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

07-Sep-1995 04:17pm

TO: (See Below)

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

SUBJECT: Immunizations Hearing

Today Sen. Bumpers chaired Senate Appropriations Subcommittee hearings on immunizations. He was the only Senator in attendance. He addressed a number of issues: linkage of immunizations with WIC, amount and use of carryover funds, and a number of secondary issues. He was pleased by reports of high immunization rates -- though he noted these were achieved prior to the beginning of VFC, he also said at one point that he was "not suggesting that we torpedo VFC." He seemed very interested in requiring WIC to require its participants to have their children properly immunized.

Other witnesses included Irwin Redlener, president of the Children's Health Fund, who said that infrastructure funds were getting lost in State and local bureaucracies and were supplanting rather than supplementing State funds, and James Richard, President of the National Association of WIC Directors, who said that while WIC can help raise immunization rates, overcrowding is already a problem in WIC clinics that immunization efforts could exacerbate.

WIC

Sen Bumpers said that he has been criticized for suggesting that WIC benefits be linked to immunizations, but that CDC studies show that these linkages improve immunization rates and that "you should use what you've got." Dr. Orenstein testified that WIC linkages had been shown to raise immunization rates. Asked by Sen. Bumpers if WIC should require all participants to have their children properly immunized, he said it was "essential" that WIC screen participants for immunization status and refer them to providers, but said he was not prepared to comment on whether voucher incentives should also be required. Mr. Richard testified that overcrowding in WIC clinics was a cause for drop-outs from the program, and that increasing visits would increase crowding. He said his association was looking at the affect of linkages on clinic visits and would share its findings with the Subcommittee.

Carry-over of Infrastructure Funds

Sen. Bumpers asked why there was so much carry-over of funds from infrastructure grants by States. Dr. Orenstein said there were many causes, including late awards of grants in the year and State difficulties expending funds. Sen. Bumpers wondered if States with large carry-over amounts, such as California, could not target these funds at "pockets of need" -- such as LA county. He also said these carryover amounts were targets for budget cutting in the current environment.

Block Grants

Sen. Bumpers said that he was generally opposed to block grants, which lack federal oversight, and that he would work to keep Section 317 out of any block grant created by the Dole welfare bill.

Other Issues

Sen. Bumpers asked about the usefulness of incentive awards; Dr. Orenstein replied that they were useful but that States had trouble planning for them since the amounts were uncertain every year. Sen. Bumpers urged CDC to develop standards for States' VFC delivery systems to prevent costs from getting out of control. Sen. Bumpers also asked about recent suggestions that children received inactivated polio vaccine (IPV) rather than the current oral polio vaccine (OPV) -- Dr. Orenstein noted that ACIP will meet to consider this next week.

Distribution:

TO: Nancy-Ann E. Min

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

NOTE TO KITTY HIGGINS

SUBJECT: Childhood Immunization Hearing--Tomorrow

Tomorrow, September 7, Dr. Walter Orenstein, Director of CDC's National Immunization Program, will testify on childhood immunization before the Senate Appropriations Subcommittee on Labor, HHS and Education. The hearing will be chaired by Senator Bumpers (D-AR), under special arrangement with Chairman Specter (R-PA).

According to Senator Bumpers' staff, the hearing will focus on issues related to CDC's categorical grant program that provides assistance to States under section 317 of the PHS Act. It will not deal with the Vaccines for Children entitlement program enacted under OBRA 1993.

We expect the hearing to focus on two issues: 1) the status of "carryover" funding to the States for development of immunization infrastructure, and 2) the use of USDA's WIC program to enhance immunization coverage.

Carryover funds are moneys that have been awarded to States by CDC but have not been expended by the States. The total amount of carryover funding in the program is expected to be approximatly $90 million on October 1, 1995.

The WIC discussion, we believe, will be an exploration of Senator's long term interest in strengthening links between public health programs and WIC clinics to assess the immunization status of the children of WIC clients and to refer underimmunized children for appropriate immunization services, or perhaps administer vaccines in the WIC clinics.

In addition to CDC's Dr. Orenstein, two non-government witnesses are expected to testify: a representative of a State WIC program, and Irwin Redlener, M.D., who heads the Children's Health Fund in New York City.

The hearing will take place at 9:30am in room 192, Dirksen Senate Office Building.

If you have further questions, please let me know.

Kevin Thurm

DALE BUMPERS
ARKANSAS

COMMITTEES:
APPROPRIATIONS
ENERGY AND
NATURAL RESOURCES
SMALL BUSINESS

United States Senate

WASHINGTON, DC 20510-0401

August 30, 1995

Walter Orenstein, M.D.
Director
National Immunization Program
Centers for Disease Control
1600 Clifton Road
Atlanta, Georgia 30333

Dear Dr. Orenstein:

On Thursday, September 7, the Senate Appropriations Subcommittee on Labor, Health and Human Services and Education will hold a hearing on childhood immunization issues. The subcommittee would like to invite you to testify on that day. The hearing will be held in Room 192 of the Dirksen Senate Office Building and will commence at 9:30 A.M.

The subcommittee's hearing will focus on several issues: (1) the latest information on immunization coverage rates and disease incidence; (2) the most current research on strategies to identify and reach underserved children; and (3) the status of funds appropriated by Congress to assist states in building and expanding immunization infrastructures.

To assure adequate time for questions, we would appreciate it if you would limit your oral testimony to ten minutes. A longer, written statement and supporting documents are encouraged and will be included in the hearing record.

Your statement should be furnished to the subcommittee by Tuesday, September 5. It should be directed to Mary Ann Chaffee, 229 Dirksen Office Building, United States Senate, Washington, D.C. If you have any questions regarding this hearing or this request, please call Ms. Chaffee at (202) 224-6439.

The subcommittee looks forward to seeing you on September 7.

Sincerely,

Dale

Dale Bumpers

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

06-Sep-1995 04:01pm

TO: (See Below)

FROM: Diana M. Fortuna
Domestic Policy Council

SUBJECT: Immunization hearing tomorrow

September 6, 1995

MEMORANDUM FOR CAROL RASCO

FROM: Diana Fortuna

SUBJECT: Hearing tomorrow on Immunization

Tomorrow morning the Senate Appropriations Subcommittee on Labor-HHS will hold a hearing on immunization. Senator Bumpers will essentially run the hearing.

Surprisingly, the hearing is not expected to focus on the Vaccines for Children (VFC) program, but on underspending in the Section 317 program. As you know, Section 317 is the older grant program that assists states with immunization infrastructure. Apparently states have not drawn down funds as expected, and a significant "carryover" of $90 million has accumulated over the past three or four years. HHS is not able to cite reasons for this, beyond the fact that some states are suffering personnel cuts or are waiting for their legislatures to take some action.

Since Bumpers is a champion of the 317 program, he is presumably concerned that this large carryover makes the program an easy target for budget cuts. Therefore, he is expected to use the hearing to argue that 317 funding should be maintained. He might use this as an opportunity to say that the VFC program is unnecessary, but the list of witnesses does not seem designed to make a big splash in this way. The witnesses are Dr. David Satcher, Director of the Centers for Disease Control, Dr. Irwin Redlener, and someone from a state health department. (We are still awaiting Dr. Satcher's testimony.)

The hearing will also touch on the latest data on immunization rates, and on current research on how to reach underserved

children. The former refers to CDC's new measurement system that shows that immunization rates are higher than previously thought. The latter refers to Bumpers' belief that cost is not a significant barrier to immunization, and that targeting "pockets of need" is the best strategy. He may argue that WIC recipients should be required to certify that their children are immunized.

Distribution:

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DRAFT: June 14, 1995 10:47am

STATEMENT OF

DAVID SATCHER, M.D., Ph.D.

DIRECTOR

CENTERS FOR DISEASE CONTROL AND PREVENTION

BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

COMMITTEE ON COMMERCE

U. S. HOUSE OF REPRESENTATIVES

June 15, 1995

DRAFT: June 14, 1995 10:47am

Mr. Chairman, I am Dr. David Satcher, Director of the Centers for Disease Control and Prevention (CDC). Thank you for the opportunity to appear before this Committee to discuss childhood immunization and to tell you about the progress we have made since October 1 when the Vaccines for Children (VFC) Program became operational. I am especially pleased to have the opportunity to set the record straight with respect to issues that have been raised by the General Accounting Office (GAO), regarding barriers to immunization, and the successes and problems of implementing the VFC program.

THE CHILDHOOD IMMUNIZATION INITIATIVE

While the focus of today's hearing is on the VFC program, it is crucial to view it as one important part of a comprehensive strategy to reduce the incidence of childhood infectious disease through a sustained, multifaceted immunization program. Recognizing that there are multiple barriers to pre-school children's immunization, the Administration with Congress, CDC, the States, health care providers and other partners, developed the Childhood Immunization Initiative (CII) to increase and sustain immunization coverage rates.

Launched in early 1993, the CII is designed to marshall efforts of the public and private sectors, health care professionals and

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volunteer organizations to: reduce most vaccine-preventable diseases to zero; increase vaccination levels for 2 year-olds to at least 90 percent for the initial and most critical doses by 1996; and establish a sustainable system to ensure that at least 90 percent of all 2 year-olds receive the full series of vaccines by the year 2000.

The Initiative includes five key, inter-related strategies that will 1) improve the quality and quantity of vaccination delivery services; 2) reduce vaccine costs through bulk purchase contracts for the 317 and VFC programs; 3) increase community participation, education, and partnerships, through local, state, regional and national outreach, conferences, and public service announcements; 4) improve the monitoring of disease and vaccination coverage through improved disease surveillance and immunization registries; and 5) improve vaccines and vaccine use through research. Taken together, these strategies will assure--once and for all--immunization coverage for our nation's youngest citizens.

We are making excellent progress towards our goal of immunizing 90 percent of the nation's children against vaccine-preventable diseases. Our most recent immunization coverage data, from the first quarter of 1994, indicate that we are at record high levels of immunization coverage for two-year-old children. We still,

however, have work to do. Our data tells us that about 600,000 to 2 million of our nation's children between 19 and 35 months of age still had not received recommended vaccinations against specific diseases. As noted in the table below, about 2 million of these children had not received the full series of vaccinations and about 1.4 million had not received necessary polio vaccinations.

Table 1

Vaccination Levels and Estimated Numbers of Two Year Olds* Children Not Fully Protected in the U.S., 2nd Quarter 1994

Vaccine	Vaccination Levels (Percentages)	Estimated Numbers of Children Not Fully Protected
DTP 3+	90	600,000
DTP4	70	1,700,000
OPV 3	80	1,200,000
MMR	92	500,000
Hib 3+	76	1,400,000
4DTP/3OPV /1MMR	68	1,900,000

* Children 19-35 months old.

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

Note (2): Hepatitis B, although a recommended childhood vaccine, is not included in the table. The coverage for Hepatitis B was only 29%, leaving 4.1 million children not fully protected. However, many of these children were born before the Hepatitis B recommendations were in effect.

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SUCCESSES AND PROBLEMS IN THE VFC PROGRAM

The VFC Program is important for several reasons; it allows eligible children to obtain immunizations in their medical homes, it provides greater access to vaccines, and it is forging new public/private partnerships to get more children immunized.

The VFC Program began a little over 8 months ago but we have made significant progress.

- o VFC is operating in all States.[1]
- o Vaccine purchase contracts were signed with the manufacturers to provide vaccines for eligible children at discounted CDC contract prices for all vaccines routinely recommended for children.
- o State health departments have enrolled almost all public providers, including public health department clinics, community health centers, and other public facilities.
- o Tens of thousands of private providers have been enrolled across the country. We expect to increase the number of private providers enrolled as more States develop systems to deliver vaccines to private providers.
- o The vaccine ordering system is working well. Over 2,400

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

bulk orders have been processed, and almost 19 million doses of vaccine have been shipped to public and private providers.

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

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

Total Federal vaccine expenditures will not be much more when VFC is fully operational than what they were before under the discretionary Section 317 program and the Medicaid program. VFC allows us to buy more life-saving vaccine for about the same amount of money and it will not be at risk of declining investments in an era reduced discretionary funding.

By purchasing vaccines at discounted CDC contract prices, both

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the Federal and State governments benefit. Before VFC, Medicaid often paid the higher vaccine private sector price for vaccine, about $270 for the total series. The discounted CDC price is about $130. Further, the State Medicaid programs had to share in the cost of vaccines. Now, Medicaid children can receive free vaccines through VFC providers, and States do not have to share the purchase price with the Federal government. This will result in millions of dollars in savings for the State Medicaid programs, which can then be used by the States for other urgent needs.

I am pleased to note that many States have already chosen to plow those savings right back into children's health concerns by raising the rates they pay Medicaid providers to immunize Medicaid eligible children. These actions serve to attract providers to the VFC program and the Medicaid program, and vastly increase the likelihood that more children will be served in their medical home.

Most State Health Departments strongly support the VFC program and value its benefit to individual children and communities as a whole. Several States, including California, Georgia, Oregon, South Dakota and Rhode Island, have reported to the Association of State and Territorial Health Officials that, without the VFC program, their immunization efforts would suffer "catastrophic"

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consequences. Some States, such as Connecticut, Kentucky, Idaho, and Michigan, advised they would have to limit the availability of some vaccines, including the *Haemophilus Influenzae* type b and Hepatitis B vaccines, and South Carolina reported that immunization rates would plummet.

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

The VFC program has strengthened and institutionalized the partnership between public and private medical communities at the National, State, and local level. More than 30 private medical professional associations are working with us to implement the VFC program. These groups include the American Medical Association, the American Academy of Pediatrics (AAP), the American Academy of Family Physicians, the American Osteopathic Association, the National Medical Association, and the Interamerican College of Physicians and Surgeons.

PROBLEMS IN THE VFC PROGRAM

The complex nature of the implementing legislation and the

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relatively short time since the kick-off of the VFC program have complicated its implementation. Some implementation difficulties are inevitable in any new and intricate program, and we are well on our way to overcome those in the VFC.

Unfortunately, the myopic focus on the issue of cost as a barrier to immunization has led some to misunderstand the complex relationship between the VFC program with the other strategies underlying the Childhood Immunization Initiative. In that vein, we believe the GAO misunderstands the VFC program and has issued a flawed report that misstates the premise of the VFC program and as a consequence misrepresents the real and potential advantages of the program.

For the record, I would like to state that we are not in agreement with most of the criticisms found in the GAO report. Moreover, we are dismayed that CDC was provided a single working day to review the report and provide GAO with our response to its findings. Despite our best efforts to convey our concerns it is my understanding that our response will not be part of the final, printed report.

<u>COST IS A BARRIER TO IMMUNIZATION</u>

We agree with the large body of literature that shows

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conclusively that the cost of vaccine is of sufficient magnitude as to cause at least two outcomes. Parents defer having their children age-appropriately immunized until they reach school-age and parents are referred routinely to overburdened public sector clinics, placing additional demands on chronically overworked resources and personnel and further contributing to missed opportunities for all clinic patients.

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

Numerous surveys of both practitioners and health departments have documented increasing referrals of patients from their

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

Referrals from doctor's offices cause delays in receipt of vaccines. Zimmerman and colleagues documented this in a study of about 500 children served by private physicians in Minnesota. It was shown that the average age of children at the time of receipt of vaccine varied according to the insurance status of the child. For the those children immunized, the third dose of DTP, which is scheduled at 6 months of age, insured children were vaccinated at an average age of 7.8 months, whereas children with no insurance were vaccinated at 11.6 months of age, almost a 6 month delay in protection. For MMR, which is scheduled at 12-15 months of age,

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insured children were vaccinated at an average age of 17.8 months compared to 20.9 months for children with no insurance. The percentage of physicians likely to refer children varied by the insurance status of the child. Children with no insurance were more likely to be referred (68 percent) compared to fully insured children (0 percent). These results document, consistent with other studies, that children without insurance are very likely to be referred for immunizations and that these referrals may produce delays in the receipt of vaccines.

The premise underlying the VFC program is not just to provide free vaccine to children as an incentive to get them immunized (and thereby raise national immunization rates). Rather the goal is to make cost-free vaccines more readily available in provider's offices, to create and maintain medical homes for children, to reduce the burden on public health clinics and thereby free-up other scarce public health resources to treat the most vulnerable populations in those communities that the GAO euphemistically terms the "pockets of need". It is this nexus, between the VFC program and the CII as a whole, that GAO has failed to understand.

ENROLLMENT:

GAO Issue: CDC has not adequately tracked provider

enrollment. There are no targets for program success to evaluate whether enrollment is proceeding at an acceptable rate. Several months into the program only 50 percent or less of private providers are enrolled according to reports from States.

- CDC is closely monitoring the enrollment of providers into the VFC program. As I noted above, over 8,100 public health clinics and over 21,000 private provider sites, many with multiple physicians per site, have been enrolled in the VFC program.

The highest priority has been given to implementation in public clinics where about 50 percent of the vaccines in the country are administered and because these clinics traditionally serve those population groups most in need of timely immunization and are located in critical geographic areas.

Because some States are not enrolling until a private delivery system to private providers is established and the absence of a delivery system in some States may cause providers to wait to enroll, we expect to increase the number of private providers enrolled as the few remaining States complete systems to deliver vaccines to private providers.

CDC is conducting a national private provider immunization study

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for a sample of practicing pediatricians, family physicians, and osteopathic physicians who provide immunizations to children under 5 years of age. This study will provide information on physicians' practices that will help CDC to better learn about enrollment efforts.

ORDERING

GAO Issue: CDC did not properly analyze software requirements and costs in developing software to order vaccine electronically.

- CDC made the correct priority decisions to have an effective ordering system functioning in a safe and timely manner to meet legislative requirements. All 50 States and the District of Columbia are effectively using the system and have placed over 2,400 bulk vaccine orders. GAO's pursuit of formalized analyses, which CDC conducted informally during the developmental period, would have delayed ordering well beyond the October 1, 1994 legislatively mandated start date.

- Our vaccine ordering system was implemented effectively and efficiently by building on an existing system. Logistics Management Institute (LMI), an independent group of experts in logistics and data systems, reviewed the VFC system and concluded it is effective and meets the program's needs.

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- CDC did analyze software and other requirements but did not have time to formalize these analyses of systems requirements, alternative systems cost benefit analysis, risk analysis, or security and disaster recovery. LMI has found that CDC had "taken steps to assure that data and systems files are systematically backed-up. Recovery, should failure occur, would in our opinion be relatively quick and inexpensive." GAO's suggestion to formalize analyses that CDC informally conducted during the developmental period would have delayed ordering beyond the October 1 deadline.

- By January 1995, CDC completed technical systems documentation for disaster recovery plans, security, and systems and risk analysis. To a large extent, these documents represent the documentation of analyses for which GAO was looking.

> *GAO Issue: CDC purchased hardware to operate the VFC software when the States already had computers. Furthermore, CDC did not follow the competitive process to purchase such hardware.*

- Existing hardware at the State level was inadequate to support VFC ordering requirements. For example, there was insufficient memory on the older computers for VFC software, and the hardware could not prevent the loss or rapid transmission of data.

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- CDC used an existing contract to purchase hardware and commercial software at substantial savings. At a cost of less than $10,000 per immunization project, or a total of about $500,000, these systems include standard components, including data security systems, identical to that being used in corporations and by private users. LMI found "hardware and software reliability to be the equivalent of similar commercial applications and sufficient to implement the VFC program."

  GAO Issue: According to a December 1994 GAO survey of States, some have to operate other computer systems for vaccine ordering, and a range of features need to be added to the CDC system.

- Significant enhancements have been implemented as the system has matured that allow data to be appropriately exported to other State computer systems and allows software to operate on the States' various Local Area Network environments. CDC is continuing its needs analysis to interface the ordering system with other data systems.

VACCINE DELIVERY

GAO Issue: CDC does not have a delivery system in place for private providers for VFC vaccines all States.

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In September, 1994 CDC began negotiations with vaccine manufacturers for the delivery of vaccines to private physicians in December. On April 10, lacking the prerequisite agreements with all four vaccine manufacturers, CDC had to discontinue these negotiations.

CDC immediately inaugurated efforts to provide for State-based, private sector delivery systems. VFC vaccine is being delivered now to tens of thousands of public and private providers. Forty-nine States are delivering vaccines to public clinics and 35 States have informed CDC they are delivering vaccine to enrolled private providers. At least 10 of the 14 remaining States reported that they plan to begin delivering vaccine this year. Five of these 10 States have already signed contracts and are in varying stages of beginning vaccine delivery.

CDC met with States in mid-May and again on June 9 and will complete discussions with vaccine manufacturers, private provider organizations, and wholesale distributors by mid-July to determine how best to improve future vaccine delivery.

ADMINISTRATION FEES

GAO Issue: CDC has based the fee caps on usual charges for vaccine administration instead of provider costs as stated

in the legislation.

- Fee caps were initially established based on "usual charge" data provided by the American Academy of Pediatrics. These fees are maximums and do not necessarily reflect the charges that will actually be passed on to patients. In fact, participating providers are required to agree that no one can be denied vaccines due to inability to pay fees.

HCFA has undertaken a study to estimate actual provider costs and expects to base future fee caps on these costs by the end of the calendar year.

ACCOUNTABILITY

> *GAO Issue: CDC has not required States to collect data to insure VFC serves only eligible children. CDC... cannot distinguish between the number of children who have been immunized under VFC and the number of doses that have been distributed.*

In building an effective accountability system, several activities were undertaken, including the development of State accountability plans, monitoring orders, and the submission of three required forms annually.

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States have the primary responsibility to ensure that VFC (and 317) vaccine is used appropriately. States have over 30 years experience managing immunization programs and because of their knowledge of unique circumstances and provider practices are in the best position to account for these vaccines. This is approach consistent with the goal of empowering States to manage program process as long as outcomes are met through performance measures.

CDC is conducting several additional accountability projects including evaluating historical vaccine ordering patterns, site visits to several States, presenting accountability options to State Health Officials and public and private providers, and contracting for a pilot study to evaluate methods of accountability for VFC vaccines based on actual usage information.

It is crucial to maintain the right balance between effective accountability and accomplishing overall program goals. If providers had to report each immunization transaction, they would be burdened with filling out and sending in over 14 million pieces of paper a year.

Private provider organizations have warned us that excessive

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paperwork would keep physicians from enrolling and the HHS Inspector General has just released a survey of several hundred physicians that found excessive paperwork could discourage physicians from participating in the VFC Program.

PROGRAM EVALUATION

GAO Issue: CDC has not established baseline data to evaluate the impact of the VFC program and has been slow to develop an evaluation plan.

Since VFC is only one of five components of the CII, the overall goal is to evaluate the effectiveness of the CII in its totality.

Despite the difficulties in isolating other immunization variables, such as education or infrastructure improvements, a comprehensive evaluation plan for VFC is being developed with the input of experts in immunization and evaluation. CDC believes baseline information can be obtained from retrospective studies that would allow comparisons of pre-VFC coverage levels with coverage after VFC.

HISTORICAL PERSPECTIVE

At the beginning of my testimony, I stated that if we continue

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our comprehensive and intensified efforts, we will achieve our goals. Any significant disruption to this country's commitment to childhood immunization will return us to an era of continued epidemic threats. The evidence is clear. Over the years, after funding for immunization has decreased, disease incidence has increased. For example, after funding for measles immunization decreased from 1968-1969, cases tripled between 1969-1971; after funding decreased from 1974-1976, cases more than doubled between 1975-1977; and after funding decreased during the 1980's, the measles epidemic of 1989-1991 occurred. On the other hand, when Federal funding for immunization increases, disease levels decrease. For example, after funding increased from 1970-1972, measles cases had decreased by 65 percent by 1973. Without assurance that immunization funding will be maintained, we have grave concerns disease levels will begin rising again.

Vaccine-preventable diseases do not respect State or National borders. If one State provides inadequate funding, support, or makes poor immunization decisions, and an outbreak of disease results, other States are threatened. The current mobility of our population will only exacerbate the spread of disease. In 1994, a multi-state outbreak of measles resulted from exposure to a child in a Las Vegas children's arcade. A child exposed in Las Vegas returned to Colorado. Three generations of cases occurred in the ensuing outbreak before it could be contained. Vaccine

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cost alone for this outbreak was at least $150,000. In 1994, a chain of measles transmission began in Breckenridge, Colorado, and spread into nine additional States. A total of 247 cases were reported, representing 36 percent of all U.S. measles cases that year. The source of the outbreak is believed to be an out-of-State tourist.

CONCLUSION

Immunization represents one of the most, if not the most, cost-effective public health intervention. However, vaccines can only be as effective as the system we have to make sure children in need get them on time. There is no magic bullet to solve the problem. No one approach, such as school laws for school-age children, will suffice for the preschool population. We believe that we can reach our goals with the sustained implementation of our current comprehensive strategy.

This nation has too often responded to crises rather than preventing them. If we are to prevent disease, we must build a comprehensive system that is secure and sustainable, not only for today's children, but tomorrow's as well. This system must fully function not only during and immediately after the threat of an epidemic, such as occurred after the recent measles resurgence of 1989-1991; but, more importantly, the system must function during

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the absence of disease which often lasts for many years after an epidemic. Never again should epidemics be the primary motivation of immunization efforts.

The CII is designed to build this disease prevention system by enhancing vaccine delivery infrastructure, building partnerships, involving the community, supporting State data systems to help parents and providers remember when immunizations are due, and much more. The CII is a major step forward in improving the health of our children, and CDC is committed to the full implementation of this Initiative.

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
415 Second Street, N.E., Suite 200, Washington, D.C. 20002
(202) 546-5400

May 3, 1995

The Honorable Carol Moseley-Braun
U.S. Senate
Washington, D.C. 20510

Dear Senator Moseley-Braun:

Tomorrow the Finance Committee will hold a hearing on the Vaccines for Children program, the federal program that provides vaccines to children who are uninsured, Medicaid-eligible, have inadequate insurance, or are Native Americans. As president of the Association of State and Territorial Health Officials (ASTHO), the organization which represents the public health department in each state, I wanted to convey our strong support for this important public health program.

There is no question that since its inception the Vaccines for Children program has endured its share of start-up challenges. However, in spite of the program's benefits which have already begun to improve immunization rates in many states, the program continues to come under an unusual amount of scrutiny. State health officers believe that any attempt to scale back or repeal the program would have serious detrimental effects on states' immunization efforts and relationships with the private provider community.

I hope you will take a moment to read the enclosed testimony that ASTHO has submitted to Chairman Packwood for the record. This document outlines the many benefits of the Vaccines for Children program, with state-specific examples of improved immunization rates. Moreover, I have enclosed copies of letters from states that are represented on the Finance Committee, which I believe demonstrate states' dedication to implementing this program fully.

I encourage you to contact your state health department if you have any questions about the program in your state. Thank you for your interest.

Sincerely,

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

Attachments: ASTHO testimony
State letters of support

dc\hill-vfc.595

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
415 Second Street, N.E., Suite 200, Washington, D.C. 20002
(202) 546-5400

May 4, 1995

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

Dear Chairman Packwood:

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

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

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

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

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

[2] Ibid.

[3] Ibid.

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

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

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

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

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

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[4] *MMWR*, March 1995.

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

[6] Ibid.

[7] Ibid.

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

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

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

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

Sincerely,

Christopher Atchison

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

dc\vfc-test.595

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

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

STATE OF DELAWARE
OFFICE OF THE GOVERNOR

May 2, 1995

THOMAS R. CARPER
GOVERNOR

The Honorable William V. Roth Jr.
Senate Finance Committee
104 Hart Senate Office Building
Washington, D.C. 20510

Dear ~~Senator~~ Roth, Bill

As I understand the Senate Finance Committee will be holding a hearing for the Vaccines for Children (VFC) program on May 4. I would like to bring to your attention the importance of this program to Delaware and thank you for your continued support and assistance in its implementation.

Delaware proudly considers itself to be on the leading edge of promoting a medical home for all children. The VFC program, initiated January 1, 1995 has proven to be a successful venture and has helped to re-establish the private/public partnerships needed to improve immunization levels.

Currently, 248 private and public providers are enrolled in VFC, which include those who serve the largest proportion of Medicaid eligible children. Additionally, all of our Federally Qualified Health Centers, school-based wellness centers and public health clinics are enrolled. These providers have received more than 30,400 doses of vaccine enabling them to vaccinate approximately 10,000 children of all ages who otherwise may not have had that opportunity.

VFC plays an integral part in our effort to reduce referrals from the private to the public sector. In addition, when children receive health care from a sole provider, they are ensured a continuity of comprehensive services. The Medical community has worked very closely with us in determining how VFC is implemented in Delaware. The providers consider the program to be invaluable and would be gravely disconcerted with government, should the program be discontinued.

VFC's optional use clause is vital to our plans for a universal immunization program (UIP). This clause allows Delaware to purchase vaccines at the federal contract price, which in many cases is one half the retail price. The goal of UIP is to assure that every

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CARVEL STATE OFFICE BLDG.
WILMINGTON, DELAWARE 19801
(302) 577 - 3210
FAX (302) 577 - 3118

child in our state, regardless of income, has access to vaccine at no direct cost to parents or health care providers. We believe this goal is attainable with VFC and the purchase power of the optional use clause to provide vaccines for all of Delaware's children.

To forge ahead with our plans for a Universal Immunization Program, we are working closely with the State's major health insurers. In exchange for their support for delivering immunizations to the many uninsured and underinsured children in Delaware, we are helping them reduce their expense for such benefits.

Delaware's unique position of having a fully functional state-wide immunization registry further emphasizes the importance of VFC and its impact in our state. We have successfully linked medical care provider participation in VFC with participation in our registry. The immunization registry not only generates reports to inform providers about a patient's immunization level, as well as a way to assess how well we are meeting our immunization objectives, but it is a mechanism by which providers are reimbursed toward the cost of administering vaccine. VFC, when combined with this technology, is an important incentive for providers to vaccinate children in their offices and provide us valuable information to plan our programs.

Once again, I appreciate your past support for the Vaccines for Children program and in particular the optional use clause.

Thank you, Bill.

Sincerely,

Thomas R. Carper
Governor

pc: The Honorable Joseph R. Biden, Jr.

(503) 731-4000
FAX (503) 731-4078
TDD-Nonvoice (503) 732-4031

Oregon

DEPARTMENT OF HUMAN RESOURCES

HEALTH DIVISION

May 2, 1995

The Honorable Senator Bob Packwood
Chair, Senate Finance Committee
259 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood:

The Oregon Health Division strongly supports the Vaccines For Children (VFC) Program as a critical piece of the Immunization Program in Oregon. The Division, which coordinates all publicly funded immunization efforts in the state, believes VFC promotes a unique partnership between private health care providers and federal, state and county governments to immunize approximately 60 percent of young Oregonians. The Vaccines For Children Program has been endorsed by the Oregon Preschool Immunization Consortium, a private/public partnership of over 40 organizations dedicated to achieving the Oregon Benchmark Goal of age-appropriately immunizing 90 percent of Oregon children by the year 2000.

One key strategy for improving immunizations rates is to ensure that all children are immunized as part of their routine medical care. A major benefit of VFC is that it allows children to receive immunizations in their private physician's office, and eliminates the need for referral to a county health department for vaccination. We know that such referrals mean parents often delay care for several months and sometimes they do not return for care at all. We are in the final stages of implementing VFC in the private sector, and Oregon providers are excited about how the program facilitates comprehensive well child care and reduces the need for referral to public clinics.

While many VFC-eligible children could receive immunizations at county health departments through the 317 program, there are thousands of other Oregon children immunized through VFC who would not be eligible for state-supplied vaccine any other way. The Division, working through the Immunization Consortium, is attempting to increase the capacity of private sector immunization services. Our concern is that a repeal of VFC would be a substantial blow to that working public/private partnership.

We respectfully request your consideration of these facts in your deliberations, and we hope you will support the Vaccines For Children Program as it assists the Division in our mission to improve the health of Oregon's children and adolescents.

Sincerely,

Grant Higginson, M.D.
Acting State Health Officer

David Fleming, M.D.
State Epidemiologist

John A. Kitzhaber
Governor

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Portland, OR 97232-2162
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Emergency

24-26 (Rev. 12-94)

May 2, 1995

The Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood;

I strongly urge you to support the continuation of the Vaccines for Children Program, and other related legislation that will protect the health of our children and the general population against diseases that are capable of disabling and sometimes killing a child or adult. Strong local and federal efforts, teamed for complete coverage of children's immunizations, are necessary for the current and future health and welfare of our people.

As you may be aware, there is a diptheria epidemic in the former Soviet Union, partially as a result of the breakdown of consistent and coordinated federal and local efforts at prevention of this horrible disease. As an elected official charged with oversight of federal efforts that benefit the country and the state, I expect that you will consider this matter very, very carefully, and to ultimately support efforts and funds to support Vaccines For Children Program.

Thank vou.

David Newman FNP
DAVID NEWMAN

May 2, 1995

The Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood;

I strongly urge you to support the continuation of the Vaccines for Children Program, and other related legislation that will protect the health of our children and the general population against diseases that are capable of disabling and sometimes killing a child or adult. Strong local and federal efforts, teamed for complete coverage of children's immunizations, are necessary for the current and future health and welfare of our people.

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Thank vou.

Senator Packwood:
Immunizations need to be available to all Americans, to maintain the health of the country.
Sincerely,
A Pastor L.N.

May 2, 1995

The Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood;

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Thank vou.

Sincerely,

Lydia Villaga MD

P.S. Senator Packwood, protecting against diseases with vaccinations is the best form of ~~ensuring~~ the health of America's future.

May 2, 1995

The Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood;

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Thank you.

Sherri Purcell RN, BSN - OHSU

P.S. Please consider that all children need vaccinations & if they are not given to low-income families, these children will not get them

May 2, 1995

The Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood;

I strongly urge you to support the continuation of the Vaccines for Children Program, and other related legislation that will protect the health of our children and the general population against diseases that are capable of disabling and sometimes killing a child or adult. Strong local and federal efforts, teamed for complete coverage of children's immunizations, are necessary for the current and future health and welfare of our people.

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Thank you.

Yours sincerely,
Bruce Cole, director of patient information, Family Medicine
Oregon Health Sci. Univ.

I hope you will continue to support this needed program, as far more money will be spent in the future on these kids if they aren't helped now.

Oregon Academy
of Family Physicians

12300 S W Tooze Road
Sherwood, Oregon 97140
Phone (503) 682-1846
FAX (503) 682-1454

May 1, 1995

The Honorable Bob Packwood
United States Senate
295 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood:

Oregon children need your support of the Vaccine for Children (VFC) program, the fate of which may be determined at Senate hearings this week.

The Oregon Academy of Family Physicians, in concert with other members of the Oregon Preschool Immunization Consortium, have worked for several years to establish mechanisms to improve the woeful immunization status of Oregon children. The Vaccine for Children program will be a **major** part of our ongoing effort.

As you may know, 60% of vaccines administered to preschool children in this state are administered by private practicing family physicians and pediatricians. The VFC program enables them to expand their outreach to unimmunized kids.

We believe Oregon is ahead of most of the rest of the nation in having established a strong working coalition for preschool immunization. WE NEED THE VFC TO CONTINUE OUR EFFORT.

Please do everything in your power to fund this vital program. It will save many millions of dollars in the long term.

Sincerely,

(Mrs.) Mary Gonzales Lundy
Executive Director

HOOD RIVER COUNTY HEALTH DEPARTMENT
1109 JUNE STREET
HOOD RIVER, OREGON 97031

TELEPHONE 503-386-1115
FAX 503-386-9181

The Honorable Robert Packwood
295 Russell, Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood:

I am writing in regards to the Vaccines for Children program. I am in total support of making immunizations more available and more accessible. However, it appears that the compromises reached with the vaccine manufacturers have erected as many barriers as the program sought to eliminate.

Family Practice Physicians in our area are very reluctant to sign up for a program that requires them to purchase vaccine at "retail" for their fully insured families, and accept "free" vaccine for uninsured, underinsured, Native American and Alaska Native patients, and those with Medicaid coverage. The record keeping, the sorting of patients into one of the two groups, and the separation of the vaccine storage appears to them to be much more trouble than it is worth.

Our health department has been doing most of the immunizations for this community for a very long time. We would much prefer that children receive immunizations from their family physician. Our rates would improve immediately.

I believe that the motivation behind this program was sincere. I know that the vaccine manufacturers risk liability and want to cover the potential cost. However, it is also true that the vaccine manufacturers are making very healthy profits that they want to protect.

As unpopular as my opinion is with the current majority in Congress, I believe that the federal government should buy and distribute all vaccine for childhood immunizations. The vaccine should be available to all health care providers at no or minimal cost, and the necessary "paperwork" should be automated, so that busy physician offices and clinics can focus on giving health care. If the "best health care system in the world" can't protect our children from preventable diseases, what is our claim to fame?

Sincerely,

Anne R. Cathey

Anne R. Cathey, Director

May 2, 1995

The Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood;

I strongly urge you to support the continuation of the Vaccines for Children Program, and other related legislation that will protect the health of our children and the general population against diseases that are capable of disabling and sometimes killing a child or adult. Strong local and federal efforts, teamed for complete coverage of children's immunizations, are necessary for the current and future health and welfare of our people.

As you may be aware, there is a diptheria epidemic in the former Soviet Union, partially as a result of the breakdown of consistent and coordinated federal and local efforts at prevention of this horrible disease. As an elected official charged with oversight of federal efforts that benefit the country and the state, I expect that you will consider this matter very, very carefully, and to ultimately support efforts and funds to support Vaccines For Children Program.

Thank vou.

Bruce Dudley MD

OREGON
HEALTH SCIENCES UNIVERSITY
3181 S.W. Sam Jackson Park Road, SN-FAM, Portland, Oregon 97201-3098
(503) 494-8382, Fax (503) 494-3878

School of Nursing
Department of Family Nursing

May 2, 1995

The Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood;

I strongly urge you to support the continuation of the Vaccines for Children Program, and other related legislation that will protect the health of our children and the general population against diseases that are capable of disabling and sometimes killing a child or adult. Strong local and federal efforts, teamed for complete coverage of children's immunizations, are necessary for the current and future health and welfare of our people.

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Thank you.
Sincerely, Marsha L Heims

Marsha L. Heims, RN
Member, Oregon Preschool Immunization Consortium
Portland, Oregon

Senator Packwood –
Wire counting on your
support! Thank you
Marsha
Pediatric + Child Health + Family
Health Nurse

May 2, 1995

The Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood;

I strongly urge you to support the continuation of the Vaccines for Children Program, and other related legislation that will protect the health of our children and the general population against diseases that are capable of disabling and sometimes killing a child or adult. Strong local and federal efforts, teamed for complete coverage of children's immunizations, are necessary for the current and future health and welfare of our people.

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Thank vou.

Teri Reese, SN

May 2, 1995

The Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood;

I strongly urge you to support the continuation of the Vaccines for Children Program, and other related legislation that will protect the health of our children and the general population against diseases that are capable of disabling and sometimes killing a child or adult. Strong local and federal efforts, teamed for complete coverage of children's immunizations, are necessary for the current and future health and welfare of our people.

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Thank vou.

I know that you will give this matter your attention as I am aware you care greatly about children's issues.

Sara Eide MD

May 2, 1995

The Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood;

I strongly urge you to support the continuation of the Vaccines for Children Program, and other related legislation that will protect the health of our children and the general population against diseases that are capable of disabling and sometimes killing a child or adult. Strong local and federal efforts, teamed for complete coverage of children's immunizations, are necessary for the current and future health and welfare of our people.

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Thank you.

Doreen Dittle CMA

Lane County

May 2, 1995

The Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, D.C. 20501

Dear Senator Packwood:

This letter is in support of the Vaccine For Children Program (VFC). As a public health nurse with twenty-five plus years of experience in both promoting and providing children's immunizations, I was very excited when this program was developed. I am now very concerned that a program which has the potential of helping the United States achieve its goal of having 90% of its children immunized by age two is in serious danger of being derailed before there is a chance to demonstrate its effectiveness.

In my opinion, there are two significant factors that the VFC program will address. Cost is a significant barrier to many families and few insurance programs cover this expense. Therefore, families will choose to defer the immunizations until a time that better fits their budget. Second, many health care providers do not make immunizations a major focus of office visits unless they are a part of the well child check. If physicians had the low cost vaccine in their offices, there would be fewer parents waiting until a better time according to the pocketbook to immunize their children. Also, with health care providers agreeing to participate in the VFC program, children's immunizations could play a larger part in their practices, because program participation should serve to raise the consciousness of immunizations in those practices.

I hope that the U.S. Senate will approve continuation of this program. Currently, immunization levels for children in the U.S. fall behind those of many third world countries. With all our resources, we should be among the world leaders, and Vaccines For Children will help us achieve that goal.

Sincerely,

Sandra L. Mowrer, R.N., MPH
Public Health Nurse

SM:ag

OPCA
OREGON PRIMARY CARE ASSOCIATION

321 SW 6th Ave., Fifth Floor • Portland, Oregon 97204 • Tel (503) 228-8852 • Fax (503) 228-9887

May 1, 1995

The Honorable Robert Packwood
295 Russell, Senate Office Building
Washington, D C. 20510

RE: Vaccines for Children Program

Dear Senator Packwood:

It has come to my attention that the House and Senate Budget committees are considering recommending the repeal of the Vaccines for Children (VFC) program. I am asking you to protect the VFC program from any attempts at repeal.

VFC is an invaluable program for Oregon as well as the nation. The VFC program is particularly effective in removing identified barriers to care for children and their families. Immunizations are not always available through the primary care provider. VFC promotes continuity of care and the ability to receive immunizations and well child care in the same setting. Ultimately, this is more convenient for the parent and assures the child will be better immunized. A second barrier to care is cost. VFC addresses this barrier by providing vaccine free of charge to vaccine eligible children. It is estimated that more than 60% of U.S. infants and children will be eligible for immunization through the VFC program. For the first time, private providers will be able to receive publically purchased vaccine in support of the national intent to significantly improve the immunization coverage level among children.

The state of Oregon is committed to the VFC program. VFC is a critical component necessary to increase the immunization coverage of Oregon's children as well as a major step to having 90% of two year olds fully immunized.

It is my belief that affordable, quality health care should be available to all Americans. Preventative care cannot begin too early, and the Vaccines for Children program assures parents that their children will be adequately protected despite their parents' income level. This is a vital service and in the current climate of spending cuts, I am requesting your full support for the VFC program.

Sincerely,

Sarah Vogel

Sarah Vogel
Program Coordinator

MULTNOMAH COUNTY OREGON

HEALTH DEPARTMENT
426 S.W. STARK STREET, 8TH FLOOR
PORTLAND, OREGON 97204-2394
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BOARD OF COUNTY COMMISSIONERS
BEVERLY STEIN • CHAIR OF THE BOARD
DAN SALTZMAN • DISTRICT 1 COMMISSIONER
GARY HANSEN • DISTRICT 2 COMMISSIONER
TANYA COLLIER • DISTRICT 3 COMMISSIONER
SHARRON KELLEY • DISTRICT 4 COMMISSIONER

May 2, 1995

Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, DC 20510

Dear Senator Packwood:

I wanted to take this opportunity to express my concern about any possibility of modifying or repealing the VFC Program. Though public clinics are the only current VFC members in Oregon, Multnomah County Health Department has been appreciative of the vaccines and the targeted populations of the VFC program. In a recent campaign, private physicians were asked to provide free immunizations on the Saturday as well as the public sector. The state agreed to provide free replacement vaccine for any children served on that Saturday. There were 48 private providers interested in participating and signed up for the program.

I believe that the "bugs" in the system can be adequately worked out and the potential success of having more and more of our two-year-olds up to date will be greatly enhanced. The public sector can not provide immunizations alone. Another benefit to the VFC program is the improved communication with the private providers. In a recent survey, clients of private providers were twice as likely as clients of public providers to erroneously believe their child was up to date with their immunizations when they were not. VFC would enhance the system's ability to keep private providers up-to-date regarding current immunization schedules.

Please do what you can to continue to support this important program.

Sincerely,

Peggy Lou Hillman

Peggy Lou Hillman
Immunization Coordinator

May 2, 1995

The Honorable Robert Packwood
295 Russell
Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood;

I strongly urge you to support the continuation of the Vaccines for Children Program, and other related legislation that will protect the health of our children and the general population against diseases that are capable of disabling and sometimes killing a child or adult. Strong local and federal efforts, teamed for complete coverage of children's immunizations, are necessary for the current and future health and welfare of our people.

As you may be aware, there is a diptheria epidemic in the former Soviet Union, partially as a result of the breakdown of consistent and coordinated federal and local efforts at prevention of this horrible disease. As an elected official charged with oversight of federal efforts that benefit the country and the state, I expect that you will consider this matter very, very carefully, and to ultimately support efforts and funds to support Vaccines For Children Program.

Thank you.

Children deserve proper immunization, regardless of income

Susan Blake MD

(503) 731-4000
FAX (503) 731-4078
TDD-Nonvoice (503) 732-4031

Oregon

DEPARTMENT OF
HUMAN
RESOURCES

HEALTH DIVISION

May 2, 1995

The Honorable Senator Bob Packwood
Chair, Senate Finance Committee
259 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood:

The Oregon Health Division strongly supports the Vaccines For Children (VFC) Program as a critical piece of the Immunization Program in Oregon. The Division, which coordinates all publicly funded immunization efforts in the state, believes VFC promotes a unique partnership between private health care providers and federal, state and county governments to immunize approximately 60 percent of young Oregonians. The Vaccines For Children Program has been endorsed by the Oregon Preschool Immunization Consortium, a private/public partnership of over 40 organizations dedicated to achieving the Oregon Benchmark Goal of age-appropriately immunizing 90 percent of Oregon children by the year 2000.

One key strategy for improving immunizations rates is to ensure that all children are immunized as part of their routine medical care. A major benefit of VFC is that it allows children to receive immunizations in their private physician's office, and eliminates the need for referral to a county health department for vaccination. We know that such referrals mean parents often delay care for several months and sometimes they do not return for care at all. We are in the final stages of implementing VFC in the private sector, and Oregon providers are excited about how the program facilitates comprehensive well child care and reduces the need for referral to public clinics.

While many VFC-eligible children could receive immunizations at county health departments through the 317 program, there are thousands of other Oregon children immunized through VFC who would not be eligible for state-supplied vaccine any other way. The Division, working through the Immunization Consortium, is attempting to increase the capacity of private sector immunization services. Our concern is that a repeal of VFC would be a substantial blow to that working public/private partnership.

We respectfully request your consideration of these facts in your deliberations, and we hope you will support the Vaccines For Children Program as it assists the Division in our mission to improve the health of Oregon's children and adolescents.

Sincerely,

Grant Higginson, M.D.
Acting State Health Officer

David Fleming, M.D.
State Epidemiologist

John A. Kitzhaber
Governor

800 NE Oregon Street # 21
Portland, OR 97232-2162
(503) 731-4030 Emergency
(503) 252-7978 TDD
Emergency

24-26 (Rev. 12-94)

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

DEPARTMENT OF HEALTH

Patricia A. Nolan, MD, MPH
Director of Health

3 May 1995

The Honorable John H. Chafee
Dirksen Senate Office Building
Room 567
Washington, DC 20510

Dear Senator Chafee:

The Vaccines for Children (VFC) Program, since its implementation in October 1994, has become an integral and important part of Rhode Island's Immunization Program.

Rhode Island has always been a **universal vaccine distribution** state, providing free vaccine to all children regardless of income or insurance status. Both state and federal funds are used to support this effort. The VFC Program has allowed Rhode Island to consolidate and augment this important public health policy position in the following ways:

1) Assurance of consistent availability of federal funds to purchase vaccine for all eligible children (approximately 40% of Rhode Island children qualify for such VFC support);

2) Assurance that new vaccines, such as the one for prevention of Chicken-Pox, are made available as recommended for all children regardless of ability to pay or insurance status;

3) Assurance that advocacy efforts to garner additional state funds to make available new vaccines for non-VFC eligible children are taken seriously; what is considered an essential entitlement for children in poverty must surely be made available to other children as well;

4) An extremely important benefit of the VFC Program for Rhode Island is the guarantee that vaccine can be purchased by the state at the federal contract rate, thus ensuring the biggest bang for the buck. This provision allows Rhode Island to purchase enough vaccine to consistently implement a **universal vaccine policy**. Without this provision, Rhode Island would be unable to continue providing vaccine for all children.

CANNON BUILDING, Three Capitol Hill, Providence, Rhode Island 02908-5097
Telephone 401-277-2231, FAX 277-6548

We firmly believe that Rhode Island and the other New England states have documented high immunization coverage rates over the years in large part as a direct consequence of free vaccine availability. In our conversation with your staff last week, we discussed other components of the immunization program, including education of providers and parents. We appreciate the support you have shown for this important public health effort.

Sincerely,

Patricia A. Nolan, MD, MPH

Patricia A. Nolan, MD, MPH
Director of Health

PAN:bjs

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

May 3, 1995

The Honorable Bob Graham
United States Senate
Washington, DC 20510

Dear Senator Graham,

I am writing to you on behalf of the children of the state of Florida in support of the Vaccines for Children (VFC) program. VFC is sound public policy and is instrumental in advancing the adequate immunization of 90 percent of Florida's two-year old children by the year 2000 and meeting the antigen-specific coverage goals by 1996. I urge you to support Vaccines for Children and to protect the program from repeal.

Physicians across Florida have embraced the VFC program. The VFC Program has enrolled over 1,500 public and private sites. These sites represent over 3,000 doctors and other health care professionals such as ARNPs and physician's assistants. Approximately 300 new private providers have enrolled in VFC since it began on October 1, 1994, usually as the result of word-of-mouth recommendations from fellow colleagues already enrolled in the program.

It is this outreach to the private physician community that has proven to be one of the most significant accomplishments of VFC. VFC has received strong support from the Florida Medical Association, The Florida Academy of Family Physicians, The Florida Pediatrics Society, The Florida Osteopathic Medical Association, The Florida Association of Community Health Centers and Florida's county public health units. These organizations are influential advocates for Florida's children, and all of them understand the importance of having vaccine readily available and have voiced their support for VFC.

There are public and/or private VFC sites in every single county in Florida. VFC has increased the availability of culturally sensitive immunization services for historically hard-to-reach patients. For example, in Miami there are 237 enrolled private provider sites in addition to the Dade County Public Health Unit. Sixty-five different Miami zip codes have at least one enrolled private provider, and a number of zip codes have multiple enrolled providers. This vaccine distribution infrastructure has been built with a great deal of effort and care and has become a valuable resource. It is not in the interest of our children to dismantle what has become so valuable to them.

Because the legislation which authorizes VFC empowers CDC's Advisory Committee on Immunization Practices (ACIP) to approve new vaccines and vaccination schedules, these recommendations can be implemented directly without being subject to fluctuations in annual appropriations. VFC makes it possible to bring the benefits of new vaccines like the one for chicken pox to Florida's children and allows Florida to be prepared for emergency situations like epidemics. In addition, the Florida immunization program has used VFC computer hardware and software systems to redesign and significantly strengthen our ability to monitor and control vaccine distribution and usage.

During its 1994 session, the Florida Legislature relied on the Congressional promise of free vaccine through VFC and reduced the Medicaid budget for vaccines by over $3,500,000. Therefore, Medicaid will not have funds to reimburse physicians for the vaccines they are purchasing with their own funds to immunize Medicaid children. A Medicaid default of this proportion would constitute a serious breach of faith with the Medicaid provider community. In addition, Medicaid children who would no longer be immunized in private physicians offices would likely turn to county public health units for immunizations. This would create both a missed opportunity to immunize a child in the physician's office and a totally unanticipated workload on the county public health system for which it is neither funded nor staffed.

I can assure you that Florida has implemented the VFC program in an outstanding manner to the undoubted benefit of Florida's children. If the federal government repeals the program, Florida will be hard-pressed to deny children vaccines, and parents and providers will surely look to the state to continue the program. It is in the best interests of the state and our children to maintain the VFC program and I hope you will strongly support its continuance.

Sincerely,

Richard G. Hunter, Ph.D.
Deputy State Health Officer

RGH/HTJ/AS
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VFC 4-3

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Gaston Caperton
Governor

Gretchen O. Lewis
Secretary

May 1, 1995

The Honorable John D. Rockefeller IV
The United States Senate
109 Hart Senate Office Building
Washington, DC 20510

Dear Senator Rockefeller:

Thank you for your continuing quest to ensure that West Virginians and all other Americans have access to adequate medical care. As you know, preventive health care is central to maintaining a healthy population. In West Virginia and the nation, the Vaccines for Children (VFC) program is playing a major role in keeping our children free of preventable diseases. VFC has greatly aided West Virginia's Immunization Program in its effort to immunize children against nine infectious diseases.

VFC is helping to strengthen the public-private partnership in health care in West Virginia. Before VFC there were 135 private health care providers administering readily available state-supplied vaccines and, as of today, there are 240 private providers giving free vaccines to West Virginia's children. With an estimated 62,000 uninsured children in West Virginia, this partnership with the private medical community is essential to the vaccine delivery system. As a result, VFC allows us to reach kids who otherwise would likely not get properly vaccinated. Although this is of invaluable benefit to the immunization delivery system, it is not the only reason that VFC is good for West Virginia and the nation. Families maintain their medical home and VFC allows the option for the state to move to a universal purchase system whereby vaccines are provided for all children regardless of method of payment.

BUREAU FOR PUBLIC HEALTH
Building 3, Room 518, State Capitol Complex
Charleston, West Virginia 25305-0501
Telephone: (304) 558-2971 FAX: (304) 558-1035

It is estimated that for every $1 invested in vaccines, $30 is saved in health care costs. Retaining the VFC program and the accessibility it provides to preventive health care is a win-win proposition. We can protect West Virginia's children and maximize health care spending. A repeal or modification of the VFC program would result in a loss of credibility with private providers and parents. I urge you and all members of the Senate Finance Committee to continue the support of the VFC program.

Sincerely,

William T. Wallace, Jr., MD, MPH
Commissioner
Bureau for Public Health

WTW:bj

Edwin W. Edwards
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS
Rose V. Forrest
SECRETARY

May 2, 1995

Honorable John Breaux
SH 516 U.S. Senate
Washington, D.C. 20510

Dear Senator Breaux:

I'm writing to inform you of the importance of the Vaccines for Children (VFC) program for Louisiana. This program supplies federally-purchased vaccines for children who are uninsured, Medicaid-eligible, Native American, or who receive care through a Federally Qualified Health Center.

In Louisiana, this program is currently providing free vaccine to children seen in public health clinics, reducing the state funds necessary to provide for the large number of uninsured children in Louisiana. With CDC vaccine grant funds reduced sharply this year and an unclear future for Medicaid in Louisiana, it is clear that we can not provide vaccine to the uninsured population in Louisiana without VFC.

Our Immunization Program is very close to implementing a statewide distribution system to provide VFC vaccine to private medical providers. The outreach efforts to prepare the private medical community for VFC has resulted in a new sense of goodwill and cooperation between public and private providers. This provides a basis for the collaboration necessary in the ongoing changes in the Medicaid system in Louisiana. If VFC is lost, this cooperative spirit will be severely damaged. The private sector will believe that public health care is unreliable and an unfit partner for collaboration.

In summary VFC not only provides needed vaccines to Louisiana's children, but also to helps us continue to move toward a cooperative, collaborative system of health care in Louisiana.

If you have questions about the VFC program in Louisiana, please call Dr. Meg Lawrence at (504) 568-5015. Thank you for your attention.

Sincerely,

Eric T. Baumgartner, M.D.
Assistant Secretary and
State Health Officer

NORTH DAKOTA
STATE DEPARTMENT OF HEALTH
AND CONSOLIDATED LABORATORIES
600 E. Boulevard Avenue
Bismarck, ND 58505-0200

OFFICE OF
STATE HEALTH OFFICER
701-328-2372
FAX 701-328-4727
TDD 701-328-2068

April 28, 1995

Senator Kent Conrad
724 Senate Hart Building
Washington, DC 20510

Dear Senator Conrad:

I would like to express my support of the federal Vaccine for Children program. The North Dakota State Department of Health & Consolidated Laboratories has been able to use the additional funds and opportunities available to us through the Vaccine for Children program to enhance the immunization practices throughout the state. North Dakota has traditionally aggressively pursued immunization of its children. After the tax cutback measure in 1989 we were not able to continue to supply all vaccines to physicians. We saw a shift of responsibilities from physicians to public health units for immunization with added confusion about immunization. We noted a marked increase in the cost of vaccines to self pay patients. We noted a decrease in the documented immunized rate. The addition of the Vaccine for Children has allowed us to become more consistent with our vaccine practices and develop a Prevention Partnership with practicing physicians.

As a practicing physician, who practiced when vaccines were provided and we were able to give immunizations to children in the office prior to 1989, then one who experienced the turmoil of patients and the added costs and lack of record keeping that resulted when patients could not be immunized in the office, I am very happy to be able to provide vaccines so that all children can be immunized. A cutback in the Vaccine for Children program would probably again take vaccine out of the physicians offices in this state. This would result in renewed confusion, the impression that the State Department of Health is unreliable as a source of vaccine and therefore not interested in the prevention of childhood illnesses, and loss of immunization rates as well as inconsistency in immunization reporting.

North Dakota has not had a case of measles since 1987. We have demonstrated a marked diminution of meningitis caused by Haemophilus influenzae Type B in the infants. We have had no cases of this disabling, life threatening disease since 1991. I have enclosed graphs demonstrating our successes in measles and Haemophilis influenzae Type B. These are results of our active vaccine program. I think it would be

detrimental to the health of the population of this state to see the Vaccine for Children program cut back in any way.

Prevention efforts are always a prime target for cutbacks as their cost benefits are somewhat difficult to predict. Prevention programs work in silence when they are working and are easily ignored. They only draw the attention of the public when they are ineffective and disease results because of the absence of the preventive effort.

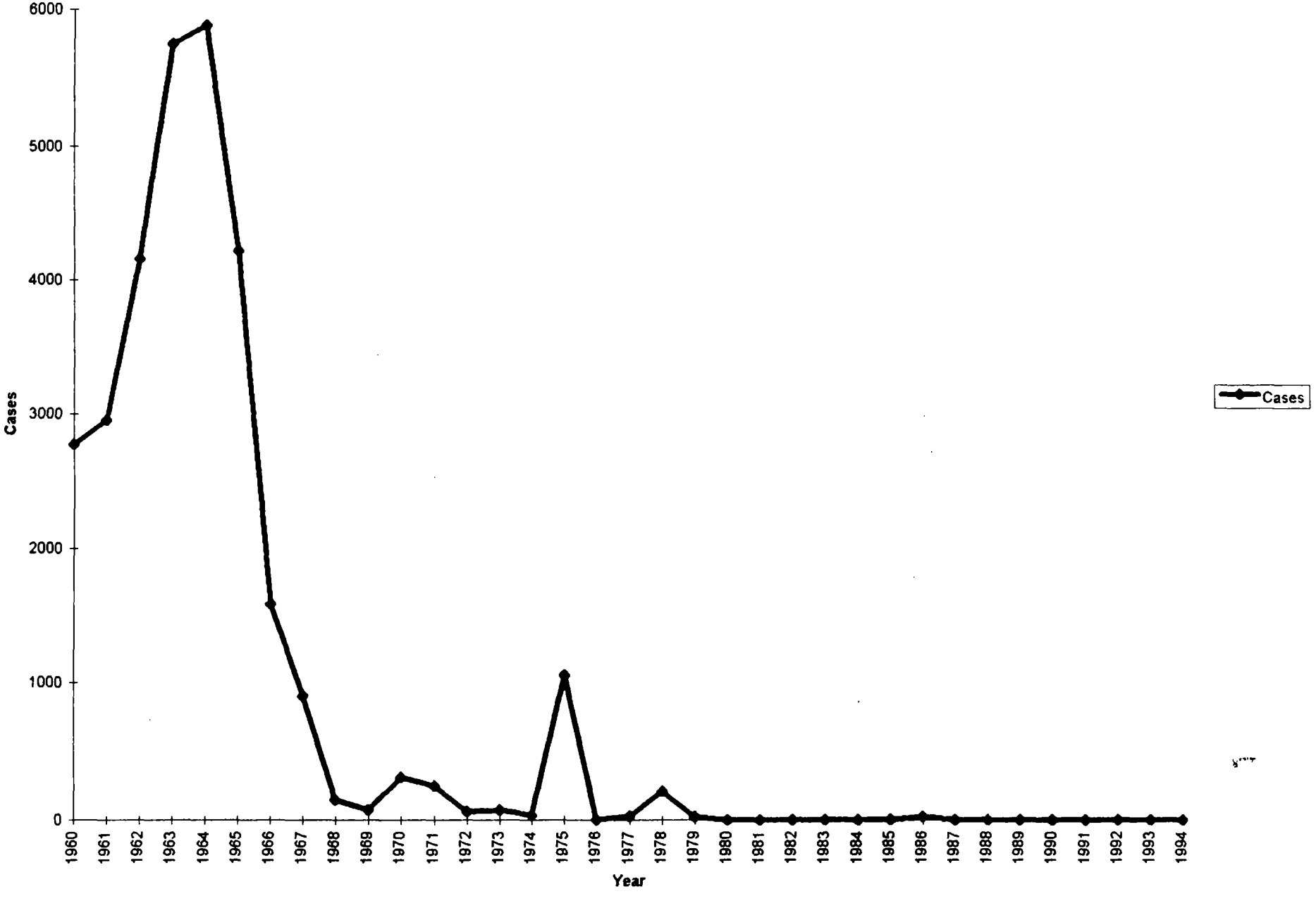
I appreciate your support in health-related matters and will be happy to meet with you or your staff to discuss this further.

Sincerely,

John R. Rice, M.D.
State Health Officer

JRR:lrr
Enc.

Measles in North Dakota




Haemophilus influenzae in ND
25
20
15
10
5
0
Cases
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
Year
Cases

South Dakota HEALTH 2000

DEPARTMENT OF HEALTH

OFFICE OF THE SECRETARY
445 East Capitol Avenue
Pierre, South Dakota 57501-3185
605/773-3361 FAX: 605/773-5683

May 2, 1995

The Honorable Larry Pressler
United States Senate
SH-243 Russell Building
Washington, DC 20510

Dear Senator Pressler:

Thank you for having staff available to meet with our Department of Health contingent last week to discuss public health in South Dakota. Our visit coinicided with the Association of State and Territorial Officers (ASTHO) annual Hill Days, so we were able to bring back home a unique perspective on the federal "culture" and how changes in Congress will impact public health not only in our state but in the nation as well. As a follow-up to our visit, I wanted to summarize some of the issues we highlighted in our conversation with your legislative assistant Stephanie Lindquist.

We concur with ASTHO's position that the Preventive Health and Health Services and Maternal and Child Health Block Grants along with the CDC Immunization Program are appropriations priorities. These block grants along with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), constitute a majority of the federal funding received by our department to carry out core public health activities in the state. These block grants have provided us with the flexibility to address priority health issues within South Dakota and at a minimum, maintaining level funding to both of these programs is vital to continuing our mission.

Immunizations are also a priority. For every dollar spent on immunization, at least $8.80 in direct medical costs is saved. This constitutes a wise investment for our state and our nation. South Dakota receives funding through two federal fund sources, the CDC 317 program and the Vaccines for Children program, for vaccine purchases and administration. With the trend of substantially increasing vaccine costs over the past decade and an increase in the number of children served, it is ever more urgent that states receive adequate resources for assuring high immunization levels in preschool and school-age children.

Finally, I would offer our department's assistance in providing you and your staff with information on assessing the impact of block granting proposals on South Dakota's public health delivery system. Presently, we are watching with a great degree of interest the family nutrition block grant, a component of H.R. 4, as it moves on to the Senate for debate. While we are supportive of public health block grants, we would rather see categorical programs such as WIC combined with related health programs rather than welfare programs. We will be providing additional information on the WIC program to Ms. Lindquist and look forward to additional correspondence with your staff on the block granting initiatives which will have a significant impact on our state.

Very truly yours,

Barb Smith

Barbara A. Smith
Secretary of Health

Oklahoma State Department of Health
1000 NE 10th St. · Oklahoma City, OK 73117-1299
J.R. Nida M.D., Commissioner

The Honorable Don Nickles
U.S. Senate
Washington, D.C. 20510

Dear Senator Nickles:

I am very concerned about the possibility of modification or repeal of the Vaccine For Children Program (VFC). A total of 69% of our state's two year old population is currently immunized appropriately. This translates to approximately 14,880 (31%) of the children born each year in Oklahoma who are not protected against diseases that are preventable with vaccines. The VFC program provides the avenue for these children to receive the vaccine from their private provider.

The availability of the vaccine to the private physicians with the VFC program eliminates the cost and access barriers for approximately 56% of Oklahoma's children. Eliminating the VFC program will have a direct impact on their ability to be protected against these serious and sometimes deadly diseases.

The public and private partnership has been strengthened with our success with the VFC. All vaccine providers are working in unison toward a common goal to protect our children. Oklahoma's VFC providers submit vaccine accountability, and all vaccine orders are reviewed prior to shipment to access the legitimacy of the amount requested. Provider assessments provide the avenue to protect against misuse and fraud. If the VFC program is repealed now, after only seven months, the credibility with parents and our private providers will be lost.

I would ask consideration be given to allow the VFC program time to produce the results that are most important, the protection for our children. The Oklahoma State Department of Health has successfully implemented this valuable program with 847 vaccine providers. To date, 687 of the 1416 (49%) physicians are participating in the VFC program. On behalf of all Oklahoma VFC participants, I ask you not to repeal or modify the program now, and to please consider allowing a longer time frame to produce the results we believe the program will provide.

Sincerely,

J.R. Nida, M.D.
Commissioner

OKLAHOMA'S 1995 IMMUNIZATION PROGRAM

Oklahoma's Immunization Program provides federally purchased vaccine for 71% of the children. The annual birth cohort is approximately 48,000 children. Each birth cohort receives a total of 613,440 doses of vaccine purchased with federal funds. These numbers are based on the results obtained from a survey of a sample of children born in Oklahoma. It is expected that 70% of these students will receive vaccine purchased with federal funds.

To date 677, of the 1416 (48%) physicians are participating in Oklahoma's Vaccines For Children program. The OSDH has expanded its existing centralized distribution system. Prior to the VFC program the Immunization Division shipped vaccine to 150 providers. This has been increased to 837 providers.

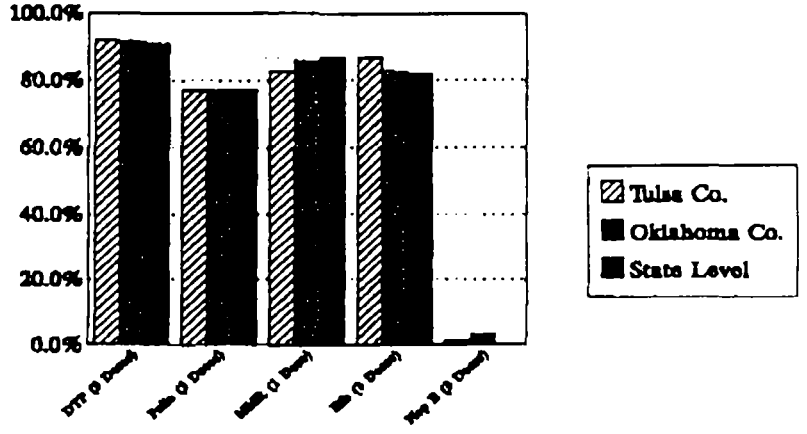
Using 317 federal funding, the Immunization Division has contracted with nine community based organizations, and Tulsa and Oklahoma County Health Departments. These contracts are to perform outreach activities and the salaries of nurses who administer the vaccines.

The "Immunization Corps" is the main infrastructure of Oklahoma's immunization program. The Corps consists of 32 nurses, clerks and outreach workers who have been assigned to help the counties increase their immunization levels. These activities include the formation of county coalitions, expanded clinic hours, local educational campaigns and special weekend clinics. The Immunization Corps is vital to the success of the immunization program. If this commitment is ended, the progress made thus far in networking with the private sector will be jeopardized.

In June, 1994, the Centers for Disease Control selected the Oklahoma State Department of Health (OSDH) as one of six areas selected as a pilot site for the national automated immunization registry. This system will furnish immunization providers with on-line access of up-to-date immunization information.

Oklahoma's two year old immunization level increased from 65% in 1993 adequately immunized to 69% in 1994. These levels were measured by a random sample survey of resident births. The same survey was also completed for Oklahoma and Tulsa Counties. The following table illustrates Oklahoma's progress toward achieving 90% immunization levels.

1994 Immunization Survey of Two Year Olds
Levels by Antigen



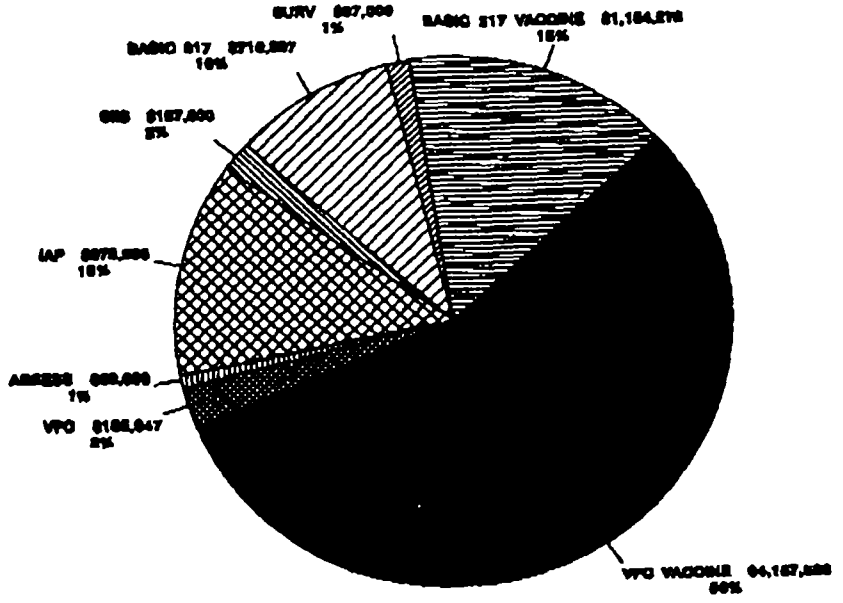
POTENTIAL IMPACT WITH REDUCTION IN 317 FEDERAL FUNDING

An example of the impact a 22% and 30% reduction in the immunization 317 federal funding is reflected in the chart below. It illustrates the current Oklahoma 1994 Two Year Old levels. A total of 70% of the vaccine received was provided through the public clinics using federally purchased vaccine. The data analysis reflects how a 22% and 30% reduction in available federal vaccine would reduce the coverage rates.

VACCINE	1994 TWO YEAR OLD SURVEY RESULTS
DIPHTHERIA, TETANUS & PERTUSSIS (DTP)	91%
- 22% Reduction	50%
- 30% Reduction	45%
ORAL POLIO VACCINE (OPV)	77%
- 22% Reduction	42%
- 30% Reduction	38%
HEAMOPHILUS INFLUENZAE TYPE b (Hib)	82%
- 22% Reduction	45%
- 30% Reduction	40%
MEASLES, MUMPS, RUBELLA (MMR)	87%
- 22% Reduction	48%
- 30% Reduction	33%
HEPATITIS B* (HEP B)	0.4%
- 22% Reduction	0.02%
- 30% Reduction	0.02%

* Vaccine recommendations for all children less than two, and the federal funding was provided in 1994. At current funding level it is projected to achieve a 90% protection rate by 1998.

OKLAHOMA 317 FEDERAL IMMUNIZATION FUNDING, BY CATEGORY, 1995



Funding Category	Amount Awarded	Percent of Total
VFC Vaccine	$4,187,528	56%
Basic 317 Vaccine	1,154,276	15%
IAP	973,205	13%
Basic 317	716,597	10%
SIIS	137,000	2%
VFC	185,947	2%
SURVEILLANCE	97,000	1%
ASSESSMENT	60,000	1%
TOTAL AMOUNT AWARDED	$7,511,553	

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF PUBLIC HEALTH
CHRISTOPHER G. ATCHISON, DIRECTOR

May 2, 1995

The Honorable Charles Grassley
135 Hart Senate Office Building
Washington, DC 20510-1501

Dear Senator Grassley,

I would like to express my deep concern regarding recent information that has indicated Congress may modify or repeal the Vaccines for Children program.

The potential ramifications of such a decision would fundamentally affect the state's contemporary efforts to reach children who otherwise would likely not receive immunizations. As a direct result of the Vaccines for Children program, the total number of public providers within the state has increased from 113 providers to 206 providers which assisted the state to increase the immunization levels from 50% in 1993, to a current 77% immunization level in the public sector. In addition, the Iowa Department of Public Health is actively enrolling private physicians in the Vaccines for Children program to increase access and remove barriers to immunization. Repealing the program would fundamentally alter the current vaccine program and effectively erect barriers to timely immunization.

For example, given the existing alternatives, repealing the VFC program would likely result in the elimination of current immunization sites. The hardest hit would be those children who cannot be served in the private sector, the uninsured, and the underinsured working middle and lower income class families. As previously mentioned, this could eliminate many immunization services for many Iowa counties where no alternative immunization services are available due to financial constraints or a lack of health care providers.

It is the belief of the Iowa Department of Public Health that the VFC program is a critical contributor to enhanced cooperation between the private medical sector and the public health sector focused at removing access barriers, and reaching the ultimate goal of all children being age-appropriately immunized.

LUCAS STATE OFFICE BUILDING / DES MOINES, IOWA 50319-0075 / 515-281-5787
FAX # (515) 281-4958 / TDD-DEAF SERVICES #(515) 242-6156

Furthermore, any change of plans at this time may result in a serious reduction in our credibility to the private medical sector. Credibility is a critical component in the effort to enroll private physicians, as we ask physicians to trust in our ability to supply vaccines in a reliable manner. Preliminary evidence in our state shows that private physicians may already be reluctant to enroll for this reason, in addition to the elimination of the National Vaccine Distribution Center Program.

Implementation of the VFC program in the private sector will allow the states current Medicaid Vaccine Replacement Program to be disbanded allowing for an increase of the reimbursable vaccine administration fee from $2.08 to $5.00 per dose.

I strongly encourage any efforts which may be taken to assure the continuation of the Vaccine for Children program. The Vaccines for Children program is a critical element of Iowa's immunization program.

Sincerely,

David Stuart for

Christopher G. Atchison
Director

State of Kansas

Bill Graves Governor

Department of Health and Environment

James J. O'Connell, Secretary

May 2, 1995

The Honorable Bob Dole
Office of Republican Leader
United States Senate
Capitol - Room S-230
Washington, D.C. 20510

Dear Senator Dole:

It is my understanding that the Senate Finance Committee will be conducting a hearing on the Vaccine for Children Program. The Vaccine for Children Program has been beneficial for Kansas because of the following:

1. It enhances accessibility for timely childhood immunizations which we know is a beneficial and cost-saving prevention activity.

2. It strengthens the private/public partnership and encourages state and local health departments to work closely with private providers to assure that children are maintained in their medical homes for comprehensive, continuous health care.

3. It saves the State of Kansas substantial dollars on vaccine purchases which enabled the state to increase the vaccine administration fee to encourage physicians to give the vaccines in their private offices.

Enclosed is the Kansas Fact Sheet on the Vaccine for Children Program which, hopefully, will help you in your deliberations. Please do not hesitate to contact me should you need any additional information. As always, we appreciate your support and assistance.

Sincerely,

Steven R. Potsic, MD, MPH
Director of Health

c: James J. O'Connell, Secretary

Office of the Director of Health
900 SW Jackson, Rm 665, Topeka, KS 66612-1290

Telephone: (913) 296-108
Fax: (913) 296-123

State of Kansas

Bill Graves Governor

Department of Health and Environment

James J. O'Connell, Secretary

VACCINE FOR CHILDREN PROGRAM AND FUNDING

FACT SHEET

The Omnibus Budget Reconciliation Act of 1993 created the Vaccines for Children entitlement program for all States and Territories to assist with vaccine purchase and to expand the health care provider base for comprehensive health care. As of this date, the State of Kansas has 144 Public Provider Sites (Local Health Departments, - there are 105 counties - Rural Health Clinics and Federally Qualified Health Centers) and 150 private Provider Sites (single and group practices).

VFC serves 4 classifications of children in the 0-18 age range:

1) Medicaid (*125,320 children estimated)

2) Children with no insurance whatsoever (*112,758 children estimated)

3) Native Americans, which includes Eskimos but not Hawaiians, (*7704 children estimated)

4) Children who have insurance but the insurance does not include vaccine, may receive VFC vaccine at a Federally Qualified Health Center or a Rural Health Center or a designate. (*15,408 children estimated)

*As of 1995, **261,190** children qualify for VFC in Kansas.

VFC totally replaced the existing Physicians Vaccine Replacement Program (Medicaid - Kansas SRS program). All Medicaid SRS health providers were invited to participate in VFC. With the savings on vaccine purchase, SRS increased the administration fees from $3 to $8 per administration in order to encourage physicians to give the vaccines in their private practices.

The Kansas Immunization Program ships vaccine to all VFC public and private providers. A third party vaccine distributor is being considered because of in-house vaccine storage liability. If the State should have to pay for distribution of State purchased vaccine, additional State funding would be a problem.

CDC is developing Vaccine Accountability Reporting Forms which are currently being piloted in 6 states which should help assess program effectiveness.

1995 VFC Direct Assistance (vaccine funding) award is $2,735,946. Total doses of vaccine provided in 1994: 399,235. Estimated total doses for 1995: 420,000.

In the event that 317 Basic Funds or VFC Funds are cut, the State will not be able to supplement with State funds, and immunizations could be severely jeopardized.

For additional information concerning any of the above, please contact Monica Mayer, Immunization Program Director at 913 296-5593.

*VFC Population Estimates and Projected Vaccine Needs, Fiscal Year 1996, Survey.

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May 1, 1995

The Honorable Carol Moseley-Braun
United States Senator
320 Hart Senate Office Building
Washington, D.C. 20510-1303

Carol

Dear Senator Moseley-Braun:

I would like to request your support in opposing any legislation that may be introduced that would eliminate or reduce federal funding for the national "Vaccines for Children" (VFC) program. The elimination or significant reduction in funding for the national VFC program would have considerable long-term adverse effects on immunization efforts currently underway in Illinois, including our efforts to immunize the vulnerable preschool-age population.

The importance of maintaining appropriate funding levels for the national Vaccines for Children (VFC) program cannot be overly emphasized. As you know, the VFC program was implemented just last October 1, 1994, after considerable effort by federal and state health agencies, private health provider associations, local voluntary interest groups, etc. Any elimination or significant reductions in Congressional support of the VFC program would place Illinois and other states in a precarious position, and could jeopardize children's health if federal funding cuts could not be made up by states. To illustrate the problems Illinois health officials would encounter if VFC funding is reduced, it is important to point out the following:

1) In anticipation of the national VFC program, the Illinois Department of Public Health terminated its interagency agreement with the state Medicaid program for vaccine replacement to Medicaid providers, as part of the state's "Healthy Kids" program. If the VFC Program is eliminated (or substantially reduced), Illinois' Medicaid eligible children now covered by the VFC program may be without free vaccine (or it could be in short supply), because no alternative to VFC currently exists for serving this population.

2) Approximately 60% of Illinois' children are eligible for the VFC program. Without the VFC program (or an alternative infusion of vaccines), it would be impossible to achieve the national FY 96 goal of 90% immunization coverage among two-year olds. Unless other state or federal resources could be identified to supplement the budget for vaccines, it will jeopardize the progress made in increasing immunization levels in the two-year old population. Inevitably, children would fall out of the vaccine delivery system, and the result will be a decrease in immunization levels throughout the state.

3) As a state health officer, I appreciate the flexibility that the federal VFC program affords me in implementation. In Illinois, we have been very successful in working with the private medical community throughout the development and implementation of the program, resulting in Illinois' VFC *Plus* Program. This program, an expansion of the

national VFC program, makes vaccine available to physicians to serve all underinsured children in their offices. Unlike the national base VFC Program, Illinois' VFC *Plus* Program eliminates the need for referral of underinsured children to federally qualified health centers, and thereby keeps them in their primary medical home. If funding for the national VFC program is eliminated or reduced to a public entitlement program (Medicaid enrolled only), Illinois health officials will have to curtail the VFC *Plus* Program and will lose the hard earned trust of the private medical community.

4) Parents of many children in Illinois have come to expect and depend upon immunization services at no cost or at a minimal cost through the public vaccine delivery system. Since the national VFC program became operational, many public vaccine providers have begun working more closely with the private health care providers in their community to ensure continuity in immunization services. This has resulted in the establishment, for the first time, of effective public/private partnerships in many communities. If availability of these services is interrupted by lack of funding to purchase vaccines, due to political issues, the loss of public confidence in government funded health programs will be dramatic.

In closing, I would like to emphasize that Illinois has the reputation of being very successful in accomplishing immunization-related projects. If our state is to be successful in achieving the national immunization goals of the Childhood Immunization Initiative, it is essential that the national VFC program not be repealed or drastically reduced.

Your support in opposing any legislation that would repeal this most worthy childhood program, or reduce its funding, would be appreciated.

Sincerely,

John R. Lumpkin, M.D.
Director of Public Health

cc: Michelle Gentry-Wiseman

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STATE HEALTH AGENCIES SUPPORT VACCINES FOR CHILDREN PROGRAM, ARE COMMITTED TO CHILDREN'S HEALTH

Washington, DC - In North Dakota, childhood immunization levels in 1994 were approximately 68%. With the implementation of the new federal Vaccines for Children program (VFC), which provides an estimated 60% of the nation's children with free vaccine and states with the option to add their own funds to purchase public vaccine for other children, immunization levels in 1995 are anticipated to increase to 85%, with the 90% goal reached in 1996.

Needless to say, North Dakota is pleased with the VFC program, and the state is not alone. According to the Association of State and Territorial Health Officials (ASTHO), state health officials across the country support VFC and have made a major commitment to redesigning their immunization programs to integrate it. They say VFC is essential to meeting national and state goals for immunizing the nation's children against disease and improving their health status.

"VFC at last provides states the necessary funding to achieve 90% immunization rates across the country, " said Christopher G. Atchison, Iowa's Director of Public Health and President of ASTHO, "ensuring that children are adequately protected against vaccine preventable disease. This is a very important commitment we have made to our children's health."

According to Oregon, there are thousands of children being immunized through VFC who would not be eligible for state-supplied vaccine any other way. The Oregon Health Division is actively recruiting and training private providers to initiate or increase immunization services.

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State health agencies have recruited thousands of private physicians and others in communities across each state to participate in the program, forging new public/private partnerships that are committed to working together to immunize more children. This grassroots support is a hallmark of VFC and critical to the program's success. In addition, many states have invested in new state based distribution systems in order to deliver vaccine directly to private physicians and clinics in the program.

State health officials report positive responses from physicians. For example, Hawaii anticipates that the program will more than triple the number of private providers distributing public vaccine to Hawaiian children. In Florida, physicians have embraced the VFC program, and the state has increased the availability of culturally sensitive immunization services for historically hard-to-reach patients.

VFC allows states to redirect state funds to purchase additional vaccine for other children in need who are not eligible under VFC and to address other public vaccine needs such as education and outreach to hard-to-reach families. South Carolina, for example, has invested $2.5 million in state funds so that 230 private physicians can vaccinate not only VFC-eligible children who are enrolled in Medicaid or are uninsured, but children whose insurance does not cover immunizations and who would be required to go to federally qualified health centers for their shots under VFC. The state says that VFC has helped them achieve the best immunization rates in the country. Currently, 82% of South Carolina's two-year-olds are adequately immunized compared with previous levels of 50% to 60%.

Despite the support and successes VFC has enjoyed, the program has suffered from dissension in Congress and among vaccine manufacturers. Three weeks before the VFC program was to start, a federal distribution system that roughly half the states planned to use was cancelled due to opposition from some lawmakers. States left high and dry had to scramble to find alternatives and dollars to support unplanned state-based distribution. Negotiations conducted by CDC with vaccine manufacturers to arrange for distribution by the manufacturers were halted after seven months when only Merck signed a contract. Nevertheless, while these problems delayed immediate full implementation of VFC, today every state has some distribution in place and CDC is working with the states to develop more complete and efficient systems.

VFC also has been challenged by some lawmakers on the basis that cost is not a real barrier to immunizations. Yet study after study indicates that cost is a very real barrier. So is the inconvenience of going to separate locations for well baby check ups and immunizations. By two years of age, children should have received 11 to 15 doses of vaccine during about five visits to a health care provider.

A 1993 survey of licensed pediatricians and family physicians in North Carolina showed that 93 percent of doctors referred children to public clinics for immunizations, nearly all because of parents' concerns about costs. Milwaukee physicians reported immunizing uninsured patients in their offices less often than patients with insurance and concluded that there is no assurance that families who decline immunizations in their physicians offices for financial reasons will subsequently have their children immunized in a timely manner.

The VFC program addresses these problems by offering the $270 full series of shots free to children who are enrolled in Medicaid, who have no insurance or have insurance that does not cover immunizations, as well as Native Americans. In addition, VFC permits children to receive their shots in their "medical homes" including private physicians' offices. Physicians no longer have to refer patients and their parents to public clinics for immunizations and can integrate immunizations into routine well baby visits. Children who are served by federally qualified health centers and rural health clinics may receive their shots during routine visits there.

According to Atchison, every new program has a few glitches that need to be ironed out, but he says the level of scrutiny and challenge being imposed on VFC is counterproductive. Increasing childhood immunization rates is a goal shared by everyone - state health departments, the Administration, Congress, private physicians, vaccine manufacturers, parents, and communities. The VFC program is taking off, and we all need to get behind it."

Immunizations are one of the most successful and cost effective ways to protect the nation's children. Childhood vaccinations in the US during the last 30 years have nearly eliminated once common childhood diseases like polio, pertussis, diphtheria, measles and mumps. However, because vaccination levels in some communities are low, outbreaks of measles and pertussis still persist and are associated with deaths and medical expenditures that could have been prevented with protective infant vaccinations. Every dollar spent on vaccines saves an average of $8.80 in sick care and related costs.

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