Flu Vaccine Shortage Spurs State Action

By Dan Lorentz

Fixing the problems that led to this year’s flu vaccine shortage—a problem of national scope and global markets—is a task best tackled by the federal government. States, however, have stepped forward to oversee the immediate challenge of targeting scarce doses to the highest priority populations. They have done so in partnership with the Centers for Disease Control and Prevention and the vaccine industry.

State health officials, attorneys general, governors and legislators are all involved, busy issuing emergency orders to target vaccine to high-risk groups, filing lawsuits to prevent price gouging, and establishing systems to monitor in-state vaccine supply.

How states are responding

Since the flu vaccine shortage was announced in mid-October, state policy-makers have approached the issue from a number of angles:

Emergency orders: In at least 14 states, governors or chief health officials have issued emergency orders to give flu shots to priority groups only. The orders conform to CDC recommendations that the vaccine be reserved for seniors 65 years old or older, all infants from six to 23 months of age, pregnant women, people with certain chronic conditions, residents of long-term care facilities, adults caring for infants less than six months of age, children two to 18 years of age receiving chronic aspirin therapy, and health care workers providing direct patient care.

Anti-price gouging activities: Attorneys general in Florida and Kansas have launched lawsuits against Med-Stat, a Florida-based medical supplier, for price gouging. Shortly after the flu vaccine shortage was announced in early October, hospitals across the country reported being offered flu vaccine for prices as much as 10 times the normal price. In addition to the lawsuits, several states are aggressively reminding vaccine vendors of price-gouging laws and encouraging consumers to report any instances of price gouging.

Importing more vaccine from abroad: The governors of New Mexico and Illinois have directed their states to contract for the purchase of hundreds of thousands of flu vaccine doses from a European manufacturer. The manufacturer, Aventis Pasteur in Lyon, France, is the same company that produces U.S. government-approved vaccine in its plant in Swiftwater, Pa. What response the federal government will take is unclear at this point: the foreign-manufactured vaccine has not yet

Continued on page 4
Activities include:

- Ensuring that children and at-risk adults are immunized against deadly diseases.
- Providing information and assistance to individuals with chronic conditions such as cancer, heart disease, and asthma.
- Monitoring and working to prevent disease and disability resulting from interactions between people and the environment.
- Researching how public health can work to prevent and control HIV/AIDS infection as well as other sexually transmitted diseases.
- Promoting the health and well-being of people with disabilities.
- Working with schools to prevent risky behavior among children, adolescents and young adults.
- Building capacity to respond to public health threats and emergencies.

Information resources on the way

The Healthy States partnership will provide new information resources for state legislators and legislative staff. CSG and its partners will produce publications in hard copy and electronic formats and convene meetings for legislators on critical public health issues. Some of these new resources include:

Healthy States Website. The Healthy States partnership will have a unique Web site that will offer informational resources for state legislators and other state officials on a variety of public health issues. Go to www.healthystates.csg.org to access information resources, publications, meeting calendar and other information about the initiative.

Meetings and Web Conferences. The Healthy States partnership will convene a number of educational and training events. Web conferences will provide an opportunity for public health experts, legislators and legislative staff to interact. Various meetings will include educational sessions on public health issues, new legislator training, and roundtable discussions with peers and public health experts.

Healthy States partners and advisors

CSG is working with other key organizations on the Healthy States initiative. The National Black Caucus of State Legislators (N BC SL) and the National Hispanic Caucus of State Legislators (N HC SL) have agreed to serve as partners with CSG in providing state legislators with timely information on public health issues.

Founded in 1977, N BCSL serves as a powerful resource and network for its membership made up of more than 600 black state legislators and their staff. N BCSL members are strong supporters of improving health in the black community, particularly educating blacks about chronic disease issues, health disparities, HIV/AIDS and sexually transmitted diseases.

The N HC SL was founded in 1989. As the top organization serving and representing the interests of Hispanic state legislators, N HC SL focuses on providing support for its members who advocate on behalf of Hispanic communities across the United States. N HC SL considers health issues to be a top policy priority and has recently worked with the N BC SL to address health disparities among minorities.

CSG will also work with the American Public Health Association (APHA) and the Association of State and Territorial Health Officials (ASTHO) throughout this initiative. ASTHO is a nonprofit organization that represents the chief health officials from state health agencies from each state, the territories, and the District of Columbia. ASTHO is dedicated to helping create solid national health policy and to assisting state health departments in the development of programs and policies to promote health and prevent disease.

APHA is the largest and oldest public health association in America and a highly influential advocate for public health, representing over 50,000 public health workers. Access to care, health disparities and public health infrastructure are the primary issues to which the APHA directs its resources and advocacy.

CSG is pleased to have the opportunity to bring these partners together with the experts at the CDC to enhance information sharing across branches and levels of government.

If you are interested in learning opportunities available through Healthy States or want to be added to CSG’s distribution list for information and events, please contact Ann Kelly, CSG’s Chief Policy Analyst for Public Health, at akelly@csg.org or at (859) 244-8255.

— Trudi Matthews is the associate director for health policy at The Council of State Governments.
Preparring Rural America: State Challenges

By Chad Foster

In the wake of the September 11th terror- orist attacks and the subsequent Anthrax scare, federal, state and local governments placed new emphasis on preparing for and responding to public health emergencies. These efforts often focused on large cities, the logic being that terrorists would be more likely to target densely-populated areas. This mindset is shifting, however, in recognition of how vulnerable rural areas are and how even a small event could have repercussions throughout the country.

**Shoring up the rural public health infrastructure**

Findings from a recent study by the ANSER Institute for Homeland Security entitled “Hometown Hospitals: The Weakest Link?” suggest that rural hospitals are unprepared for possible acts of terrorism. Dr. Elin Gursky, author of the report and a Senior Fellow for Biodefense and Public Health with the ANSER Institute notes that “while rural hospitals throughout the nation have achieved different levels of preparedness, many remain inadequately prepared to respond to either a bioterrorist event or an emerging infectious disease.”

The study examined possible causes for the disparities between rural and urban hospital facilities and systems. Among those possible causes are: work force shortages, a lack of access to health care, fiscal restraints, high degrees of complacency, and the perception that rural areas are not at risk.

The report also made recommendations to state and local leaders to improve the readiness of rural hospitals.

Consolidate planning for homeland security funds. The current system of federal funding promotes insular planning for the various homeland security disciplines, including agricultural, emergency management, law enforcement and public health. By consolidating the planning of disparate programs at the state and regional levels, states can promote an integration of resources and efforts among the disciplines.

Integrate public health systems vertically and horizontally. The public health community is often fragmented at the state and local levels. Developing or expanding regional response capabilities would help to unite local planning efforts; foster mutual aid at the intrastate and interstate levels; promote cost sharing; create a network for regional knowledge sharing; and facilitate state management of public health activities and grant programs.

Improve communications interoperability. The lack of communications interoperability among public safety and health officials continues to hinder preparedness, especially in rural areas. In planning for a response, dispatch centers, ambulance personnel, emergency medical technicians and hospital personnel must be able to communicate with each other.

Address false or invalidated expectations of support. While conducting the study of rural hospitals, Gursky found that “there were expectations that the police and military would guard the hospitals and that the state health department would vaccinate people— all expectations of external support that I believe have not been validated.”

**Protecting agriculture**

Agro terrorism is another concern in preparing rural America. According to a report by the Midwestern Legislative Conference, “many experts consider attacks on agricultural interests both easier to carry out and more likely to inflict widespread economic damage than other, more familiar forms of terrorism.” “One of the biggest challenges is simply grasping the entire farm-to-fork continuum,” stated Richard Kirchoff, executive director for the National Association of State Departments of Agriculture.

The report also made recommendations to protect agriculture.

Consolidate planning for homeland security funds. The current system of federal funding promotes insular planning for the various homeland security disciplines, including agricultural, emergency management, law enforcement and public health. By consolidating the planning of disparate programs at the state and regional levels, states can promote an integration of resources and efforts among the disciplines.

Integrate public health systems vertically and horizontally. The public health community is often fragmented at the state and local levels. Developing or expanding regional response capabilities would help to unite local planning efforts; foster mutual aid at the intrastate and interstate levels; promote cost sharing; create a network for regional knowledge sharing; and facilitate state management of public health activities and grant programs.

Improve communications interoperability. The lack of communications interoperability among public safety and health officials continues to hinder preparedness, especially in rural areas. In planning for a response, dispatch centers, ambulance personnel, emergency medical technicians and hospital personnel must be able to communicate with each other.

Address false or invalidated expectations of support. While conducting the study of rural hospitals, Gursky found that “there were expectations that the police and military would guard the hospitals and that the state health department would vaccinate people—all expectations of external support that I believe have not been validated.”

This complex system includes supply chains for feed, animal and animal products; crop production and its associated supply chains such as seed, fertilizer and related materials; post-harvesting components of the food supply chain, including processing, production, packaging, and storage and distribution; and retail food sales, institutional food services, and consumption at restaurants and home.

Timing is critical throughout. “We have a short duration food supply between the day it’s produced and the day it’s consumed, probably six or seven days… so if there is a problem introduced into the system, we have to identify it fast,” said Kirchoff.

To this end, in 1999, the Centers for Disease Control and Prevention established the Laboratory Response Network. The LRN is a national network of approximately 120 labs that supports public health, agricultural security and environmental testing needs. It provides a much-improved approach to identifying, confirming and responding to the presence of biological and chemical agents. The network includes FDA and USDA labs, and others that are responsible for ensuring the safety of the food supply. A number of the USDA labs are responsible for animal testing, especially for zoonotic cases or those that may be passed from animals to humans.

**Special considerations for rural America**

Because of their population densities and critical infrastructure, urban areas present many unique security threats to the states. However, emergency planning and preparedness dollars should not be directed to urban areas at the expense of rural community preparedness.

Considering that rural areas not only contain a significant segment of the US population, but also produces the food consumed in the urban areas, it is clear that rural areas should receive special consideration for future planning and grant programs. Low population density does not translate to a low probability of terrorist attack. Rather, many rural and agricultural interests may be easier and more attractive targets for terrorists, especially given the vulnerabilities and possibilities of widespread economic damage.

— Chad Foster is the chief policy analyst for the public safety and justice group at The Council of State Governments.
Vaccine Shortages (Continued from page 1)

been approved for the U.S. market by the Food and Drug Administration. On December 7, the U.S. Department of Health and Human Services announced it would purchase an additional 1.2 million doses of vaccine manufactured and approved for use in Germany from GlaxoSmithKline and administered under an Investigational New Drug (IND) application. Under an IND, individuals receiving this imported vaccine must sign a consent form.

Monitoring supply. In Texas, the governor has asked the state to develop a system to track and inventory the state’s supply of flu vaccine. Minnesota and North Dakota are surveying health care facilities county by county to determine if vaccine supplies are adequate to meet priority needs.

Public information campaigns. In Rhode Island, the state health department has produced a poster asking healthy adults and children to skip the flu vaccine this year. Minnesota is asking its health care workers to forego getting a flu shot or substitute with FluMist® vaccine, a nasal spray vaccine produced by MedImmune that is only approved for use in healthy people, five to 49 years of age. Many other states have launched aggressive efforts to educate the public about the need to prioritize giving flu shots to those at high risk and to suggest ways to avoid spreading the flu virus.

Immunization policies at state health facilities. California recently passed legislation that requires a skilled nursing facility to offer immunization for flu and pneumococcal disease to residents aged 65 or older. Georgia enacted legislation providing that nursing homes offer annual flu shots. Many other states have already enacted laws or set rules establishing immunization policies for their long-term care facilities.

State efforts won’t solve underlying problem

This aggressive state action to make sure the vaccine is effectively targeted to high-risk people could save lives.

According to a 2000 CDC study, an estimated 900 deaths were prevented for every 1 million doses of flu vaccine administered to those 65 years and older. On average, the flu is associated with 36,000 deaths and more than 200,000 hospitalizations annually in the United States.

But while states are rightly taking the situation seriously and working hard to make sure those at high risk are prioritized to get flu shots, there is little they can do to avert future vaccine shortages. That’s a problem best tackled at the national level.

Fragile vaccine supply system

Currently, three vaccine manufacturers are licensed to produce influenza vaccine for use in the United States; two produce inactivated, injectable vaccine (the “flu shot”) and one makes a live attenuated vaccine delivered by nasal spray.

When Chiron Corporation, one of the two makers of the flu shot vaccine for the United States, was prohibited from supplying any of an expected supply of 48 million doses produced at a manufacturing plant in Liverpool, England because of contamination problems, the United States abruptly lost nearly half of its anticipated vaccine supply for use in people at high risk of complications from the flu. And although there was no shortage of nasal spray vaccine, it is not

Fact File

- 36,000 Americans die from the flu each year—most of whom are over age 65.
- Together, the flu and pneumonia are the seventh leading cause of death in the United States and the fifth leading cause among adults over 65.
- Kids miss about 38 million school days every year because of the flu.
- Adults lose 70 million workdays while sick with the flu or tending to those who are sick with the flu.
- The health care costs associated with vaccine-preventable diseases in adults are more than $10 billion a year.
licensed for use in most people for whom influenza vaccine is recommended.

The sudden drop in vaccine supply underscored just how fragile the US vaccine supply system is.

The current system has two major vulnerabilities. First, the United States has little capacity to regulate overseas production of vaccine. In the Chiron case, for example, British health officials didn’t immediately tell American officials about their concerns over the Liverpool plant because the British government didn’t have an information exchange agreement with the U.S. Food and Drug Administration. Instead, the FDA had been relying mainly on the manufacturers themselves to warn of problems.

Second, there are manufacturing and market challenges associated with the production of vaccine in the United States. Drug manufacturers say that strict manufacturing standards, combined with the relatively low profitability of vaccine production and the high cost of product liability, explain why only two factories produce the bulk of vaccine for the United States.

It’s worth noting that shortages of the flu vaccine are not the only vaccine shortages that bedevil public health officials. The same factors that make flu vaccine supply vulnerable—high costs, strict standards, and regulatory oversight problems combined with low profitability—also apply to vaccines for various childhood diseases.

Between 2001 and 2004, the United States experienced shortages of vaccines against eight of 11 diseases prevented through routine vaccination of children. To begin building a more robust vaccine supply system, a recent Institute of Medicine report recommends that the government provide subsidies and other forms of tax incentives to attract more pharmaceutical firms into the business of making vaccines.

And a 2002 Government Accountability Office report says that if the FDA’s manufacturing standards are keeping vaccine companies out of the U.S. market because of the

Avoid close contact. Avoid close contact with people who are sick. When you are sick, keep your distance from others to protect them from getting sick.

Stay home when you are sick. If possible, stay home from work, school, and errands when you are sick. You will help prevent others from catching your illness.

Cover your mouth and nose. Cover your mouth and nose with a tissue when coughing or sneezing. It may prevent those around you from getting sick.

Clean your hands. Washing your hands often will help protect you from germs.

Avoid touching your eyes, nose or mouth. Germs are often spread when a person touches something that is contaminated with germs and then touches his or her eyes, nose, or mouth.

For more information, go to the CDC’s comprehensive flu web site at www.cdc.gov/flu.
In the last 100 years, three flu pandemics have occurred—the worst of which was the 1918 pandemic which caused over 500,000 deaths in the United States and more than 20 million worldwide. Experts are warning that the time is ripe for another pandemic.

— Dan Lorentz is a health policy analyst at The Council of State Governments.

In Brief—Recent Reports and Studies


According to this report, there has been a 17.5 percent improvement in America’s overall health during the past 15 years. However, the report also shows that the rate of improvement is slowing significantly due to a combination of personal, community and public health issues. This year, Minnesota, New Hampshire and Vermont were ranked the healthiest states in the country. The least healthy states were Tennessee (48), Mississippi (49) and Louisiana (50).

Damp Indoor Spaces and Health, www.nap.edu/books/0309091934/html

This Institute of Medicine report looks at the relationship between respiratory health and exposure to damp or mold, and it makes several recommendations on how policy-makers can respond.


A new analysis from the Centers for Disease Control and Prevention shows that rates of HIV/AIDS diagnosis in the United States stayed steady for the years 2000-2003, but sharp racial disparities remain. The rate of HIV/AIDS diagnosis among black females in 2003 (53 cases per 100,000 population) was more than 18 times higher than among white women and almost five times higher than among Latina women. In addition, black women accounted for 69 percent of female HIV diagnoses during 2000-2003. The rate of HIV/AIDS diagnosis reflects the number of new diagnoses of HIV per 100,000 people, regardless of whether infection has progressed to AIDS.


This document provides a vision for developing and implementing CDC’s National Environmental Public Health Tracking (EPHT) Network. Information from the EPHT network will help federal, state and local agencies develop and evaluate effective public health actions to prevent or control chronic and acute diseases that can be linked to environmental hazards.


This national study by the Center for Studying Health System Change found that the health insurance gap among Latino, black and white Americans persisted in 2003, with one in three Latinos, one in five blacks and one in 10 whites under age 65 lacking health insurance.


Another national study by the Center for Studying Health System Change found that the proportion of low-income, privately insured, working-age Americans with chronic conditions who spend more than 5 percent of their incomes on out-of-pocket medical costs jumped from 28 percent to 42 percent between 2001 and 2003. Overall, about 57 million working-age Americans live with chronic conditions, such as diabetes, asthma or depression, and more than one in five, or 12.3 million people with chronic conditions, lived in families with problems paying medical bills in 2003.
Smart Solutions: Delaware Rewards Healthy Behavior

A 2004 CSG Innovations Award winner, Delaware’s Health Rewards program has two primary goals: to empower state employees to make positive choices about their health care and to save money for the state’s self-insured health plan.

“Employee health and wellness is a critical component of an efficient and productive work force,” said Gov. Ruth Ann Minner. “Delaware’s state government is one of the state’s largest employers, and we are working hard to find creative solutions that motivate employees to take charge of improving their overall health and address rising health care costs.”

In February 2003, Delaware formed a partnership with Blue Cross Blue Shield and Cardio Kinetics, a cardiac rehabilitation and preventive medicine facility, to conduct a pilot study of the fitness of 100 randomly selected state employees. Participants were given an initial assessment to determine their current health status. This included a health history questionnaire; a baseline and exercise EKG; a blood pressure test; blood work to measure cholesterol, lipids and glucose levels; a test to determine carbon monoxide levels; body composition measurements; and strength testing.

Based on the results, participants received physician referrals, when appropriate, and advice on how to improve their short- and long-term health. The initial assessment was followed by “fit stop” check-ups performed by Cardio Kinetics to monitor the employees’ progress.

Delaware officials report the following results of the pilot project:

- 55 of the participants who originally reported their fitness activity as sedentary were active at least three times per week on follow-up.
- Two of the five smokers who attended the assessment quit by the time of the follow-up.
- Of the five people who had hypertension, all were treated and none tested with high blood pressure at a six-month check-up.
- The number of emergency room visits for the pilot group decreased significantly compared to a control group.

In September 2004, Delaware expanded the pilot program to 1,500 employees. Officials estimate the expansion will save the state health insurance plan almost $1 million annually. "There are not many win-win opportunities where we can improve quality and reduce costs simultaneously but this is one," said state Treasurer Jack Markell. “We hope that other states and employers can adopt similar programs.”

Markell was one of the program’s originators, along with Gov. Minner; Tom Hall, CEO of Cardio Kinetics; and Dr. Paul Kaplan, medical director of Blue Cross Blue Shield of Delaware.

Participation in the expanded program is free, voluntary and on a first-come, first-served basis. Delaware officials are offering employees different rewards to try to determine how to motivate employees to achieve the best results. All participants will get the initial health assessment, fit stops, and a year-end evaluation. One-third will get additional coaching to improve fitness. Another third will get the coaching and a $100 bonus if they can demonstrate that they have improved their health as a result of participating in the program.

“This program is a continuation of our long-standing commitment to preventive medicine as a way to save health care dollars,” Minner said.

For more information, contact Jack Markell, Delaware state treasurer, at (302) 744-1000 or jack.markell@state.de.us.

— Nancy Vickers is a national program associate for The Council of State Governments.

Calendar of Events

February 2005


March 2005


April 2005


June 2005

June 5-8 CSG Spring Committee and National Task Force Meeting, Lake Tahoe, CA. More information: www.csg.org


July 2005

July 12-15 National Association of County and City Health Officials—Association of State and Territorial Health Officials 2005 Joint Meeting, Boston, Massachusetts. More information: www.astho.org

July 16-19 National Governors Association Annual Meeting, Des Moines, IA. More information: www.nga.org


July 30-Aug. 3 CSG/Southern Legislative Conference Annual Meeting, Mobile, AL. More information: www.sclatlna.org

July 31-Aug. 3 CSG/Midwestern Legislative Conference 60th Annual Meeting, Regina, Saskatchewan, Canada. More information: www.csgmidwest.org

August 2005


December 2005

In partnership with the Centers for Disease Control and Prevention, The Council of State Governments announces its new Healthy States initiative to educate state officials on public health issues. Areas include cancer, diabetes, immunization, school health, HIV/AIDS, environmental health and more.

Look for these new resources and services:

- Quarterly newsletter, issue briefs and other publications
- e-Weekly
- Inquiry service
- Issues analysis
- Comprehensive website

For more information, check out the Healthy States website at www.healthystates.csg.org.