free vaccinations only for low-income and uninsured youngsters.

Nonetheless, the administration bulled ahead with a plan to build a central government warehouse where all vaccines would be stored for distribution. Except that, \$700,000 into the project, the warehouse plan was declared unworkable and scrapped.

\$700,000: That's another 9,300 babies who could have been immunized with money the government simply wasted.

Health and Human Services Secretary Donna Shalala said Friday the administration now wants to set up a system where all kids are vaccinated at their primary physician's office, with the government somehow reimbursing doctors for low-income children. She repeated the charge that pharmaceutical companies are price-gouging on vaccines, and said Republicans like Klug are blocking improvements in childhood immunization rates by insisting that low-income children be vaccinated at public health clinics.

But given the administration's track record on the vaccination program to date, it's no wonder that Congress wants a second opinion. There's no guarantee that yet another federal cure won't be worse than the disease.



FAX TRANSMISSION

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Office of the Secretary

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COMMENTS:

Please deliver to Jennifer
As soon as possible.

Danks



U.S. Dept. of Health and Human Services
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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

M E M O R A N D U M

To: Jennifer Klein
From: Dan Porterfield, *DP* Director of Speechwriting
Subject: Response to the 6/18/95 Goldberg op-ed
Date: 6/20/95

This response has been signed off on by Secretary Shalala and a number of senior officials, including Kevin Thurm, Melissa Skolfield, and Bill Corr.

Please review and return any comments to me at 690-7470 before 10:00. We will send to Jodie Allen tomorrow morning.

Thank you.

Draft Response to the 6/18/95 Goldberg article

Donna E. Shalala

Secretary of Health and Human Services

June 20, 1995

A few critics of the Clinton administration's Childhood Immunization Initiative (CII) have resorted to using errors and distortion to attack our efforts. The most recent example is Robert M. Goldberg's op-ed piece, "Made in Washington: The Great Vaccine Scare" (WP, 6/18/95). I would like to set the record straight.

First, the Clinton administration did not "invent" this country's longstanding infant immunization problem. Let's look at the reality:

- In the two years before President Clinton took office, about 50 to 55 percent of America's two-year-olds were not properly vaccinated.
- Historically, we have witnessed repeated outbreaks of preventable infectious disease, including the 1989-91 measles epidemic that struck more than 55,000 people and took more than 130 precious lives, many of them young children.
- Today, while our immunization rates are the highest ever, there are almost two million children who have not received all the shots they need by their second birthday. That's not good enough for me.

These are the facts, and, as Aldous Huxley once wrote, "Facts do not cease to exist because they are ignored."

Mr. Goldberg also errs by ignoring the true scope of the Childhood Immunization Initiative (CII), which is the most comprehensive vaccination effort in American history.

Our approach is to increase rates right now -- while also building a permanent system to sustain high rates in the future. This means addressing all the different barriers that prevent immunization -- and we are doing that:

We have increased funds and flexibility for state and local communities, so they can create new clinics in underserved areas, lengthen clinic hours, hire additional staff, and expand other key services.

We are working to develop more effective systems for detecting disease before outbreaks occur and measuring vaccination coverage levels.

We are conducting research to improve vaccine use and, one day, to immunize children against more diseases with fewer shots.

To ensure that parents and health professionals understand the importance of proper immunizations, we have initiated a

national and community-based outreach effort the likes of which this country has never seen -- and we are drawing on the volunteer efforts and good will of a spectacular array of public and private partners.

Mr. Goldberg says nothing about these efforts, though surely he is aware of them. Instead he focuses on only one of the CII's five elements, which is the Vaccines For Children Program (VFC).

Here's how VFC works: Poor and uninsured children are eligible to receive government-purchased vaccines right in their doctor's offices. Under the old system, the only way the uninsured children of working families could get government-purchased vaccines was to leave their private doctors and make multiple trips to public clinics -- which contributed to fragmented care, overcrowding at the clinics, and missed opportunities to vaccinate.

Numerous studies show that private doctors end up referring patients to public health clinics because of the high cost of vaccines. That's why state health officials and private doctors overwhelmingly support VFC: It means more children will receive care in their "medical homes" and will be immunized on time. We are pleased that in just eight months since VFC became operational, more than 23,000 private health providers, including

doctors, clinics, and hospitals (many of which have multiple physicians) have enrolled in the program.

Mr. Goldberg's article is riddled with other factual errors.

He incorrectly claims that VFC increases federal vaccine purchase expenditures by \$587 million between 1993 and 1996. In fact, the increase is just \$75 million -- and we're buying a few types of vaccine we didn't buy in 1993. This is a wise investment. For example, every dollar spent on the measles/mumps/rubella vaccine saves \$21 in health costs -- and untold hardship for families.

He falsely accuses me of using 1986 data at a 1993 hearing when 1992 data were available. This is not so: I used 1991 data because 1992 data were not yet available. By the way, one year ago, Mr. Goldberg made the same erroneous charge in the pages of *The Wall Street Journal*. We corrected him then, and do so again now.

And he suggests that the administration does not support efforts in Dallas, Chicago, and Maryland to increase immunization rates in families receiving WIC and AFDC. *Au contraire*, Mr. Goldberg. We have aggressively promoted these innovations and are evaluating their results!

5

I could go on, but surely my views are clear: To paraphrase Dorothy Parker, Mr. Goldberg's article "should not be tossed aside lightly. It should be thrown with great force."

Instead of disinformation, we need a stronger national commitment to protecting our youngest and most vulnerable children with all the shots they need -- when they need them.

And that means we all must do our part.

Health professionals must take every opportunity to vaccinate children during office visits. Parents must take responsibility for bringing in their children for shots. Community leaders and the private sector must spread the message about the importance of proper immunizations. And we who are public servants must continue to fight for children and families.

Snowmobiles — Continued

falling through the ice (i.e., hypothermia). These findings are consistent with previous studies of fatalities associated with the use of OHRVs (1,2). For example, contributing factors for nondrowning deaths following incidents on frozen water surfaces have included high speeds attained on such open surfaces and unexpected uneven terrain (e.g., ice ridges) (1). The findings in this report also indicate that some snowmobile drivers and passengers did not wear helmets. Although this investigation could not assess the effectiveness of helmet use, a previous study estimated that helmet use can reduce the risk for death among all-terrain vehicle operators by approximately 42% and can reduce the likelihood of head injury in a nonfatal incident by approximately 64% (3).

The findings in New Hampshire are subject to at least three limitations. First, rates of injury and death could not be determined because of the lack of an accurate denominator. Although previous studies have used registered OHRVs as a denominator, this number may vary in relation to season and other environmental factors (e.g., inclement weather). Second, because approximately one third of nonfatal injury reports were completed only by persons involved in the incident, some information reported may not be valid (e.g., helmet use, speed, and alcohol use). Finally, these findings probably underestimate the true incidence of snowmobile-associated injuries because of underreporting. Review of hospital emergency and discharge records could assist in evaluating the extent of underreporting.

Information from the injury reporting system in New Hampshire may be useful for public health surveillance and assessment of snowmobile and other OHRV injuries (4). In addition, this data source can be used by the New Hampshire Snowmobile Association and other organizations to target high-risk groups for intervention programs. Since 1975, DFG has operated a safety training course for OHRV users. State law requires that any OHRV operator driving off their private property either possess a valid driver's license (minimum age: 16 years) or have taken this course. Operators aged <30 years should especially be targeted by any intervention strategy; in particular, young operators with a valid driver's license are encouraged to take the DFG safety course.

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**Physician Vaccination Referral Practices
and Vaccines for Children — New York, 1994**

Although vaccinations are among the most effective preventive public health measures available, many children are not vaccinated on time (1). One identified barrier to timely vaccination is referral of children by primary-care physicians to other medical settings for vaccination (2). This report summarizes a survey by the New York

Vaccines for Children — Continued

State Department of Health of vaccination referral practices among New York physicians and describes the implementation in New York of Vaccines for Children (VFC), a national program making federally purchased vaccines available at no cost to health-care providers for administration to eligible children (3).

During April 1993, a random sample of 1137 licensed pediatricians and family-practice physicians (from a total $n=5392$) in New York were surveyed by mail about vaccination practices. Of 752 (66%) responses, 502 (67%) were from actively practicing primary-care physicians. Of these, 250 (50%) referred all or some of their patients elsewhere for vaccinations. Of referring physicians, 228 (91%) referred patients to a local health department clinic; 109 (44%) had increased the number of patient referrals during 1983–1993, while seven (3%) had decreased referrals. In addition, 63 (25%) reported that the number of well-child-care visits had decreased during 1983–1993, while five (2%) reported increases during that time. Of the 250 referring physicians, 246 provided reasons for referral and rated those reasons as "very important," "somewhat important," or "not important" (Table 1). Financial hardship was a "very important" reason for referral for 217 (88%) of those surveyed; the lack of vaccination coverage by private insurance was "very important" for 132 (54%). Physicians also were asked whether the government should underwrite the cost of mandatory vaccinations. Overall, 409 (54%) respondents indicated that some or all of the costs of childhood vaccination should be underwritten.

Since October 1, 1994, free vaccine has been available to VFC participating providers in New York. Categories of federally eligible children aged <19 years include those on Medicaid, those who are uninsured, those who are underinsured who visit federally qualified health centers, and American Indians/Alaskan Natives. New York also provided free vaccine to underinsured children who receive care in any medical setting and any child served at a local health department.

TABLE 1. Reasons for vaccination referral by physicians*, by importance — New York, 1993

Reason	Very important		Somewhat important		Not important	
	No.	(%)	No.	(%)	No.	(%)
Financial hardship for patient	217	(88)	14	(6)	15	(6)
Private insurance not covering vaccinations†	132	(54)	56	(23)	58	(24)
Free vaccine to physicians discontinued by health department‡	110	(45)	34	(14)	102	(41)
Vaccine purchase costs for physician	94	(38)	56	(23)	96	(39)
Insufficient Medicaid reimbursement	74	(30)	43	(17)	129	(52)
Vaccine availability	36	(15)	42	(17)	168	(68)
Vaccine-related liability	24	(10)	31	(13)	191	(78)

*N=246 of 250 physicians who reported referring patients elsewhere for vaccinations.

†As of April 1994, all New York State-regulated major medical health insurance policies, exclusive of self-insured entities, were required to cover all childhood vaccinations.

‡In 1986, the New York State Department of Health discontinued distribution of free vaccine to any physician through county health departments.

Source: New York State Department of Health.

Vaccines for Children — Continued

Medical-care providers were recruited for VFC through articles published in professional organization newsletters and by mailing of registration packets to licensed pediatricians, family physicians, osteopathic physicians, and medical facilities. As of December 27, 1994, a total of 1378 physician practices in New York (including at least 1972 individual physicians and at least 362 health-care facilities) were participating in VFC.

To determine the extent of enrollment by Medicaid providers, the list of VFC enrollees was compared to a list of providers who billed Medicaid for childhood vaccines during federal fiscal year 1993. Of 2168 physicians who billed Medicaid for childhood vaccines in 1993, a total of 1213 (56%) had enrolled. Among the 166 physicians who submitted a minimum of 1000 claims for individual vaccines, 143 (86%) had enrolled, while 653 (68%) of 956 physicians not yet enrolled had submitted fewer than 50 claims.

In September 1994, the New York State Department of Health conducted a telephone survey of health-care providers who had returned registration forms and declined participation in the program to determine reasons for nonparticipation and to guide future recruitment efforts. Of the 41 physicians who had declined, 29 (71%) were contacted. Of these, five (17%) were retired, five (17%) did not accept patients aged <19 years, six (21%) were subspecialists or in academic medicine and did not provide vaccinations, six (21%) indicated that most of their patients would not be eligible, one (2%) had multiple reasons for not registering, and the six (21%) with patients who could benefit from VFC agreed to register as a result of the phone call.

From September 15, 1994 (the first date vaccines could be ordered), through December 27, 1994, a minimum of 2,496,000 doses of vaccine had been ordered and approximately 2,456,000 doses were shipped to VFC participants. The average time between placement of orders and receipt of vaccine by providers was 1 week.

Reported by: HG Cicciello, MD, GA Bunn, DR Lynch, SC Meldrum, MS, GS Birkhead, MD, D Morse, MD, State Epidemiologist, New York State Dept of Health, S Freidman, MD, N Jenkucky, MPH, New York City Dept of Health, EE Schulte, MD, Albany Medical Center, Albany, New York. National Immunization Program, CDC.

Editorial Note: In the United States, approximately 2 million children need one or more doses of recommended vaccines (4). In a 1993 retrospective survey of children entering kindergarten in New York, only 53% had been appropriately vaccinated with the recommended vaccines by age 2 years (5). Important barriers to timely vaccination include missed opportunities to vaccinate at each health-care visit, inconvenient clinic hours, inadequate parental awareness of the need for timely vaccination, inadequate vaccination tracking, the costs of vaccines, and the referral of children from the private sector to the public sector. This report demonstrates that vaccination referrals, in part attributable to vaccine costs, are common among New York primary-care providers. Implementation of VFC is expected to reduce these financial barriers.

The actual number of VFC participants in New York probably is underestimated by VFC enrollment figures because many physicians work in facilities or in group practices where only the physician-in-chief is registered in the program. In addition, the impact of the program on vaccination coverage and overall occurrence of vaccine-preventable diseases cannot be determined yet. However, VFC has allowed New York to increase provision of vaccine to more children in primary-care settings where they first seek care. In states where vaccines have been made available for all children,

Vaccines for Children — Continued

vaccination rates of preschoolers are approximately 10% higher than the national average (AG Holtmann, University of Miami, unpublished data, 1993).

The Childhood Immunization Initiative (CII) has designated vaccination of pre-school-aged children a national priority and has established 1996 and year 2000 goals of vaccinating at least 90% of children by age 2 years with the recommended number of doses of diphtheria and tetanus toxoids and pertussis, polio, *Haemophilus influenzae* type b, hepatitis B, measles, mumps, and rubella vaccines. The five strategies of CII, which address both financial and nonfinancial barriers to vaccination, are to 1) improve the delivery of vaccines; 2) reduce the cost of vaccines for parents (VFC); 3) enhance awareness, partnerships, and community participation; 4) monitor vaccination coverage and disease; and 5) improve vaccines and their use. VFC, as an integral part of this initiative, will assist physicians and other health-care providers in reaching these national goals.

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Differences in Maternal Mortality Among Black and White Women — United States, 1990

The risk for maternal mortality has consistently been higher among black women than white women. The 1990 national health objective of reducing maternal mortality to no more than five deaths per 100,000 live births for any racial/ethnic group was nearly achieved for white women, for whom the maternal mortality ratio* was 5.7 in 1990 (1); for black women, however, the ratio was 18.6. The year 2000 national health objectives include reducing the overall maternal mortality ratio to no more than 3.3 deaths per 100,000 live births and to no more than five for blacks (objective 14.3) (2). This report summarizes race-specific differences in maternal mortality among black and white women for 1990 and compares these with trends in mortality from 1940-1990.

Maternal mortality ratios were calculated at 10 year intervals from 1940 to 1990 using data contained on death certificates filed in state vital statistics offices and com-

*The maternal mortality ratio is the number of maternal deaths per 100,000 live births. CDC's National Center for Health Statistics (NCHS) uses the term maternal mortality rate as required by the World Health Organization. In this report, the term "ratio" is used because the numerator includes some maternal deaths that were not related to live births, and thus were not included in the denominator. For this analysis, 3 years of data were combined to calculate maternal mortality ratios to promote statistical reliability and stability in the estimates. For example, 1990 ratios are based on data from 1989 through 1991. In addition, beginning with the 1989 data year, NCHS began using race of mother instead of race of child to tabulate live birth and fetal death data by race. In this analysis, race for live births is tabulated by the race of the child for maternal mortality to maintain comparability of ratios.

THE WHITE HOUSE

WASHINGTON

APRIL 3, 1995

MEMORANDUM FOR CAROL RASCO
JENNIFER KLEIN

FROM: LEEANN INADOMI
OFFICE OF CABINET AFFAIRS

SUBJECT: VACCINES FOR CHILDREN PROGRAM

Attached is an AP article from today on the immunization program.
HHS wanted to be sure you saw it.

Vaccine Program, Oct., 730

Drug Makers Cry as States Expand Federal Vaccine Program

WASHINGTON (UPI) — All Tennessee children might one day get immunized for free, whether they're rich or poor, insured or not. Delaware may let insurance companies buy vaccines at the deep discounts the federal government allotted for the needy.

It's part of a new trend to expand a federal vaccination program for the poor. But critics say the move is creating an open-ended entitlement that could drain the pharmaceutical industry of profits used to research new vaccines.

"What in the world excuse do we have penalizing research and development to buy vaccines for insured and affluent children?" asked Merck & Co. vaccine chief Thomas Vernon.

The Clinton Administration vehemently defends its Vaccines for Children program. But health officials are beginning to consider industry criticisms, and next month may begin debating ways to lower the program's tab without sacrificing the poor.

"If we can craft a compromise that could ... preserve some private market and allow us to deal where cost is an issue, we might begin to help," said Dr. David Smith, a member of the National Vaccine Advisory Committee that guides federal immunization policy.

Under Vaccines for Children, or VFC, the federal government buys vaccines for public clinics and certain private doctors at specially discounted prices, which they give free to any Medicaid-eligible, uninsured or Indian or Eskimo child. In addition, any child whose insurance doesn't cover vaccinations can get free shots at special clinics.

VFC is having an impact, said Smith. In his state of Texas, only 30 percent of 2-year-olds had all their shots in 1993. Today, 55 percent do, an increase Smith partly attributes to VFC and the months of publicity that preceded its Oct. 1 start.

But when Congress created VFC, it included a clause that states could add their own funds or federal grants to buy the cheap vaccine for any child. Led by Tennessee and Delaware, an untold number are considering the deal.

Companies "do stand to lose money," acknowledged Paul Silverman of Delaware's Division of Public Health.

Delaware has proposed that insurers donate funds they normally spend vaccinating policyholders. Adding those funds to some tax dollars, the state would buy VFC-priced vaccine and distribute all the shots. Not only would every child get free shots, but doctors wouldn't have the insurance paperwork hassle that now forces many to send patients to public clinics for vaccinations, Silverman argued.

"Some things are worth the money," agreed Dr. Kerry Gateley of Tennessee, which has proposed using state money and federal grants on a similar program. "We're not seizing vaccine from manufacturers and robbing them blind. ... I think they're going to make money."

But critics say VFC already allowed the government to buy up to 65 percent of many states' vaccine for as low as half-price. If states buy 100 percent at such discounts, companies will be drained of profits that finance new vaccines, Vernon argues.

The National Vaccine Advisory Committee hopes to hear, at its April meeting, from outside consultants hired to determine if that

is a problem, Smith said.

The controversy comes atop new congressional concern that VFC alone will cost millions more than anticipated, largely because three new vaccines are about to join the list of free shots. VFC is pushing federal vaccine spending from \$300 million in 1993 to nearly \$1 billion by 1996, said Rep. John Porter, R-Ill.

"It is time, in my judgment, to make changes now," Porter, chairman of the House Appropriations subcommittee that funds health programs, said at a recent vaccine meeting.

Slashing VFC would be a mistake, Smith warned. "The congressional budget may see savings but the local community will pay the price of not being immunized," he said.

The administration is looking for savings alternatives. One proposal is to slash the vaccine excise tax, which funds the no-fault compensation program for vaccines' rare side effects.

The tax varies from a few cents to almost \$5 a shot. The measles vaccine, for instance, costs the government \$10 a shot plus a \$4.44 tax. Converting to a flat 50-cent tax would save government and private vaccine buyers together \$70 million a year in contributions to the \$830 million trust fund, said program director Thomas Balbier Jr.

APWR-04-03-95 0844FNT

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Received by NewsEDGE/LAN: 4/3/95 7:50 AM

Date: 04/21/95 Time: 14:36

First Lady Pushes Toddler Vaccination

WASHINGTON (AP) Elba Varela thrust the yellow immunization records toward first lady Hillary Rodham Clinton, eager to prove her twins have all the required vaccinations and even a few optional shots.

Getting those 11 shots by age 2 is vital to protect toddlers against childhood killers but too few are as well protected as the Varela twins, Mrs. Clinton said Friday in kicking off National Infant Immunization Week.

"Immunizations are one of the easiest ways we know how to protect our children," she told parents at an inner-city health clinic. Yet just 67 percent of 2-year-olds are fully vaccinated, and only half in some cities.

So how, Mrs. Clinton asked, does the Mary's Center for Maternal and Child Health vaccinate 95 percent of its toddler patients on time?

Nurses don't let parents forget, sometimes even coaxing them in from the supermarket, the mothers responded. At one site, they can get pediatric care as well as parental education and prenatal and social services.

"Here, I have a lot of help," said Varela, whose 19-month-old girls were born Siamese twins, fused at the chest.

They're doing well now, but Abigail has a severe heart malformation that makes her extremely vulnerable to infection. So the twins and their older sister have every required vaccine plus optional ones like annual flu shots to fend off as many germs as possible, Varela told the first lady.

The government is trying to boost preschool immunization through education campaigns, free vaccine and other programs, but the efforts ultimately depend on parents, Mrs. Clinton said.

"There are many things in our life that are out of our control," she said, noting the children killed in this week's Oklahoma City terrorist bombing. "But there are things in our control ... and immunization and child health concerns are among these."

APNP-04-21-95 1436EDT

E X E C U T I V E O F F I C E O F T H E P R E S I D E

11-May-1995 12:52pm

TO: Carol H. Rasco
TO: Jeremy D. Benami

FROM: Diana M. Fortuna
Domestic Policy Council

SUBJECT: Here is the vaccine item

The National Vaccine Advisory Committee meets today to consider the findings of a study on the economics of the vaccine industry. This committee's role is to advise the Public Health Service, and its members include vaccine manufacturers. The committee commissioned this study to determine whether the industry's R&D efforts will be hurt by the new Vaccines for Children program. VFC allows the Federal government to purchase a larger share of the vaccine market at the low government contract price, and the industry charges that this will reduce revenue so much that research will be affected.

PHS determined that the consultant hired for this contract could not answer this question because it is too early in the VFC program to have good data about VFC's impact, and because the vaccine manufacturers were reluctant to share what data they do have with the consultants. Several weeks ago, Senator Bumpers' key staffer on VFC told The New York Times and others that PHS was "suppressing" the results of this study and sent GAO to interview HHS staffers about this charge. HHS responded by disclosing their decision publicly. HHS press staff were able to persuade reporters not to write the story.

PHS may be criticized at the meeting for its decision. HHS is working to put out the story that they have been straightforward on this issue, and that it is too early for any study of how VFC will affect vaccine R&D.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

MAY 11 1995

Ms. Martha McAteer
Letters to the Editor
The Washington Post
1150 15th Street, N.W.
Washington, D.C. 20071

Dear Ms. McAteer:

James Glassman's May 8 piece, "Another Galloping Entitlement," presents false impressions about an issue so critical to the health of our children that I must restate the facts for you and your readers.

The facts are clear: Today, vaccines exist to protect children from ten diseases that can lead to serious illness or even death. In the United States, up to two million children between the ages of 19 and 35 months are currently vulnerable to these diseases because they have not been fully immunized. Numerous cost-benefit studies show that for every \$1 spent on routine childhood immunization, the Nation saves as much as \$29. In short, we have vaccines that can save lives and scarce health dollars; but neither can be accomplished if we do not deliver the vaccines to children when and where they need them.

Mr. Glassman's piece correctly notes that many children are not fully vaccinated against disease because of "missed opportunities" for immunization. As I stated before the Senate Finance Committee last week, the cost of vaccines contributes to difficulties and delays in getting children fully immunized based on the recommended schedule. When parents without insurance cannot afford the cost of vaccinations from their private doctor, they must then schedule and make a second visit to a public clinic, which can delay or prevent timely immunization. The Vaccines for Children (VFC) program, by providing free vaccines to doctors who serve poor and uninsured children, is helping eliminate the "missed opportunities" that Mr. Glassman decries. The program actually lowers the price that Federal and State governments pay for vaccine for Medicaid-eligible children, and, by contributing to reductions in cases of communicable disease, it is making all of us safer in the process.

It is also important to remember that the VFC program is only one facet of the Clinton Administration's Childhood Immunization Initiative which is designed to rebuild our Nation's immunization delivery system, reduce vaccine costs, increase public awareness and community partnerships, enhance the monitoring of disease

Page 2 - Ms. Martha McAteer

and vaccination coverage, and improve vaccines and vaccine use. As such, it is certainly not the "galloping entitlement" Mr. Glassman describes so recklessly. To the contrary, VFC is a limited program which, at modest cost, provides only vaccines, and only to certain categories of poor and uninsured children. It also helps meet a clear goal: immunizing America's children against devastating--but preventable--disease.

Sincerely,



David Satcher, M.D., Ph.D.
Director

TUESDAY, MAY 9, 1995

James K. Glassman

Another Galloping Entitlement

Congress is finally starting to work on the budget, and it's clear that cutting the deficit to zero wouldn't be nearly so difficult if it weren't for entitlements—those mandatory programs that grow and grow without any fixed annual constraints.

For example, Medicare (health care for the elderly) cost the federal government just \$6 billion in 1970; it now costs \$178 billion and is projected to hit \$458 billion in another 10 years.

How does an entitlement grow from \$6 billion to \$178 billion? Take a look at the newest one, the Vaccines for Children program (VFC), which was slipped into the massive budget bill of 1993 as a stalking horse for the Clintons' health reform plan.

Health reform, of course, never made the race, but the ill-conceived VFC gallops on. Once born, entitlements never die.

Immunizing children against measles, mumps, tetanus and the like is admirable and necessary, but this government program is expensive, impossible to manage and based on a faulty premise—which is that the reason children aren't fully vaccinated before the age of 2 is that vaccines are too expensive.

To solve this non-problem, the Clinton administration is buying up the vast majority of the pediatric vaccines in the country (at a cost of \$493 million this year) and providing them free to poor children who are eligible for Medicaid and other children (no matter what their parents' income) whose insurance doesn't cover the shots.

The Department of Health and Human Services says the program will cover an incredible "60 percent of the nation's children." This time-honored entitlement strategy—giving free benefits to middle-class people who can already afford them—dates back to Franklin D. Roosevelt's political prescription for Social Security. It builds a stronger constituency than an entitlement strictly targeted to those who actually need it.

It's true that many young children don't get all their vaccinations, but as an official of the General Accounting Office reported to the Senate Finance Committee last Thursday, the reason isn't cost.

Most under-immunized children are poor—and, the GAO points out, they already "have access to free vaccine through Medicaid or public health clinics."

Even more remarkable, these kids see doctors and nurses "an average of six to eight times during a given year," according to research by the Centers for Disease Control (CDC). The children could easily get their free shots then—on occasions that are called (in health care jargon) "missed opportunities."

The GAO calculates that if toddlers in Rochester, N.Y., were given polio vaccines during "missed opportunities," their immunization rates would rise from 80 percent to 95 percent.

Who is blame for children missing their shots and increasing the risk of getting terrible diseases? Not the parents—not the evil drug manufacturers which, as President Clinton put it, are pursuing "profits at the expense of our children."

When the VFC program was announced in 1993, said Douglas Besharov of the American Enterprise Institute at a recent AEI conference, "it was very hard to be mean and nasty and say, you know, it's the parents, stupid—because you were immediately labeled as some kind of right-wing ideologue."

Now, the evidence is clear. Most parents act responsibly, but the ones who don't need a little coercion. They already have it when their children are older: School districts won't admit kindergarteners who haven't been vaccinated, and as a result, by age 5 nearly 100 percent have had their shots.

But coercion can be applied earlier as well. For example, the state of Maryland in 1992 began reducing a family's welfare grants by \$25 a month for every preschooler who wasn't properly immunized. The state also gives \$20 bonuses for every family member who receives an annual check-up.

"The information from our health department is that immunizations are up," says Grace Clark, the Maryland official in charge. "It's very exciting."

In fact, says Helen Szabliya, an official of the state's Department of Human Resources, "If you compare the immunization rate for our welfare clients who have the carrot-and-stick approach vs. middle-class children and working poor without this approach, I'll bet you our rate is higher."

Besharov says that other states have introduced similar carrots and sticks, and successful experiments have linked receipt of federal Women, Infant and Children's (WIC) food vouchers to immunizations.

Meanwhile, however, the VFC and its attendant promotional programs are consuming \$843 million a year in taxpayer funding—and that number will certainly rise. You can see the entitlement growth path emerging already: More vaccines will be added to the list, then other pharmaceuticals besides vaccines, then drugs for adults as well as children. . . .

Judging from the incredulous reactions of some of the senators at last week's hearing, many legislators simply didn't understand what the Vaccines for Children program was all about. One who did was liberal Sen. Dale Bumpers (D-Ark.), who last year described it as "a bureaucratic nightmare" and "an impending train wreck."

One big problem is that "vaccine investment is suffering under VFC," says Robert Goldberg, who heads Brandeis University's Gordon Public Policy Center. With the government having just about nationalized the market, drug companies are reluctant to spend money to develop new vaccines.

What can be done? Not much. Rep. John Porter (R-Ill.), who heads the appropriations subcommittee that oversees health spending and who is highly critical of the program, told the AEI conference in March: "Very frankly, it would be very difficult to zero out the VFC."

After all, it may be misguided and expensive, but it's for the kids. And, better yet, it's an entitlement program—which, in Washington, makes it immortal.

Correction

The identification of Judith H. Bello in her op-ed piece yesterday should have noted that she is trade counsel to Nissan North America.

Herb Kohl

Guns in Schools: Congress Can't Just Turn Its Back

The Post has supported the Supreme Court's 5 to 4 ruling invalidating the Gun-Free School Zones Act, a bipartisan measure designed to keep guns out of schools [editorial, April 28]. The Post and the court felt that Congress should have no power to stop the harm guns cause in the classroom and argued that the 50 states are in a better position to fight this epidemic of violence.

While I would agree that the Constitution limits Congress's power, this decision goes too far. Recognizing the need for Congress to respond to national problems, the court has refused to interpret the Constitution in such a narrow, formalistic way for 60 years. I am concerned that this ruling may threaten the safety of our children and hamper Congress's ability to establish national standards to protect our citizens.

The criticism of the Gun-Free Schools Act rests on the notion that because guns in schools do not substantially affect interstate commerce (which Congress can regulate) the law is unconstitutional. Yet the Supreme Court has previously read Congress's Commerce Clause powers more broadly to justify a variety of laws protecting public safety, civil rights and the environment.

For example, the court upheld Congress's power under the Commerce Clause to impose civil rights laws on a restaurant owner because products he sold were shipped from other states.

The court pointed out that because food sold in the restaurant traveled across state lines, Congress had the power to enforce the Civil Rights Act of 1964 to end discrimination in public accommodations. If wandering potato chips affect interstate commerce enough to justify civil rights protections for diners, surely the guns that kill our children each year should trigger federal intervention. After all, the raw materials for

Taking Exception

these weapons are mined in one state, manufactured in another and kill kids in yet another state. These crimes undermine our educational system and, left unchecked, will ultimately diminish our national economic competitiveness.

The Post also claims that this ruling will be interpreted narrowly, not affecting other significant public safety laws that rely on the Commerce Clause. The court, however, had the opportunity to say just that, but didn't. Nowhere in Chief Justice William Rehnquist's opinion is there a hopeful sign that the court will not impale other laws using the same reasoning as this case. In fact, Justice Clarence Thomas explicitly called for a new interpretation of the Commerce Clause

in future cases. I hope The Post is right, but it is unclear whether this decision is a minor judicial speed bump or a major constitutional detour. As Justice David Souter wrote in his dissent, "Not every epochal case comes in epochal trappings."

While the court's concerns in this case can be fixed by a technical amendment (which we will soon introduce) there are more than 100 other statutes that rely exclusively on Congress's Commerce Clause powers. Through its vague ruling, the court is inviting challenges to federal laws governing firearms, drugs, civil rights and the environment. These lawsuits could clog the courts for years, questioning the constitutionality of everything from wetlands protections to the ban on machine guns to the federal drug-free school zones law.

The Post also claims that 40 states have similar bans on guns in schools, but that doesn't tell the whole story. When we started our efforts in 1990, few states had similar laws and some applied only to concealed weapons or to the use of a gun in a school. Now, though many states have taken their lead from Congress (which was one of the purposes of our effort), about 10 states still don't prohibit guns in schools—and existing state school gun bans have become a patchwork of differing approaches. A uniform federal standard is still critical to protecting all of our

schoolchildren from deadly weapons. Moreover, prosecutors should have the flexibility to bring violators to justice under either state or federal statutes, whichever is appropriate.

Finally, the Supreme Court and The Post seem to miss the practical impact the ruling will have on our nation's schoolchildren. The Gun-Free School Zones Act was a common-sense approach to a national epidemic plaguing our education system. Teenagers today are seven times more likely to be killed by a gun than they were 30 years ago. The National Education Association estimates that 100,000 kids bring guns to school every day. How can Congress turn its back on our children when their safety is being threatened on a daily basis?

While lawyers and justices can create elegant, academic arguments to shoot down the Gun-Free School Zones Act, gun violence is a crisis that cries out for a national solution. If this were a contagious disease affecting our children, no one would question the federal government's authority to intervene. Just because the killing is caused by a gun instead of a virus, the federal government should not be blocked from trying to save lives.

The writer is a Democratic senator from Wisconsin.

Date: 06/15/95 Time: 16:39

GOP Challenges Cost of Vaccination Conference

WASHINGTON (AP) How many kids can you immunize for \$1,015,900?

About 13,500, figured Republicans on the House Commerce health subcommittee, and they chastised the director of the Centers for Disease Control and Prevention for spending that much on an immunization conference at a Los Angeles hotel last month.

The health agency flew out 176 members of its Atlanta headquarters staff and put them up at the Century Plaza Hotel for four nights for the conference, which cost three times as much as one held in Charlotte, N.C., the year before.

Rep. Scott Klug, R-Wis., asked Dr. David Satcher, the CDC director, Thursday if vaccinating 13,500 children wouldn't have been "a better way to spend that money?"

"It depends on how many children get vaccinated because of that conference," said Satcher, but allowed that the conference costs had gotten out of hand.

Rep. John Bryant, D-Texas, thought it was the Republicans who wasted money by having four color photos of the Century Plaza's lobby, ballroom and facade blown up into posters and displayed in the hearing room.

Bryant denounced it as "an outrageous attempt" to distract attention from the CDC's "great work."

Satcher, while apologetic, said the meeting drew almost 1,700 participants, up sharply from the year before. Most were involved in the grassroots work of getting children immunized, he said.

Klug asked if the conference couldn't have been held in Atlanta in "a little less ostentatious quarters."

Satcher replied that the CDC got a government rate of \$89 a night for its employees, no different than hotels charge in Madison, Wis. Klug's hometown.

"This was not a resort. It was not a beachfront hotel. It was a hotel that could handle a large number of people," the CDC director said.

Rep. Henry A. Waxman, D-Calif., evoked laughter when he expressed surprise at seeing "these blown-up photos of one of the fine hotels in my district."

In a poke at congressional junketeering, Waxman added, "Many of the members of this committee have been flown out to many of these hotels in my district the Beverly Wilshire, the Beverly Hills, the Century Plaza hotel usually at the expense of some lobbying organization" to give speeches.

Meantime, the General Accounting Office, in a critical report, said the \$500 million Vaccines for Children program "is not likely to prevent outbreaks of vaccine-preventable disease."

The GAO found no evidence that the cost of vaccine for parents has been "a major barrier to children's timely immunization."

It suggested a better, less costly strategy would be to concentrate on the "missed opportunities for immunization" when poor children get care from Medicaid, public health clinics and other providers.

Satcher testified that ``we are at record high levels of

immunization coverage for all the needed vaccines," with 90 percent of children under age 3 immunized against diphtheria, tetanus and whooping cough. But up to 1.9 million children are still missing some of their shots, he said.

APNP-06-15-95 1642EDT

BC BUMPERS-DANFORTH SKED
THE FEDERAL NEWS REUTERS TRANSCRIPT SERVICE

NEWS CONFERENCE WITH:
SENATOR DALE BUMPERS (D-AR)
SENATOR JOHN DANFORTH (R-MO)

TOPIC: VACCINES FOR THE CHILDREN PROGRAM

U.S. SENATE GALLERY

TUESDAY, JULY 19, 1994

TRANSCRIPT BY: FEDERAL NEWS SERVICE
620 NATIONAL PRESS BUILDING
WASHINGTON, DC 20045

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SEN. BUMPERS: Let me say at the beginning we appreciate your attendance;
number two, that Senator Danforth and I, and our distinguished colleagues on
the House side, are not in a turf fight, or any other kind of fight with
either CDC or HHS. All of us here have been deeply immersed in immunization
-- the immunization program -- as we lawyers say, since the memory of man --
(inaudible) -- not. And we have a deep and abiding interest in reaching the
immunization levels that we talked about last year when we passed fairly
dramatic changes in this program.

I do not personally have anything against a new system of distribution, if
it makes any sense and will save money. But the GAO report, which we are here
today really to release publicly for the first time, the GAO report which we
requested about six weeks ago fortifies the deep concerns we had about the
ability, for example, of the General Services Administration to put together
this mammoth

distribution center in Burlington, New Jersey, have it up and running with
70,000 names of physicians around the country on software; validate the
packaging of vaccines, and validate the addresses of the people who would
receive it.

Now, that sounds like a bureaucratic word, but to reduce it to its
simplest term it means this: GSA has never stored or shipped a dose of
vaccine in its history. It is not an uncomplicated system. On the contrary,
it is a rather sophisticated system. First, you must make sure that unfrozen
vaccine, for example, MMR -- measles-mumps- rubella -- is stored at 34

degrees when it leaves the warehouse and is at 34 degrees when it arrives at its destination. You have to make sure that it will do that for 96 hours, even though the pharmaceutical companies try to get it there within 48 hours. The polio vaccine is a frozen vaccine. You have to make sure it's frozen when it leaves and frozen when it gets there. Otherwise it will be thrown out and definitely not used.

When you look at the packaging that some of the pharmaceutical companies have developed, it isn't all that complicated; and yet it has to be a certain dimension, you have to put things like football players put on a strained muscle -- cellophane or plastic ice bags. Some of them have ice, some of them have water. You have to have exactly the right mix to make sure the vaccine stays at 34 degrees. And you have to make sure that you put just the right amount in a certain sized package to make sure the polio virus is still frozen when it gets there. As I say, this is not an insurmountable chore, but it is not something you can do on the spur of the moment.

Once you validate the packaging, you must then validate the shipping. And that one of the validations you have to do is to make sure that these 70,000 physicians who are going to be receiving the vaccines, that you have their name and their address correct, and preferably their office hours, because if you get the vaccine there on Friday afternoon when they've just shut down for the weekend, you've got a problem.

So all I'm saying is when you start in on a distribution system like this it is not uncomplicated. In my opinion, it would have been utterly impossible for GSA to even come close to validating 70,000 physicians' names, develop the packaging, the thermometers, do the procurement -- everything it was going to take to get this shipped. I'm not telling them not to do it. I'm not saying it's the worst idea in the world -- though I have some questions about it. All I am saying is to presume to embark on a program to raise our immunization levels to 95 percent of all the children of this country -- to presume to do that with this system is foolish in the extreme. I can tell you there isn't one thing about this distribution system that is going to immunize one more child.

And then let me just say that I was concerned about the fact that all of a sudden HHS says doctors will be allowed to charge patients who are uninsured -- let me go back and explain the three categories.

You have youngsters coming in who are insured. There are a few who may not be insured, but whose parents want their children to pay for the vaccine and to pay for the service. That's the first category.

Number two, you have children coming in who are not insured that the private physician will immunize free of charge as far as the vaccine is concerned: he gets the vaccine free -- we will replenish that private physician's stock of vaccine. The physician is entitled to charge what the law says are his costs in this second category. In addition to that, the physician can charge for an office visit. It was estimated at the time we passed this bill that the office cost -- that is, for the syringe, paperwork and so on -- was five to seven dollars per child. But if you do a survey of what the physicians normally charge as their cost, it runs around -- I mean customary charge, rather than cost -- it's about \$15. On top of that, they're entitled to charge that child's parents for an office visit, which can range anywhere from 20 to 50 dollars.

The third category of course is the Medicaid child, virtually all of whom will get their shots at public health clinics, but who are eligible to get their shots in the doctor's office free. Number one, if the doctors are allowed to charge their customary charge, this program is going to cost a lot

more than we thought it was going to cost. Number two, when you have a physician ordering vaccines from the state to cover -- to replenish his Medicaid vaccines, you have him perhaps sending an order to Burlington, New Jersey to replenish his stock of vaccines for uninsured children who were immunized by the private physician. And, thirdly, possibly ordering from the pharmaceutical company to replenish the stock of the vaccine that he gave private patients who were insured.

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**** filed by:RB--(--) on 07/19/94 at 13:45EDT ****

**** printed by:WHPR(BTOI) on 07/19/94 at 14:54EDT ****

BC BUMPERS-DANFORTH
----- AUTOBREAK (2) -----

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x x x insured.

All of that vaccine that arrives in the physician's office goes into the refrigerator, and I am quite sure it is commingled there. It's going to be very difficult for that doctor to keep up with the lot number, everything it would take, if we had a batch of vaccine that went bad to know which ones. It's going to be very difficult for him to order knowing which ones are free and which ones he is supposed to pay for. In short, we had one I considered an insurmountable problem, and I value the strong support of my colleagues in making sure that we don't embark on this.

There's one point I want to make in conclusion. That is I've held hearings every year in the Health and Human Services Subcommittee on Appropriations, and every year the proof is conclusive that our immunization levels are not higher not because of the cost -- there is virtually no evidence that the cost is a big impediment. The problem is we don't have clinic hours long enough, we don't have doctors oftentimes who even mention immunization to their own patients. We have public health clinics in Los Angeles where children have gone 10 and 15 times and immunization has never been mentioned to them. We're putting something like 124 or 125 million dollars into outreach programs, clinic hours -- all of those things that have a proven track record of increasing immunizations. This distribution system -- I'll reserve judgment on whatever they finally do until they do it and I hope to be able to maybe sign off on it -- but I can tell you that in itself is not going to immunize one child, in my opinion.

Now let me defer to my distinguished colleague and very good friend, Senator Danforth.

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**** printed by:WHPR(BTOI) on 07/19/94 at 14:55EDT ****

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SEN. DANFORTH: Well, Senator Bumpers, thank you very much. And you have been the leader in this area for a long time. Let me reiterate what Senator Bumpers has said. All of us share the same concern. We would like to immunize every child in the United States far before that child enters first grade where they have to be immunized. The goal is to increase immunization, to make sure that children are immunized. And I commend in a way the concern of the administration and the concern that at HHS. You can just visualize really good hearted souls at HHS trying to say well how do we increase immunization, what can we do about it. And there is something about the mentality of a lot of people who are good hearted people, who say well if we're going to do this, if we are going to immunize people, who is the "we"? Well the "we" has to be those of us who we see around us here in Washington, here at HHS. We have to do the immunization. And so how should we do it?

Well, the first thing we do is just buy a lot of vaccine, we should do the buying. We should buy 80 percent of the vaccine in the United States. We should buy more vaccine than it takes to immunize every child in the country, and then with that vaccine we have to do something, so let's get a warehouse. Well we have one and the warehouse is in New Jersey, but the warehouse unfortunately isn't used for vaccine purposes because we've never been in this business before. But there are some things in the warehouse that we can get rid of, furniture, paper, paint, solvents, adhesives, some 5,000 different products that are located in this warehouse. So let's get rid of those things and spruce up the warehouse and then bring in some refrigeration equipment, then we can store the vaccines and then we can send them out by Federal Express.

But we've never done this before. We don't know whether the containers are adequate, we don't know exactly how the distribution is to function, as Senator Bumpers pointed out. Perhaps the doctor's office is closed when the vaccine arrives. We now have a private distribution system that works, the problem isn't the distribution system. And to replace a private distribution system which works, which is tried and true, with one that is developed on short order from whole cloth, is just a mistake. It's a good hearted mistake, it's a kindly mistake, but it's an impractical mistake.

And the notion of buying up all the vaccine, 80 percent, whatever it is of the vaccine, is a mistake. As Senator Bumpers pointed out, and as the GAO report indicates, cost isn't the problem. People who are in need right now can get free vaccines. The problem is something

other than cost, the problem is something other than the distribution system. The problem is a lack of knowledge on the part of parents, the difficulty of parents of keeping track of multiple shots for their children. The problem is that today sometimes when you go to a doctor's office, when a parent takes a child to a doctor's office for treatment of say a bad ear or whatever, the doctor doesn't immunize the child while the child is there, for economic reasons. These are problems which can be solved, these are problems which can be addressed. And this is the point that Senator Bumpers has been making for some quite time, we should address them, and we should increase immunization.

But this program is one that is absolutely bound to go totally haywire. It's just bound to go haywire. You can't get the government in the business of buying all this vaccine, warehousing all this vaccin , and distributing all

this vaccine, and have it not go haywire. So again, I would say to the people at HHS, you are good people, but this is not a good program.

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x x x program.

Q Jack Luke (ph) from Wisconsin. Let me just make a couple of points because both Dale and Jack have made a good deal outlining some of the central points, but let me start back at the beginning. This entire immunization program was sold for the House and the Senate last year based on statistics that said only 50 or 60 percent of the pre-school age children in this country have been immunized. It turns out those figures actually came from 1985. And if you look at the most recent statistics in 1993, we are already over 90 percent. So even before the warehouse and the government program is off the ground, we've already reached most of the goals that were outlined in the legislation last year.

Which brings us to why do we see a need to change the distribution system, given the fact that, as has already been pointed out, there was no evidence last year that either price or distribution had anything whatsoever to do with low immunization rate. Instead the problems were parental responsibility, an outreach in communities and education.

Now let's take a doctor in California just as an example. Today a physician in Southern California can call a warehouse, in some cases just miles away, and ask them to drop vaccine off the next morning. Now the doctor in California under the new system will have to pick up the phone and call the California Department of Public Health, who will then call the Center for Disease Control in Atlanta, which will then call the General Services Administration in Washington, which will then call the warehouse in New Jersey, which will then finally ship the drug all the way across the country again.

Now we've already tried publicly financed distribution centers in the past. There have been two major studies, one done on the Department of Defense, and one done on the Veterans Administration. And the conclusion was it could be done cheaper in the private sector, in fact generally the operations in the public sector costs 12 times more than already existing distribution systems.

Now also think about this just one final time to kind of make this final point. The General Services Administration, which is in the business of handling paper clips and chairs and paper and copying machines, is now for the first time in its history going to handle a perishable commodity. The General Services Administration warehouse in New Jersey at any given time will have one third of all the vaccines in the country stored in one central facility. And according to the GSA's own map, the cold storage facility for vaccines is located next to the room where flammable products and chemicals are stored.

So this system will work great assuming we can beat the private sector in shipping costs, when every study says it can't, assuming that distribution costs and the distribution itself were originally part of the problem, which they never were, and fingers crossed that there is never an accident at a General Services Administration warehouse where it goes up in flames and one third of the vaccines in this country go up in flames overnight. So I concur with my colleagues from the Senate, and with Ron Wyden from Oregon who you will meet in a minute, that there's a way to solve this problem, and it's putting more money into community outreach and putting more money into vans in order to serve kids in neighborhoods, it's not setting up one more government bureaucracy and one more government warehouse that frankly isn't needed, it's

just expensive.

REP. WYDEN: I'm Ron Wyden of Oregon and I particularly want to commend Senator Bumpers. The fact of the matter is, Senator, there are a lot of kids across this country that are going to get help because you have been at this year after year after year, and I just want the record to show who has been doing all this -- and Jack Danforth and Scott Klug, it's great to team up with them as well.

It seems to me that the American people have made it very clear that they want the youngsters of this country to be immunized. And what we now have is a new report that indicates that some very important problems have to be resolved or we are not going to be able to move further towards the day when all the kids in this country are immunized. I think we ought to note that in about 54 days the first vaccine is to be shipped by the government to 50,000 doctors across the United States, and what the Congressional auditors have raised is some very troublesome issues that have to be resolved first.

For example, my home state of Oregon -- and I spoke yesterday with the Health Department officials that are going to run the program -- they've indicated that the October 1st deadline is, in their words, totally unrealistic. According to the folks in Oregon, they have been unable to even begin to enroll providers for the new program. My state thinks that the October 1st deadline at best, they would be able to sign up about 20 percent of the doctors needed. And in addition, to accomplish even that degree of provider enrollment, the state is very concerned about having to divert resources from proven programs that are getting kids immunized, along the lines of what Scott Klug has mentioned in the area of community education.

So it seems to me that the Department of Health and Human Services ought to look at some key kinds of questions right now. First, they do need to find money to fund the state implementation of the program without diverting resources from proven programs now under way, or they are really going to have to ask Congress for a delay in the implementation date of this program. Public health officials in my state have recommended that January 1st would be a more realistic kind of deadline.

Finally, on the point that Senator Bumpers has mentioned about the fact that the fee schedule might increase the cost for families where they would have to pay for a vaccination, I am very hopeful that the administration will move to ensure that these families would have a right to have their fees waived. I think it is important that they not face additional financial problems.

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Finally, let me close -- it seems to me that what this report really indicates is the very substantial problem you face when you try to go at health care reform piece meal. If our country had real health care reform with universal health care coverage, then we would be in a position to attack this issue in a comprehensive way. Perhaps some of these problems that have been exposed by the General Accounting Office could have been avoided. So, I'm very grateful to you, Senator Bumpers, and look forward to teaming up with you and our colleagues on a bipartisan basis.

SEN. BUMPERS: Thank you very much, Ron. Speaking of refrigeration, we could use a little of that in this air that's in here right now. One announcement before we take your questions, and that is the HHS subcommittee on appropriations will hold a hearing Thursday afternoon at 2:00 PM in their regular meeting room on this subject. You're all cordially invited. Yes?

Q -- (Off mike) --

SEN. BUMPERS: Let me say to you in all fairness, you may get separate answers on that. I have not made up my mind, really, whether or not this is a good idea, because I don't know the numbers. I know that HHS says it would save money; I'm not sure how. I think, as Senator Danforth has said, I'm always reluctant to try something new when an old system seems to be working very well. The distribution system we have now is demonstrated on this chart -- the new one is demonstrated on that chart. It is immensely more complicated. It is my belief -- I'll just blow this out -- it is my belief, we'll start here, in the past the government CDC has purchased 50 percent of all the vaccines in this country. Fifty percent were sold by the pharmaceutical companies in the private sector.

Obviously, the cost to the government on their contracts for that 50 percent was substantially less than private physicians paid. And now, out of this system the government proposes to buy 80 percent. Now what you have to bare in mind is if the government were using the existing distribution system and could buy 80 percent of the vaccine at the same price they've been paying for the 50 percent, there would be a substantial savings for the government. My guess is that perhaps this idea of a big warehouse in Burlington, New Jersey was calculated or conditioned on the proposition that since we were going to be buying roughly 80 percent of the vaccines, whereas incidentally, I think (it actually ?) was intended in the bill that we would buy 60 percent, but now we're headed for 80 percent.

I think this warehouse idea was designed to take care of a significantly bigger federal purchase than they have made in the past. And when they make claims for savings, I've never quite understood that unless they're using that as their savings. Because obviously, this warehouse is going to be an expensive undertaking. It's going to take people to run it; it's going to take a lot of electricity to keep the power, keep the refrigeration at the right temperature and so on. That's one of the reasons that we're going to hold a hearing Thursday afternoon to explore that. Jack, would you like to address that?

SEN. DANFORTH: I can't conceive that we're going to be better off as a country by opening the warehouse in New Jersey, or by creating this new

distribution system. And I think that when you have a system that's working, you don't begin wrecking that system, and there's no way that this amount of dislocation can't have a negative effect on the current distribution system. So, I think that it's a mistake; I really believe that it's a mistake. And I think that if the goal is to increase immunization, and that is everybody's goal, there are ways to accomplish that; there are certainly ways to explore accomplishing that short of buying up huge amounts of vaccines and creating this new governmental distribution system.

SEN. BUMPERS: Ron, I want you and Scott to address this also. But let me just say that CDC or HHS, first of all, they tried to get the VA to do it, then they tried to get the defense department to do it; neither one of them wanted any part of it. But they never one time submitted this to the private sector for bids to see whether or not it could be done cheaper in the private sector than the government's doing it. And I think that was a very bad mistake. -- (Inaudible).

SEN. DANFORTH: Well, in terms of our motives, I think there were kind of two-steps. The first step is to see how the program, as drawn up, is going to work and if it has a chance of working. And I think the evidence, at least in the GAO report, suggests that the program, as on the drawing board, is falling apart even as we speak. They've only signed up four out of 15 pharmaceutical companies; the staff at the GSA warehouse in New Jersey has not been trained at this point; they've not tested, as Senator Bumpers said, any of the packing equipment to see if it will hold up to FDA standards. So even if you assume this is a good idea, I think it's very difficult to believe it will be ready to go up and running in the next 60 days.

Now, as a general statement, last year, there were a number of questions raised in the house side in ways and means, and in energy and commerce on which I said, which essentially looked at this from the beginning to say, wait a minute, there's a very serious problem out there. But how, in God's name, is the government warehouse going to solve any of it. So, I have no objections in spending more money on kids immunization programs; I think it's money well spent. I just don't think the answer's in a warehouse in New Jersey.

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SEN. BUMPERS: Ron, you want to address that?

REP. WYDEN: I think you all have said it very well, and maybe to just highlight Senator Bumpers, here's an example again of what my state has said, or part of the problems that I think have not really been addressed. You know, we're talking, for example, about the impact this is going to have on low-income families, and the question of whether or not they're going to be able to get the doctor's fee waived. Well, my state has said that the Center for Disease Control indicated to them that families have the right to refuse to pay doctors only if it's their regular doctor.

Well, what we know is that a lot of low-income folks in our country don't have regular doctors, so I think what Senator Bumpers and our group is really saying is that we are seeing countless of these kinds of administrative problems that have got to be resolved.

SEN. BUMPERS: Yes.

Q -- (Off mike.) --

REP. WYDEN: No, I've not in the immediate past. I have spoken to him over the last year in regard to the general problem. Wisconsin, several years ago, had a celebrated measles epidemic in the Milwaukee area where we actually had a number of deaths. And it was one, I think, point of controversy that really started this whole debate going again. What public health officials discovered in Wisconsin, I think much to their chagrin, was that 97 or 98 percent of those kids were already eligible for free vaccines because they were Medicaid patients. And so, that really raises the questions again about how do you get that 98 percent of the kids.

It's not going to happen from a warehouse; you reach them by education and making it clear to parents they have a responsibility, and by making sure the clinics are accessible and available and with outreach programs. So I think, you know I can't speak for Wisconsin health officials, but I think given the discussions we've had over the course of the last year, I think we're on the same wavelength.

Q Knowing as much about the government as you do, and I must assume that you -- (inaudible) --

SEN. BUMPERS: Jack?

SEN. DANFORTH: I didn't vote for it.

SEN. BUMPERS: This was a presidential initiative, and with all due respect to the president, who was obviously operating on information handed to him by CDC and HHS, and the information was very badly flawed. Scott has already -- I think it was Scott that pointed this out. They were using information that was old; that showed the immunization levels of children in this country were 50 percent when, in fact, shortly after this bill passed, we learned from CDC that, for example, MMR levels are at 90 percent. DPT, I think, is at 86 percent. Polio is at what, Marianne? Eighty?

So you can see that we did not have the crisis on our hands that was portrayed to us at the time. And so, all of us went to work, and I had heard these figures whispered -- these new figures. But we went to work with this legislation saying, we've got to do something different; we've got to do something dramatic. I voted, unlike Senator Danforth, I voted for it. But it was not my -- the bill I didn't craft. It's not the kind of a bill I would have crafted.

Q Let me just follow up on that.

SEN. BUMPERS: Sure.

Q Is there any possibility that you're -- (inaudible).

SEN. BUMPERS: Well, I don't think you can lose if you can -- for example, if I had my way right now, I'd scrap the money about to spent on the warehouse and add it to the funds for outreach, clinic hours, education awareness, all of those things, Because that has a proven track record. This has no track record, and I'm afraid the one it's about to make could be almost fatal -- it wouldn't be fatal to the program, but it would be very devastating to it.

Q -- (Off mike) --

SEN. BUMPERS: Yes, yes. In my opinion, we will have such legislation.

Q Senator -- (inaudible) -- there are about three million kids born annually in the country, and -- (inaudible).

SEN. BUMPERS: No, the program is designed -- we want to get the 95, somewhere between 95 and 100 percent. And that's always been our goal. When Betty Bumpers got me involved in this in 1972, and I was governor of my state, and she frankly, just at loose ends, she was -- I don't want to get into that Hillary Clinton, she was tired of pouring tea, it wasn't that. She wanted to do something meaningful and take advantage of her position in the state, and so she chose this.

**** filed by:RB--(--) on 07/19/94 at 14:32EDT ****
**** printed by:WHPR(BTOI) on 07/19/94 at 14:55EDT ****

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And the first thing, you know, she was deeply involved, and I remember one Saturday with the help of the National Guard, Nurses Association, about ten different volunteer organizations, we immunized 300,000 children in one day and did not have, incidentally, one single reaction. It was an absolute masterpiece of work, and a stroke of luck not having a reaction. So, I got deeply involved in that, and I've been deeply involved in it ever since. The idea is to eradicate these diseases. We could eradicate measles; polio is about to become extinct on the planet. As you know, Central and South America had the last wild virus polio in the world, and that's about gone. We can eliminate measles, we can eliminate all of these devastating childhood diseases. They sound benign because we say childhood, the truth is they are devastating. When I first got involved in it, eight percent of the people in mental institutions in this country were there because of some syndrome from one of these childhood diseases. So you are talking about cost-benefit ratio that is really staggering.

But let me make one other point. I put a thing in the Congressional Record this morning which I invite you to read. And I'm reluctant to say this, and it's not denigrating of anybody's religion, but it is a fact. We have had over 500 cases of measles this year, due largely to two outbreaks, and both those outbreaks were pools of Christian Scientists where the children were not immunized. Once the outbreak, they were immunized. I mean I don't understand -- I don't choose to talk about what they permit and what they don't permit -- I am just saying that any time you develop a pool that is receptive to one of these diseases, you face a very good chance of getting it. And you will -- if we had 99 percent -- if we had 99 percent of the children in this country immunized against all of these diseases, the chances of a pool that would be receptive to these childhood diseases barely exists. You cannot guarantee that you would always do it, but the higher the level, the less chance of that pool being there. So what we want to do is to eliminate the possibility of the pool and eliminate the disease. And we can do it -- we've done it on polio, we can do it on measles and mumps and rubella.

Q Can I ask one -- just some numbers for you. When this program came up last year there were 13 states -- is that right -- that had universal immunization programs which meant everybody regardless of income or insurance coverage could get free vaccines. And the balance of the states did essentially a public-private split, so private insurance covered, if you had Medicaid you were taken care of. This program was really designed to fill two gaps -- a, kids of families who did not have insurance at all, so essentially too wealthy to be on Medicaid, but still struggling, or secondly, kids who had insurance, but whose insurance did not cover immunization programs. That was the real kind of slice of the pie that this was designed to hit. But obviously, as you've heard, it's a much broader shot than --

Q How much -- (inaudible)

REP. WYDEN: I don't know that.

Q Does anybody know?

SEN. BUMPERS: Nobody can answer that question, but Scott that's an excellent response.

Q (Inaudible)

SEN. BUMPERS: You are trying to create a high class divorce and I don't want to get into that. (Laughter)

Q (Inaudible)

SEN. DANFORTH: I would think we would have to go back to scratch, yes. I mean it just seems to me that this is something that is not just wrong in some specific component, but that it's wrong in design, that it's just a mistake, a mistake in concept. A mistake in concept that if there is a problem, the way to do it is the big government approach, the Washington approach. And I think that that was a bad concept. I think that it was reached for the best reasons, but I think that that is the kind of a mentality that -- there's a problem -- I mean we are the ones who have to fix it and we have to fix it in the most grandiose conceivable way.

MORE

**** filed by:RB--(--) on 07/19/94 at 14:35EDT ****
**** printed by:WHPR(BTOI) on 07/19/94 at 14:56EDT ****

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Q (Inaudible)

SEN. DANFORTH: I don't know the answer to that. My impression of the origin of it -- and you know in this bipartisan gathering I don't want to sound partisan -- but my impression of the origin of this was that when the new administration came in it wanted to do something, and that it saw this as something that was very important to do, and that this was going to be one of the new energetic efforts in the early stages of the administration, so that it worked its way into the budget last summer and here we are.

And again I want to say I don't to sound critical of motives because I'm not, I think that the motives in fact are very good. But I think it's just a view of things, it's a way of saying there is a problem, we are the solution, the solution has to be as big and as centralized and as expensive and grandiose as we can possibly make it. And when you do that, first of all you have a negative effect on what is going on right now, which is a good system. You have a negative effect on that good system, have to. I mean you can't come in with this sort of very heavy handed approach without effecting the way things have been done for a period of time, and done well for a period of time. And then secondly you create all of these real problems that would have to be resolved, the problem of the warehouse, the problem of refrigeration, the problem of computerizing the delivery system and actually getting a delivery system. When you look at it, that is Senator Bumpers product, it -- I mean it looks crazy. I mean it just looks crazy. And this is the old system.

SEN. BUMPERS: I don't have -- (laughter) --

SEN. DANFORTH: I don't think you can have both, so yes, I think that you just have to start from scratch. I am not an historian, but I think that it was something that was done by people who are very earnest and very energetic and wanted to do the right thing, and it turned out to be haywire.

Q How much money does Congress appropriate -- I'm having a little trouble here -- (inaudible) --

SEN. BUMPERS: We have obviously failed miserably here this morning. (Laughter.)

Q I mean is there a problem in immunizing our children throughout the country or --

SEN. BUMPERS: There is a problem, and let me reiterate what it is. It is a lack of awareness, it is clinic hours, it is failure to have sufficient outreach programs to reach the low income children who are the ones who are mostly unimmunized. And what we are seeing is this distribution system does not do one thing to solve that basic problem. And what I said was if we were to spend the money that we are spending on this new distribution system, which looks like a possible disaster in the making, if we were to put that money into the proven programs that have brought us to these 90 percent levels, we would be eminently better off.

Let me make one other observation. As you mentioned, Betty Bumpers being on the advisory committee, I remember several months ago she came by, she came home one evening, she had been to the committee meeting, she said "I want you to check something, I just heard the craziest thing today, that the government is talking about storing all this vaccine in New Jersey." So that was really the beginning of my knowledge of this.

And the other thing I want to mention is, you heard me say a moment ago, on that Saturday in Arkansas when we immunized 300,000 children, Betty was admittedly rhapsodic about what had been eminently successful. But then she said that same evening, "This is good for your political career and it's good for the children who are immunized, but it is not a solution. This is a one shot thing that all the cameras covered today, but three years from now we'll be right back where we are right now with the same number of unimmunized children." And she said, "Unless we somehow develop a system in this country to keep up with children from the time they are born until they are six years old, we will never get immunization levels where they ought to be."

Q How much is this program costing -- how much would it cost?

SEN. BUMPERS: Well this is a \$500 million program. Marion, how much was it last year?

Q I'm talking about the difference between that distribution system and the one --

SEN. BUMPERS: I can't answer that precisely. I can tell you that the total program is \$500 million this year and that's roughly \$100 million more than last year, maybe more.

Q You made the statement that if we put the money from what we would spend on this --

SEN. BUMPERS: Whatever amount it is -- I don't know what the amount is -- all I know is it could be better spent, that's the point I was trying to make.

Q Well how are you going to handle that --

SEN. BUMPERS: No, no, no, you are talking about millions. They say they are going to save \$30 million. I don't know how they calculate that. We'll find out Thursday afternoon.

Q Senator Bumpers, what do you intend -- legislation to stop this from being implemented, what do you intend to do about the program?

SEN. BUMPERS: We will use language on the Appropriations Bill to say none of the funds herein may be used until a certain time, namely if they go forward with the distribution system, that they satisfied us. Now Senator Danforth may wish to go further than that and just torpedo the whole idea. That's difficult to do on an Appropriations Bill. John, do you want to say anything about that? (Laughter)

SEN. DANFORTH: Well there will be perhaps other opportunities to deal with health questions on the floor of the Senate -- (laughter) -- between now and October. Actually when the health care bill was marked up in the Finance Committee, I considered offering an amendment to that legislation dealing with this and basically converting it into an average program, but it was impossible under the circumstances because we -- limited ourselves to

five minutes per amendment, and this can't -- I mean we can't discuss this in a press conference, much less to try to deliberate in the Finance Committee in five minutes. I think that Senator Bumpers' hearing is going to be a very important hearing because I think it will provide the basis for us devising a constructive approach to it.

Let me just say one thing on the money part, we want to spend money on immunization. When you talk about spending money on health care, that's one of the best ways you can spend money on health care, through immunization. We want to do it, we want to immunize children, we want a program that works. The only question is what is it that works. We believe that what works is education, what works is outreach, what works is some very specific ways of making it more likely that physicians will actually immunize children when the children come into the office. Those are the real issues
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**** filed by:RB--(--) on 07/19/94 at 14:39EDT ****
**** printed by:WHPR(BTOI) on 07/19/94 at 14:56EDT ****

BC BUMPERS-DANFORTH

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be addressed. The GAO has said that this scheme isn't going to produce any more immunizations,--so it's really much ado about nothing.

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**** printed by:WHPR(BTOI) on 07/19/94 at 14:56EDT ****

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Q (Inaudible)

REP. WYDEN: On the House side, John Porter from Illinois raised similar questions on the appropriations bill, and essentially, we decided not to do anything consciously in the House to force a vote until we got into the conference. And I would suspect you may see an attempt to instruct conferees to essentially agree to the Senate's position on this (thing?).

SEN. BUMPERS: My guess is to conclude that answer to that questions is we will put language on the appropriations bill saying that none of the funds herein may be used at least until something, because I'm not sure we're going to get a health care bill. We could address this in a health care bill, and that would be the best place to do it if I knew that bill was going to pass and be signed by the President. I'm not sure of that right now, and I don't want to take any chances on this, so we probably will put a prohibition. One more question.

Q On that issue, given that the people who designed and -- (inaudible) -- are presumably the ones who are involved in designing and improving the rest of the -- (inaudible) -- on health care, given your low opinion of this system, what gives you greater confidence in the other position -- (inaudible).

SEN. BUMPERS: I would strongly urge you not to draw a parallel between this program and what might happen in national health care. (Ardent ?) proponents -- I've read several times -- (ardent ?) proponents of a national health care bill of any kind have said this is a typical prelude for people on what will happen if we have national health care; that it will be this compounded on a daily basis. I don't believe that. I happen to very strongly favor a national health insurance bill.

And to say that because this system, because in my opinion poor judgement was used about how to raise immunization levels in this country, doesn't make my national health insurance a bad idea.

SEN. DANFORTH: Well, let me just say that Dale Bumpers is my friend, and he is the host of this news conference, and I wouldn't begin to start a disagreement with him in this particular forum.

-- (Off mike.) --

SEN. DANFORTH: I would just say that among us, there might be some different nuances in answering the question that you ask.

SEN. : But the bottom line is, it seems to me, is the General Accounting Office says that some serious problems need to be fixed. It does not say in this report, throw this entire thing out the window and begin from square one. It says some serious problems need to be fixed. I strongly support what Senator Bumpers has called for which is that we are going to hold off until the problems are fixed. I think among the four of us, you would get wide agreement that the central concern is how you get families educated.

In my state, not a single youngster is going to go without because of cost. But we do know that some youngsters are going to go without because

their parents don't know about it; maybe they don't have a ride to a public health program. So what we're going to do as we try to fix this program is employ a hands-on public health response, rather than some kind of bureaucratic -- (inaudible) -- program.

SEN. BUMPERS: One final point you should understand, and that is any child who is uninsured, that is if his insurance doesn't cover immunization, that child -- I don't care if he's the bankers son -- can go to the clinic and be immunized free. Is that a correct statement? So you bare in mind, that's another reason cost is not prohibitive. If somebody wants to go to the clinic or their private physician to get -- because they trust him more, for example, and they intend to pay a \$10 to \$15 cost, plus a \$50 office visit, if they don't want to do that, they can go down the block or wherever to a public health clinic, and avoid all of those costs and get a free immunization. That's one thing -- that is the one salient thing that is really new about this kind of a program.

Q Senator Bumpers, -- (inaudible).

SEN. BUMPERS: I didn't intend to sound gloomy, John, I just wanted to say that I know when that thing comes to the floor -- I didn't intend to sound gloomy about the prospects for passage of a national health bill, I simply wanted to say that I think you're talking about apples and oranges when you talk about a program here that we have suggested has gone awry. But there isn't anything about this that can't be corrected in roughly short order. And to suggest that this is typical of the government when they involve themselves in health care, is terribly wrong.

You shouldn't lose sight of the fact that 90 percent of the children in this country are immunized. That says a lot; that says this program has been largely successful. We want it to continue being successful, but to draw a parallel because something has suddenly gone awry in the program to say, this is what we're going to get if we have national health insurance, I think, is an erroneous parallel, an erroneous comparison and just has no foundation.

Thank you.

END

**** filed by:RB--(--) on 07/19/94 at 14:43EDT ****
**** printed by:WHPR(BTOI) on 07/19/94 at 14:56EDT ****