Opening Statement of the Honorable Tim Murphy
Subcommittee on Oversight and Investigations
Hearing on "Examining the U.S. Public Health Response to Seasonal Influenza"
February 3, 2015

(As Prepared for Delivery)

Today we convene the first meeting of the Subcommittee on Oversight and Investigations in the 114th Congress. I welcome back members who served here last session, particularly my friend and colleague, Diana DeGette, the ranking member, and our new members for the 114th Congress.

The Subcommittee is here to examine the U.S. public health response to seasonal influenza. America is experiencing a severe flu season with an unstable predominant strain that could result in one of the deadliest and costliest flu seasons in recent memory. An estimated 50,000 people will die. Over 200,000 will be hospitalized, most of these will be senior citizens.

Last February, when public health officials needed to decide what strains would go into this year's seasonal flu vaccine, the FDA bet on the wrong predominant strain. Just a few weeks after the FDA's decision, doubts already were already beginning to creep in the scientific community about the FDA's decision. By September, the US vaccine was such a poor match for the dominant strain of flu that the World Health Organization, with consultation from the CDC, revised the vaccine formula – But, not for the United States. It was changed for the southern hemisphere nations.

In other words, the American people were stuck with a vaccine that wasn't going to work for nearly 4 out of 5 people and nearly 9 out of 10 seniors. Despite a growing body of knowledge that the vaccine for the United States would not be effective, production went forward anyway for a number of reasons we will discuss today.

With a mismatched strain, this year's vaccine is estimated to be only 23 percent effective. It's even lower for the elderly (12%).

While this season's vaccine has lower-than-usual effectiveness, CDC is still recommending vaccination for everyone 6 months or older. In addition to vaccination, CDC has also recommended that all high-risk patients should be treated with antiviral drugs as soon as possible when influenza is suspected.
What are agencies doing to communicate to the public?

Many are choosing not to vaccinate against the flu because they hear the vaccine doesn't work, so why bother. We're seeing a similar result with measles vaccinations but for very different reasons, and now we're paying the piper as more than 100 have been stricken with a disease of measles that had once been eradicated from our shores.

False rumors still exist that vaccines and a preservative for multi-dose vaccines, which once used a microscopic amount of mercury as a preservative to prevent bacteria growth, led to autism. There is no credible evidence to support that claim. In fact, mercury is not used as a preservative in the MMR vaccine, and in developing nations where vaccination rates have increased, autism rates have not changed.

So in addition to understanding why this year's flu vaccine missed so badly — and what should be done to protect the public in future years — I hope we can use this platform to educate the public and advance vaccine development in the interest of public health.

Now on the flu vaccine, we must know: Did the federal government do everything it could at the right time to respond to the challenge of this year's flu season?

As I noted, the CDC knew in late September that there was a significant mismatch — as great as 50% — with the U.S. vaccine. However, the CDC did not issue a health advisory in response to this mismatch until more than two months later. Did the CDC make the right public-health decision to delay the health advisory, especially on delaying a recommendation to treat high-risk patients with antivirals? Could vaccine manufacturers have developed a new vaccine for high risk groups?

The CDC and the FDA tell us that the significant change in the strain could not have been addressed any earlier than September 2014, way too late to make changes in the U.S. vaccine. However, one flu expert at the University of Utah School of Medicine has stated on the record that there was a pretty good indication about the drifted strain by April or May 2014, that "probably" would have led to a decision to change at that time if strain selection decisions for manufacturing were made in May instead of February. In hindsight it was a bad decision – and thousands will die. Surely there are lessons to be learned here to do something different in the future.

In 2009, when there was a similar outbreak of the swine flu, federal agencies declared a public health emergency and responded by producing a monovalent — or single strain — vaccine to protect the public in a short time. In only 12 weeks they had developed this new vaccine. Here we must know — was a monovalent "rescue" vaccine targeting the drifted strain a possible response? Who made the decision not to go forward with a different vaccine?

If not, was this partly because the FDA and other agencies lacked emergency authority to respond? Did they recognize the problem and ask for authority to respond quicker?

If an astounding 50,000 deaths and 200,000-plus hospitalizations does not equal an emergency then what is? Shouldn't we be treating this problem with more urgency?

Is there even a backup plan in the event of a vaccine mismatch to a deadly strain?

HHS has set a goal for states to vaccinate 70 percent of their population as part of the Healthy People 2020 initiative, but overall vaccination rates in the U.S. have been around 45 to 46 percent the last few years. CDC has not even met its target of 50 percent vaccination. Does CDC have an effective strategy to increase vaccination rates? Or is there a better strategy for reducing flu deaths than seeking further increases of vaccination rates in all sub-groups?

So we're meeting here today to challenge some of the policies and decisions, but in the spirit of us all working together to make improvements in the public health response to seasonal flu. I am encouraged by the potential of ongoing research and innovation. We appreciate the cooperation and attendance of witnesses from CDC, FDA, NIH and BARDA. We need your input to help us decide how we change this system for the better.

I welcome our witnesses today and thank them for their help in this inquiry.

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