

**Opening Statement of the Honorable Fred Upton
Subcommittee on Oversight and Investigations
Hearing on “Examining the U.S. Public Health Response to Seasonal Influenza”
February 3, 2015**

(As Prepared for Delivery)

Thank you, Mr. Chairman, for convening this hearing on the U.S. public health response to seasonal influenza. We remain in the midst of a particularly harsh flu season and preliminary estimates show that this year’s vaccine is only 23 percent effective in preventing folks from going to the doctor for treatment, even lower for high-risk groups. Usually, the flu vaccine is about 50-60 percent effective. I, like many folks back in Michigan and across the country, believe we can do better in addressing this major public health threat.

Every year between 5 percent and 20 percent of Americans get the flu virus. In a severe flu season like this one, there could be up to 50,000 deaths, over 200,000 hospitalizations, and more than \$10 billion spent on direct medical costs. The flu is, and should be, a top priority for U.S. public health.

We understand that the reason this year’s vaccine has lower effectiveness is because it is no longer a good match for the flu strain that has become dominant. The flu virus strain changed significantly during the six months after the strain selection decision for the U.S. vaccine was made, and we have been told it was too late to change the vaccine for the U.S. As a result of the evidence of change in the virus, the World Health Organization in September 2014 recommended changing the flu vaccine for the Southern hemisphere to use in their upcoming flu season that starts in April. The CDC continues to recommend vaccination in the United States, even with the lower effectiveness, and that high-risk patients be treated as soon as possible with anti-viral drugs.

While it is difficult to know when or how seasonal flu viruses are likely to change, leading to a need to change the vaccine for that year, we have made significant improvements in the past 10 years and it seems like we should be able to do better. There were known weaknesses in the surveillance system. In 2011, the World Health Organization conference found that a key test used to check for flu virus changes was not very effective in detecting evidence of changes in the deadliest flu strain. Our understanding is that this same test is still used. What tests were used as an alternative to the inadequate test?

And when we learned that there was a shift in the virus, what other options were available to respond to the mismatch in viruses? Was there a way to deploy a rescue vaccine targeting just the changed virus? Was there a way to improve the effectiveness of this season's vaccine by adding substances that boost the immune response?

Improving our response to a severe flu season with a mismatched vaccine could mean saving thousands of lives. My concerns and questions do not diminish my admiration and support for the dedication of the U.S. public health agencies working on flu preparedness. It is because of their talent and hard work that I believe improvement is really possible. We can work together to make that happen. I am also eager to learn about the latest research and innovation, and how we can better support and leverage these advances to improve our response to seasonal influenza.

I welcome all our witnesses, and look forward to their testimony.

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