

Merck Backs Off Campaign to Make Cervical Cancer Vaccination School Entry Requirement for Preteen Girls

On February 20, Merck & Company announced that it would suspend its aggressive campaign to persuade state governments to make Gardasil—the company’s anti-cervical cancer vaccination—a requirement for preteen girls to attend school. Merck’s about-face comes as states across the country consider such requirements, led by Texas, where Gov. Rick Perry (R) established one through an executive order. It also comes amidst backlash to such mandates from a diverse group of critics, ranging from proabstinence conservatives and vaccine skeptics to mainstream public health organizations.

Gardasil was approved in June 2006 as a highly effective, first-of-its kind vaccine for four strains of human papillomavirus (HPV): two that cause seven out of 10 cases of cervical cancer and two that cause nine out of 10 cases of genital warts. Public health experts see universal vaccination as key to reducing the 3,700 deaths from nearly 10,000 cases of cervical cancer in the United States each year, as well as the millions of abnormal Pap results and accompanying follow-up care. The Centers for Disease Control and Prevention (CDC) has recommended routine vaccination for all girls 11–12 (before they engage in sexual activity) and “catch-up” vaccination for ages 13–26. The vaccine is now included in the federal Vaccines for Children Program (VFC), which provides free vaccination for Medicaid recipients and the uninsured.

Research strongly suggests that school entry requirements for vaccination are the most effective tactic available, which is why more than 20 states in 2007 have considered such a step. That has not stopped some social conservatives from arguing that HPV vaccination will encourage promiscuity and that abstinence until marriage is the answer to preventing cervical cancer. As Perry asked in announcing his executive order, however, “If the medical community developed a vaccine for lung cancer, would the same critics oppose it claiming it would encourage smoking?” Critics also argue that because HPV is transmitted through sexual contact, it is not a threat for transmission in a school setting. This position ignores the fact that states require vaccination for several diseases that are not transmitted casually, including tetanus and Hepatitis B, to protect Americans throughout their lives and eradicate disease in the larger community (related article, Fall 2006, page 12).

Other arguments against school entry mandates revolve around parental autonomy (although almost every state allows parents to opt their children out of vaccinations on religious and sometimes even broader grounds), as well as concerns about the safety and long-term efficacy of a new vaccine. At a February 2007 conference, CDC officials presented data indicating that side effects have been overwhelmingly minor and rare.

Despite supporting widespread vaccination, some public health groups also have expressed unease over what they deem an unusually rapid call for a mandate and have emphasized a series of financial and logistical challenges to widespread vaccination uptake. Gardasil costs \$360 for three shots over six months, which is extremely expensive by vaccine standards. In addition, providing the vaccine to adolescents may be difficult, as they are an age-group for whom there is no established protocol for regular health care visits. Health care advocates are arguing for enhanced public funding and private insurance coverage to prevent the VFC from being overwhelmed and to serve adults ineligible for public subsidies. They are also calling for public education campaigns to help parents better understand HPV and allay their concerns over vaccination.

Finally, advocates are stressing the continuing need for regular Pap smears—the widespread use of which is credited for the United States’ relatively low cervical cancer rate. Without these steps, advocates fear that low-income and minority women, already facing serious disparities in Pap smear utilization and incidence of cervical cancer, will fall further behind. That said, it may well be that universal vaccination requirements for school entry are the surest way to protect these very women.

—*Adam Sonfield*

More Reproductive-Age Women Covered by Medicaid—But More Are Also Uninsured

Over the first half of the decade, the proportion of women of reproductive age covered by Medicaid increased by one-third, from 9% in 2000 to 12% in 2005. Yet, this increase—of nearly two million women—was matched by an increase in the proportion of reproductive-age women who were uninsured (from 18% in 2000 to 21% in 2005). Both trends were likely driven, in part, by the continuing decline of employer-sponsored health insurance and by the recession that followed the 2000 stock market crash.

In 2005, 7.4 million women aged 15–44 looked to Medicaid (and related public programs, including the State Children’s Health Insurance Program) for their health care, including contraceptive services and supplies, prenatal care and delivery services, screening and treatment for sexually transmitted infections, and other vital sexual and reproductive health services. Among women of reproductive age in families with incomes below the federal poverty line, 36% were covered by Medicaid in that same year. Yet, because Medicaid eligibility is severely restricted, and because poor reproductive-age women are unlikely to be offered or able to afford private insurance, 41% were uninsured.

The importance of Medicaid to women of reproductive age varies widely by state, reflecting differences both in states’ economic climate and their eligibility criteria for the program. The proportion of reproductive-age women enrolled in

Medicaid in 2004–2005 ranged from 6% in New Hampshire to 26% in Maine (see table); Maine covers working parents up to an income level nearly four times as high as the limit in New Hampshire. In eight states and the District of Columbia, at least 15% of such women looked to Medicaid for their care; in 13 states, fewer than 10% were covered under the program. Mirroring in part the same influences, the proportion uninsured ranged from 10% in Minnesota to 32% in Texas.

Decidedly uncertain is whether Medicaid can continue to serve as a levee against the tide of the uninsured. The Deficit Reduction Act of 2006 gave states new flexibility to impose cost-sharing and restrict their package of Medicaid benefits—flexibility that could undermine the program’s provision of reproductive health services (related article, Spring 2006, page 2). Another provision of that law, which requires Medicaid recipients who are citizens to provide documentary proof of their status, has the potential to delay or deny care for millions of Americans (related article, page 7). Nevertheless, there are early signs of promise: As the political, economic and social costs of uninsurance become increasingly clear, federal and state policymakers, with Massachusetts leading the way, have renewed debate over ways to counter the problem, either incrementally or through some form of universal coverage.—*Adam Sonfield*

NOT NEARLY ENOUGH

Even in states where Medicaid enrollment is relatively high, considerable numbers of women remain uninsured—nationally, almost twice as many.

Women Aged 15–44, 2004–2005

	Covered by Medicaid		Uninsured	
	Number	%	Number	%
U.S. Total*	7,433,000	12.0	12,860,000	20.8
Alabama	120,000	12.7	197,000	20.8
Alaska	18,000	12.9	30,000	21.9
Arizona	201,000	16.6	287,000	23.7
Arkansas	71,000	12.6	143,000	25.3
California	1,095,000	14.2	1,846,000	23.9
Colorado	62,000	6.2	214,000	21.4
Connecticut	77,000	10.8	104,000	14.8
Delaware	20,000	11.6	26,000	14.7
Dist. of Columbia	27,000	19.8	18,000	13.5
Florida	290,000	8.4	956,000	27.7
Georgia	218,000	10.9	464,000	23.2
Hawaii	23,000	9.3	27,000	11.1
Idaho	30,000	10.1	63,000	21.3
Illinois	289,000	10.8	478,000	17.7
Indiana	165,000	12.7	269,000	20.8
Iowa	73,000	12.3	73,000	12.2
Kansas	50,000	9.0	81,000	14.5
Kentucky	119,000	13.7	154,000	17.7
Louisiana	114,000	12.3	245,000	26.5
Maine	69,000	26.2	31,000	11.9
Maryland	72,000	6.0	228,000	19.0
Massachusetts	186,000	13.7	190,000	13.9
Michigan	270,000	12.9	316,000	15.2
Minnesota	109,000	10.0	112,000	10.3
Mississippi	102,000	16.5	143,000	23.1
Missouri	169,000	14.2	209,000	17.5
Montana	18,000	9.8	46,000	25.1
Nebraska	38,000	10.5	52,000	14.4
Nevada	32,000	6.3	118,000	23.3
New Hampshire	15,000	5.5	42,000	15.7
New Jersey	122,000	6.9	349,000	19.6
New Mexico	59,000	15.2	118,000	30.4
New York	756,000	18.5	727,000	17.8
North Carolina	220,000	12.0	355,000	19.4
North Dakota	11,000	9.1	16,000	13.0
Ohio	306,000	13.1	336,000	14.4
Oklahoma	74,000	10.3	201,000	27.8
Oregon	88,000	11.9	178,000	24.2
Pennsylvania	278,000	11.3	360,000	14.6
Rhode Island	44,000	19.2	31,000	13.6
South Carolina	120,000	13.6	183,000	20.8
South Dakota	17,000	11.2	24,000	15.3
Tennessee	245,000	19.5	211,000	16.8
Texas	404,000	8.1	1,586,000	31.9
Utah	51,000	9.3	106,000	19.0
Vermont	27,000	21.3	17,000	13.8
Virginia	108,000	6.8	286,000	18.0
Washington	152,000	11.5	211,000	16.0
West Virginia	42,000	11.8	86,000	24.3
Wisconsin	160,000	14.0	143,000	12.5
Wyoming	10,000	10.3	20,000	20.3

*2005 data. Source: Guttmacher Institute tabulations from Current Population Survey, 2005–2006.