



## American Public Health Association

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July 17, 2006

The Honorable Richard Burr  
Chairman  
Bioterrorism and Public Health Preparedness  
Subcommittee  
Senate Committee on Health, Education,  
Labor and Pensions  
424 Dirksen Senate Office Building  
Washington, DC 20510

The Honorable Edward Kennedy  
Ranking Member  
Bioterrorism and Public Health Preparedness  
Subcommittee  
Senate Committee on Health, Education,  
Labor and Pensions  
113 Hart Senate Office Building  
Washington, DC 20510

Dear Senators:

On behalf of the American Public Health Association (APHA), the oldest, largest and most diverse organization of public health professionals in the world, dedicated to protecting all Americans, their families and communities from preventable, serious health threats and assuring community-based health promotion and disease prevention activities and preventive health services are universally accessible in the United States, please accept the attached document as comments to the July 12 version of the Pandemic and All-Hazards Preparedness Act.

Thank you for your attention to and leadership on this important public health issue. We look forward to working with the Subcommittee as it discusses the national capacity to prepare for and respond to pandemic influenza and other all-hazards public health emergencies. If you have questions, or for additional information, please contact me or have your staff contact Courtney Perlino at (202) 777-2436 or [courtney.perlino@apha.org](mailto:courtney.perlino@apha.org).

Sincerely,

A handwritten signature in black ink that reads 'Georges C. Benjamin'.

Georges C. Benjamin, MD, FACP  
Executive Director

The American Public Health Association (APHA) is the oldest, largest and most diverse organization of public health professionals in the world, dedicated to protecting all Americans, their families and communities from preventable, serious health threats and assuring community-based health promotion and disease prevention activities and preventive health services are universally accessible in the United States.

For over 130 years, APHA has been in the forefront of numerous efforts to prevent disease and promote health. The Association has affirmed the importance of immunizations as one of the most effective means of preventing infectious disease. Influenza presents a grave threat to the public's health, even in this pre-pandemic period, causing an average of 36,000 deaths and more than 200,000 hospitalizations per year. Preparing for an influenza pandemic on the local, state, national and international levels is essential to ensure the health and safety of the American people.

APHA appreciates that the Subcommittee has been responsive to some of the concerns of the public health community that were reflected in the changes made between the June 23 and July 12 drafts. However, APHA remains concerned with the inadequacy of the sections on loan repayment for public health professionals and the countermeasure tracking program. Also, there remains a hole in the legislation in terms of how the uninsured and underinsured individuals of this country will be able to access needed preventive, emergency and treatment services in the event of an influenza pandemic.

### **Section 313 – Public health workforce enhancements**

Although APHA appreciates the efforts of the Subcommittee to insert language related to a loan repayment program for public health professionals, the current language is neither cost-effective nor sufficient to respond to the urgency of the public health workforce shortage. Studies have already shown time and time again state loan repayment and direct financial incentive programs have resulted in some gains in the number of qualified public health practitioners and improving retention rates. There is no need for a federal demonstration program, but rather a permanent, comprehensive, federally-funded loan repayment and scholarship program for public health students and professionals based on existing data of what works.

The need for a permanent, federally-funded student loan repayment and scholarship program versus a demonstration program is also evidenced by the successes of student loan repayment and scholarship programs in distributing health professionals to underserved communities. In fact, approximately 14.5% of the physicians and 22.6% of the dentists working at community health centers are there as a result of federal or state student loan repayment programs. 44.6% of physicians and 32.6% of dentists in rural community health centers receive student loan repayment. National Health Service Corps and state loan repayment programs have been shown to be effective in redistributing dentists in underserved communities.

The cost-effectiveness of the proposed grant program to support state loan repayment programs is also much lower than a federal program that directly provides loan repayment to public health professionals. The most noteworthy difference in terms of cost is that under the grant program, two levels of overhead costs (federal and state) would be supported versus only one. The language in this section also assumes that the level of education needed in the public health workforce is a master's degree in public health. However, that is not true, as some of the most critical shortages lie

in professions such as epidemiology that in fact require a Ph.D.—therefore, this loan repayment program would not assist in ensuring a pipeline of individuals in all public health professions.

Therefore, APHA strongly stresses the need for Subcommittee to consider modeling the loan repayment program language after already-existing language in S. 506, Public Health Preparedness Workforce Development Act of 2005. This legislation would provide for the repayment of student loans for individuals who work in federal, state, local or tribal public health agencies for at least three years. Without this change of language, APHA will be unable to support this legislation.

### **Section 203 – Vaccine tracking and distribution**

APHA supports the creation of a tracking system for vaccines and other countermeasures. Such a tracking system should be dual-use in nature, used both for seasonal AND for pandemic flu. Overall, APHA welcomes the term “influenza vaccine” as encompassing both seasonal and pandemic flu vaccines, not just the pandemic vaccine. A dual-use tracking system will be more effective than having two separate systems, as it would allow for the system to be perfected during the annual flu seasons leading up to an eventual pandemic. We already have problems reaching priority populations and ensuring they get the seasonal flu shot in a timely manner; this tracking system would hopefully improve the rates of these populations getting vaccinated. If we can become successful in reaching these populations during annual flu seasons, then there is a higher probability for success for us being able to reach populations most at risk during a pandemic. Having a tracking system only for pandemic influenza vaccine will ultimately lessen the effectiveness of such a system in the event of a flu pandemic, as there will be no opportunity to test and make needed changes to the system beforehand, which would be the case if it is used during the annual flu season as well.

APHA is pleased the Secretary of Health and Human Services is responsible to track and facilitate the distribution of influenza vaccines. We support the current language of this provision. If this language changes, or if the tracking system will not be dual-use in nature, APHA will not be able to support this legislation.

### **Ensuring Access to Care in the Event of a Public Health Emergency**

APHA remains very concerned that the current draft of the Pandemic and All-Hazards Preparedness Act does not address how care will be provided during and after a public health emergency, especially to the uninsured. Uninsured individuals will need to have access to appropriate countermeasures. Equally important, however, is that they are able to receive the medical care that they need. Without the creation of a standardized, emergency Medicaid designation before such an emergency occurs, these individuals will be less likely to receive care. If they do receive care, health providers, such as hospitals, will be increasingly financially strained due to uncompensated care. In the event of a flu pandemic, when millions could be hospitalized and be in need of medical care, this may mean that hospitals and other health providers will have to shut their doors.

Despite the utilization of Medicaid waivers following Hurricane Katrina, waivers are not suitable mechanisms to ensure access to care for some of our nation’s most vulnerable in the event of a public health emergency. This is especially true in response to such public health emergencies as pandemic flu, where the situation can change in a matter of hours resulting from its quick spread from person to person. Therefore, before such an event occurs, an emergency Medicaid designation needs to be created for low-income, uninsured individuals. Such a designation would be similar to

what Senators Grassley and Baucus attempted following Hurricane Katrina with S. 1716, the Emergency Health Care Relief Act of 2005.

### **Additional Section by Section Comments**

#### **Title I—National Preparedness and Response, Leadership, Organization and Planning**

##### ***Sec. 2801***

APHA supports the Secretary of Health and Human Services as the lead on all federal public health and medical response to all-hazards public health emergencies. However, APHA believes that the Subcommittee should reconsider the roles of such agencies as HHS in the operationalization of that National Response Plan in response to pandemic influenza. It is unclear what the relationship between HHS and the Department of Homeland Security would be in this regard, as the expertise on this issue lies within HHS, yet DHS is named the agency responsible for coordinating the overall federal response of an influenza pandemic. The NRP also fails to acknowledge that the response to such public health emergencies as pandemic flu that are by name not related to public health or medicine really should follow HHS's lead in terms of responding. For example, transportation restrictions in the event of pandemic flu should be triggered by findings within HHS, not the Department of Transportation.

##### ***Sec. 2811***

APHA is pleased with the changes made to the language of this section that clarifies the need for coordination between the Assistant Secretary for Preparedness and Response at HHS and the Chief Medical Officer at the DHS to avoid duplication and overlap in responsibilities. Although the language was changed for the better in terms of transferring authority of several programs and initiatives currently housed in the Centers for Disease Control and Prevention and other agencies to the Assistant Secretary for Preparedness and Response at HHS, the Assistant Secretary would still have authority over the Hospital Cooperative Agreement Preparedness Program, which we oppose. The expertise to manage this program effectively and efficiently lies within HRSA, not within the new office.