THE CSTE WASHINGTON REPORT

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EDITOR'S NOTE:. The *Third National Report on Human Exposure to Environmental Chemicals*, released July 21 by The Centers for Disease Control and Prevention (CDC), shows a significant decline in exposure to secondhand smoke and continued decreases in children's blood lead levels. The report also suggests the need for more research into health effects of exposure to low levels of cadmium. "This is the most extensive assessment ever of Americans' exposure to environmental chemicals; it shows we're making tremendous progress, and that's good news," said CDC Director Dr. Julie Gerberding. "Exposure to secondhand smoke continues to plummet and blood lead levels in children are way down. However, many challenges remain. CDC is steadfast in its commitment to health protection, including protection from environmental threats." -- additional details are provided in this Washington Report.

The CSTE Washington Report is provided as an information resource for members of the Council of State and Territorial Epidemiologists on federal legislation and regulation affecting public health and epidemiology in the U.S. Legislation cited in the report can be accessed via http://www.thomas.loc.gov Regulations cited can be accessed via http://www.gpo.gov

APPROPRIATIONS UPDATE – The Senate Appropriations Committee finished work on its FY 2006 Labor-HHS-Education bill on July 14th. Funding levels for selected agencies and programs are provided below. The House has completed work on its corresponding bill, but it is unclear when or if the Senate will take up the bill on the Senate floor, particularly given the distraction of the Supreme Court nomination process. As reported in earlier this month, the Senate bill contains a gimmick for providing nearly $3 billion in additional funding that was knocked out by the House and the Administration during conference deliberations last year. It is expected the same result will occur this year. This would result in significantly lower funding levels for a number of programs in a final negotiated bill -- comparable to the House bill funding levels which have been endorsed by the Administration -- and make passage of a stand-alone bill on the Senate floor very difficult. A more likely scenario is that the Labor-HHS-Ed bill will be wrapped into an omnibus bill consisting of all the FY 2006 appropriations bills that have not yet passed both Houses of Congress, probably totaling at least 5-6 bills, and conference negotiations will take place in a more informal exchange between the four Subcommittee principals: Senator Specter (R-PA), Senator Harkin (D-IA), Rep. Regula (R-OH) and Rep. Obey (D-WI). For the past three years the omnibus bill has resulted in an across-the-board cut to all non-defense, non-homeland security domestic discretionary programs in order to boost funding for a few priority areas.

CENTERS FOR DISEASE CONTROL AND PREVENTION

INFECTIOUS DISEASES

Infectious Diseases Control

FY2005	$ 225,589,000
Pres, FY06	$ 224,761,000
House FY06	$ 229,471,000
Senate FY06	$ 229,437,000

Immunization – Sect. 317

FY2005	$ 480,794,000
Pres, FY06	$ 528,714,000
House FY06	$ 531,714,000
Senate FY06	$ 510,706,000

HIV-AIDS

FY2005	$ 662,267,000
Pres, FY06	$ 657,694,000
House FY06	$ 657,694,000

Senate FY06	$ 657,694,000

Coordinating Center for Health Promotion

FY2005	$ 1,021,709,000
Pres, FY06	$ 964,421,000
House FY06	$ 981,847,000
Senate FY06	$ 974,080,000

SELECTED CHRONIC DISEASE PROGRAMS

Heart Disease and Stroke

FY2005	$ 44,618,000
Pres, FY06	$ 44,627,000
House FY06	$ 46,120,000
Senate FY06	$ 44,918,000

Diabetes

FY2005	$ 63,457,000
Pres, FY06	$ 63,471,000
House FY06	$ 64,960,000
Senate FY06	$ 63,757,000

Cancer Prevention and Control

FY2005	$ 309,705,000
Pres, FY06	$ 309,778,000
House FY06	$ 312,600,000
Senate FY06	$ 310,109,000

Tobacco Control

FY2005	$ 104,345,000
Pres, FY06	$ 104,370,000
House FY06	$ 104,370,000
Senate FY06	$ 104,370,000

Nutrition and Physical Activity

FY2005	$ 41,930,000
Pres, FY06	$ 41,939,000
House FY06	$ 41,939,000
Senate FY06	$ 41,939,000

BRFSS

FY2005	$ 7,642,000
Pres, FY06	$ 7,643,000
House FY06	$ 7,643,000
Senate FY06	$ 7,643,000

Oral Health

FY2005	$ 11,204,000
Pres, FY06	$ 11,207,000
House FY06	$ 12,000,000
Senate FY06	$ 11,254,000

Environmental Health

FY2005	$ 147,483,000
Pres, FY06	$ 146,888,000
House FY06	$ 147,483,000
Senate FY06	$ 148,245,000 (estimated)

Health Tracking Network

FY2005	$ 24,438,000
Pres, FY06	$ 24,356,000
House FY06	$ 24,356,000
Senate FY06	$ 24,838,000

Injury Prevention and Control

FY2005	$ 138,237,000
Pres, FY06	$ 137,931,000
House FY06	$ 138,237,000
Senate FY06	$ 140,737,000

National Violent Death Reporting System

FY2005	$ 3,469,000
Pres, FY06	$ 3,096,000
House FY06	$ 3,469,000
Senate FY06	$ 3,469,000

Occupational Safety and Health

FY2005	$ 286,041,000
Pres, FY06	$ 285,930,000
House FY06	$ 251,241,000
Senate FY06	$ 257,121,000

($34,800,000 is transferred for central business services and support and this reduction is not expected to impact program funding which is equal to the FY2005 level.)

Prevention Block Grant

FY2005	$ 131,000,000
FY2005 after reprogramming	$ 118,000,000
Pres, FY06	$ 0
House FY06	$ 100,000,000
Senate FY06	$ 100,000,000

Terrorism Preparedness – State and Local Grants

FY2005	$ 926,736,000
Pres, FY06	$ 797,138,000
House FY06	$ 859,736,000
Senate FY06	$ 797,138,000

ATSDR

FY2005	$ 76,041,000
Pres, FY06	$ 76,024,000
Final Conference	$ 76,024,000

LEGISLATIVE UPDATE – The Senate Health, Education, Labor and Pensions Committee unanimously approved the "Wired for Health Care Quality Act," (S. 1418). The bill blends other legislation addressing health information technology, especially development and adoption of electronic medical records: S. 1272 (Frist-Clinton), and S. 1355 (Kennedy-Enzi). Major provisions of the bill: authorizes the establishment of the Office of the National Coordinator of Health Information Technology (OCHIT), establishes a collaborative to adopt health information technology standards (similar to Secretary Leavitt's American Health Information Community), authorizes two grant programs for individual providers to encourage linkage to a broader network, and a grant to develop IT consortia.

Recently introduced bills of interest, all of which have been referred to the Health, Education, Labor and Pensions Committee for consideration –

Environmental health -- S. 1442, "Coordinated Environmental Health Network Act of 2005," introduced on July 21st by Senator Clinton (D-NY). This bill essentially provides an authorization for the existing CDC Health Tracking program. Among key provisions, however, is an authorization for the establishment of an applied epidemiology fellowship program at an annual funding level of $2.5 million for FY 2006 – 2010. The language for the section is below:

> `(c) APPLIED EPIDEMIOLOGY FELLOWSHIP PROGRAMS-
>
> `(1) IN GENERAL- Beginning in fiscal year 2006, the Secretary, acting through the Director, shall enter into a cooperative agreement with the Council of State and Territorial Epidemiologists to train and place, in State and local health departments, applied epidemiology fellows to enhance State and local epidemiology capacity in the areas of environmental health, chronic disease, and birth defects and development disabilities.
>
> `(2) AUTHORIZATION OF APPROPRIATIONS- There is authorized to be appropriated to carry out this subsection $2,500,000 for fiscal year 2006, and such sums as may be necessary in each of fiscal years 2007 through 2010.

Lyme and other tick-borne diseases – Three bills have been recently introduced, two of which have been reported on in previous reports: H.R. 2526, introduced on May 23rd by Rep. Kelly (R-NY), H.R. 2877, introduced on June 14th by Rep. Smith (R-NJ), and S. 1479, introduced on July

25th by Sen. Dodd (D-CT). The bills are similar: establish an HHS Advisory Committee which must include representatives of state and local health departments or national organizations of state and local health departments; call for improved diagnostics, improved surveillance, and prevention awareness activities. The Kelly bill is less detailed and authorizes $10 million in funding for FY 2006 and such sums thereafter; the Smith and Dodd bills provide $20 million in funding. The Smith and Dodd bills each include the following language regarding surveillance:

> SURVEILLANCE AND REPORTING- Such activities include surveillance and reporting of Lyme and other tick-borne diseases--
>
> (A) to accurately determine the prevalence of Lyme and other tick-borne disease;
>
> (B) to evaluate the feasibility of developing a reporting system for the collection of data on physician-diagnosed cases of Lyme disease that do not meet the surveillance criteria of the Centers of Disease Control and Prevention in order to more accurately gauge disease incidence; and
>
> (C) to evaluate the feasibility of creating a national uniform reporting system including required reporting by laboratories in each State.

Amyotrophic Lateral Sclerosis – S. 1353, introduced June 30th by Senate Minority Leader Harry Reid (D-NV) with bipartisan support. The bill would establish an ALS registry within CDC. Sen. Reid made the following remarks with regard to the bill:

> "The legislation I am introducing today would create an ALS registry at the Centers for Disease Control and Prevention and will aid in the search for a cure to this devastating disease. The registry will collect data concerning: the incidence and prevalence of ALS in the U.S.; the environmental and occupational factors that may contribute to the disease; the age, race or ethnicity, gender and family history of individuals diagnosed; and other information essential to the study of ALS. The registry will also provide a secure method to put patients in contact with scientists conducting clinical trials and scientists studying the environmental and genetic causes of ALS."

PANDEMIC FLU PREPARATION – Congress and the Administration have provided funding through budget amendments and a number of appropriations bills for both global and domestic pandemic flu preparedness. A few days ago, for instance, the Administration sent up a budget amendment to the Appropriations Committees providing an additional $150 million for pandemic flu antiviral and vaccine purchase. The funding was offset primarily through cuts in non-health programs and via non-obligated amounts in a few HRSA accounts. Below are excerpts from various Congressional Appropriations reports specifying that certain amounts must be committed to pandemic flu preparation:

Senate Foreign Ops committee report

The Committee provided $25,000,000 to prevent and control the spread of the Avian influenza virus in the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Tsunami Relief, 2005 (Public Law 109-13), and authority to use the Tsunami

Recovery and Reconstruction Fund for these purposes. The Committee recognizes the potential global catastrophe that could result from human to human transmission of the virus, and recommends $10,000,000 in fiscal year 2006 funds to support ongoing efforts to control it. The Committee encourages the State Department, USAID and other appropriate U.S. Government agencies to engage foreign governments in affected regions to develop standardized procedures, consistent with best medical health practices, for the treatment of humans and animals infected by the virus. The Committee is alarmed by reports of the approval by the Government of the PRC to use an antiviral drug intended for humans on chickens, in violation of international livestock guidelines.

Senate Labor/HHS committee report

The Committee notes that several outside organizations, including the Trust for America's Health, have made recommendations regarding pandemic preparedness. The Committee encourages CDC to consult with outside experts in its preparations for, and response to, a potential pandemic.

The Committee is aware that the Department is developing a pandemic influenza response plan. The Committee recognizes that local public health departments, working with their States, play essential roles in responding to influenza outbreaks, including monitoring of local vaccine availability, distribution and redistribution of vaccines and antiviral medications to high priority populations, implementation of necessary epidemic containment measures, and communication to the public. Therefore, Committee encourages the Department to assure that all aspects of Federal pandemic influenza planning are consistent with operational realities at the local level and will have the intended public health results when implemented locally. The Committee further urges the Department to assure that Federal pandemic flu planning avoid duplication and inconsistency with other Federal directives concerning public health preparedness.

Public Health and Social Services Emergency Fund - The Committee is aware that a recent study projected that over half a million Americans could die and over 2.3 million could be hospitalized if a moderately severe strain of a pandemic flu virus hits the United States. Given the potential for such a scenario, the Committee urges the Department to finalize its August 2004 draft Pandemic Influenza Preparedness and Response Plan and make it publicly available. In addition, the Committee urges the Department to examine the study's key recommendations, including those relating to stockpiling medical supplies, and developing emergency communications plans; stockpiling additional antivirals and developing surge capacity plans for hospitals and health care providers; and increasing vaccine production and the development of new technologies for vaccines.

House Labor/HHS committee report

Pandemic Preparedness and Avian Flu - The Committee is increasingly concerned about the threat posed to public health by avian flu and pandemic influenza which public health authorities estimate could kill 90,000 to 300,000 people in the United States. Public health preparedness with respect to a pandemic influenza cuts across a broad array of federal public health activities. As a result, the Committee recommendation includes funding to enhance several of CDC’s functions to assist in improving our nation’s capability of detecting, controlling, and responding

to potential health threats related to influenza in general, and novel influenza strains in particular. Included is:

> $102,500,000, which is $3,498,000 above fiscal year 2005,within Infectious Diseases Control to, among other things, enhance the sentinel physician surveillance system, assist state and local health departments to improve vaccine delivery, and conduct research aimed at developing rapid molecular methods for characterizing influenza viruses:
>
> $36,500,000 for Global Disease Detection, which is $15,074,000 above the fiscal year 2005 enacted level, to build upon the $15,000,000 provided in the Emergency Supplemental Appropriations Act of Defense, the Global War of Terror, and Tsunami Relief Act, 2005, for combating the spread of the avian influenza virus in Southeast Asia, and to enhance the global surveillance and response network for infectious diseases.
>
> $265,680,000 for vaccine purchase grants, which is $35,441,000 above the fiscal year 2005 comparable level, to help improve the stability of the influenza vaccine market and ensure a plentiful supply of influenza vaccine for 2004/2005 flu season; and
>
> $530,000,000 for the Strategic National Stockpile, which is $63,300,000 above the fiscal year 2005 comparable level, to maintain and expand the Stockpile's supplies and countermeasures for assisting State and local governments in responding to both terrorist and naturally occurring public health emergencies, including the purchase of influenza countermeasures {not language in President's budget}.

In addition, $120,000,000, which is $20,802,000 above fiscal year 2005, is provided within the Public Health and Social Services Emergency fund for pandemic preparedness. The purpose of these funds is to ensure a year-round influenza vaccine production capacity in the U.S. and the development and implementation of rapidly expandable influenza vaccine production technologies.

The Committee recognizes that although a combination of efforts will be needed to address an influenza pandemic, early in an outbreak, especially before a vaccine is available, use of antiviral drugs may ease some of the symptoms of individuals infected and might slow the spread of the pandemic. Given the lag time in production and the high demand from other countries, the CDC must commit now to purchasing an adequate stockpile. The Committee is aware that the World Health Organization has recommended that nations stockpile enough antiviral treatments to cover 25% of their population. The Committee is concerned that the United States currently has enough antiviral treatments stockpiled to treat only 1% of the population and urges the CDC, in conjunction with HHS and NVPO, to determine what percentage of the U.S. population antiviral stockpiles should have the capacity to treat and how many doses are needed to meet this benchmark and report back to the Committee with these findings by no later than January 1, 2006.

The Committee urges CDC to review and approve state pandemic influenza plans in order to ensure nationwide preparedness standards and to facilitate regional coordination. Further, CDC should recommend that States make approved plans publicly available.

In addition, the Committee urges CDC to develop and implement a public education campaign about pandemic influenza and preparedness, including information concerning the potential need for general vaccination and personal precautionary measures. CDC should also develop a strategy for communicating with the business community to provide information about the economic disruptions and community needs that may arise during a pandemic period.

House Emergency Supplemental committee report

The conference agreement includes a general provision, similar to language proposed by the Senate, providing $25,000,000 to combat the spread of the avian influenza virus. The conferees are gravely concerned by the current outbreak in Southeast Asia, and therefore initiate a coordinated inter-agency program to prevent and control the spread of this virus. The conferees understand that the Centers for Disease Control and Prevention (CDC) of the Department of Health and Human Services have the necessary expertise to implement the bulk of these activities and have accordingly transferred $15,000,000 to CDC for use in combating the spread of the avian influenza virus in Southeast Asia. The conferees appreciate the valuable role the World Health Organization (WHO) played in combating the SARS outbreak and expect that the United States agencies will work closely with both the WHO and the Food and Agricultural Organization to address the human and animal components of this outbreak of the avian influenza virus. The conferees recognize that, given the variety of specialties necessary to mount such a program, an inter-agency taskforce and plan will be developed and implemented. The Committees on Appropriations expect to be consulted by this taskforce not later than 30 days following enactment of this Act on the status and implementation of such a plan.

The conference agreement also includes a new paragraph providing an additional $58,000,000 to the Public Health and Social Services Emergency Fund to be transferred to the Centers for Disease Control and Prevention for the purchase of influenza countermeasures for the Strategic National Stockpile. The conferees understand that influenza countermeasures include, but are not limited to, antiviral medications and vaccines. The conferees believe these funds are urgently needed to enhance our nation's preparedness to respond to a severe influenza outbreak, particularly in light of the current reports of Avian influenza activity in Southeast Asia.

Emergency Supplemental Appropriations bill language (now statute)

Sec. 4104. Of the funds appropriated under this chapter, $25,000,000 shall be made available for a coordinated program to prevent and control the spread of the avian influenza virus: Provided, that not less than $15,000,000 of such funds should be transferred to the Centers for Disease Control and Prevention: Provided further, That prior to the obligation of such funds, the Centers for Disease Control and Prevention shall consult with the United States Agency for International Development on the proposed use of such funds: Provided further, That funds made available by this section and transferred to the Centers for Disease Control and Prevention shall be for necessary expenses to carry out Titles III and XXIII of the Public Health Service Act.

House Agriculture Appropriations report language

Avian Influenza.--The Committee provides $22,837,000, the same as the request, for activities relating to the prevention, control, and eradication of Low Pathogenic Avian Influenza (LPAI). Within the total amount, $8,000,000 is for indemnities, $3,000,000 is for surveillance activities, and $5,000,000 is for cooperative agreements with states. Funding is provided for live bird market closure for disinfection, as needed. The Committee is concerned that LPAI, which appears to be endemic in certain live bird markets in urban areas, could mutate into highly pathogenic forms. To prevent this from happening, a robust surveillance and control system in both commercial poultry industries and live bird markets is important. The Committee believes that industry cooperation and program fairness will be maximized through the indemnification of losses.

The Committee notes that the Animal and Plant Health Inspection Service (APHIS) has combated Low Pathogenic Avian Influenza (LPAI) through both depopulation and vaccination, depending on individual circumstances. An emergency vaccination protocol was used most successfully after an outbreak on a farm in Connecticut. The Committee strongly encourages APHIS to utilize funds of the Commodity Credit Corporation or to utilize other authority to compensate producers for vaccination costs and related flock losses previously incurred due to the outbreak in Connecticut and the resulting sequential depopulation and restricted use of a USDA approved and authorized avian influenza vaccine.

House Agriculture Appropriations bill language

SEC. 704. - New obligational authority provided for the following appropriation items in this Act shall remain available until expended: Animal and Plant Health Inspection Service, the contingency fund to meet emergency conditions, information technology infrastructure, fruit fly program, emerging plant pests, boll weevil program, up to $8,000,000 in the low pathogen avian influenza program for indemnities.

Senate Agriculture Appropriations report language

Most experts estimate there will be a lag time of six to nine months before a vaccine can be produced in sufficient quantities to protect individuals against a pandemic strain of influenza to which most people will have no natural immunity. While issues around vaccine manufacturing, distribution, safety and access are complex, the United States and other nations are putting protocols in place now with respect to creating a rapid-response approval process for a pandemic flu vaccine. The Committee encourages the FDA's Center for Biologics Evaluation to continue its efforts in working with potential influenza manufacturers to facilitate the development of influenza vaccines for a pandemic.

CALL FOR NOMINATIONS FOR COLLABORATION ON HEALTH IT -- The Department of Health and Human Services (HHS) is formally calling for nominations for the American Health Information Community (the Community), a public-private collaboration that will help develop standards and achieve interoperability of health information. Secretary Mike Leavitt announced his intent to form the Community on June 6, 2005. The collaboration will provide a forum for public and private interests to recommend specific actions that will accelerate the widespread application and adoption of electronic health records and other health information technology. The draft charter for

the Community, which specifies the purpose and criteria for membership, was posted on the HHS Web site, and the notice of the formation of the Community was published in the Federal Register.

“Our health care system is saturated with inefficiency,” HHS Secretary Mike Leavitt said. “Until we adopt modern information technology practices -- like electronic health records, e-prescribing, and systematic adverse drug event reporting -- we will not have cost-effective medical care in this country, and we will have far too many medical errors. The American Health Information Community will accelerate the development of the standards necessary for the modernization we need.”

The Community will be governed by the Federal Advisory Committee Act and will have up to 17 voting members, including the chairperson. The Secretary of HHS will appoint the members of the Community and serve as chairperson. Members will include officials from HHS and its component agencies, as well as representatives from other appropriate federal agencies, state government and the private sector. Criteria for membership in the Community break down the following way:

Public Sector
Eight members from the federal government and one member from state government will be appointed, including representatives from the following entities:

* Department of Health and Human Services, including the Office of the Secretary, the Centers for Medicare & Medicaid Services, and the Public Health Service
* Department of Veterans Affairs
* Department of Defense
* Department of Commerce
* Department of the Treasury
* Office of Personnel Management
* State leader (e.g., a governor, state CIO, or other state official)

Private Sector
Eight members from the private sector will be appointed. Each representative should be a key decision-maker in his or her industry and should have broad support from peers and related professional organizations. Candidates who have responded to the recent Requests for Proposal on health information technology will need to declare this fact and refrain from certain discussions if selected. Private sector members will be selected from the following stakeholder groups:

* Consumer and Privacy Interests
* Purchasers
* Third-Party Payers
* Hospitals
* Physicians
* Nurses
* Ancillary Services (e.g., laboratories and pharmacists)

* Information Technology Vendors

Members shall serve two-year terms, and those who are not considered full-time federal employees will be paid a daily rate plus per diem. Private sector members who serve as special government employees will be subject to financial disclosure and conflict of interest requirements. Some private sector members may serve as industry representatives and will not be special government employees.

Nominations
To be considered for membership in the Community, please send a one-page letter summarizing your qualifications by Aug. 5, 2005. If you have already sent in a nomination and have received a written response that indicates receipt of your information, then your nomination has already been filed. If you would like to amend a previous submission after reading the charter, please send your amended nomination with the word RESUBMISSION in bold letters on the cover of your letter. Please send all nominations *to only ONE* of the following destinations:

E-MAIL: onchit.request@hhs.gov
FAX: (202) 690-6079
MAIL: ONCHIT c/o Mari Johnson
Department of Health and Human Services
200 Independence Ave, Suite 517D
Washington, D.C. 20201

For questions on the American Health Information Community nomination process, please call this toll free number: 1-866-505-3500.

The Web address for the Community's draft charter is:
www.hhs.gov/healthit/ahiccharter.pdf

CDC RELEASES EXTENSIVE SURVEY OF AMERICANS' EXPOSURE TO ENVIRONMENTAL CHEMICALS -- The *Third National Report on Human Exposure to Environmental Chemicals*, released July 21 by The Centers for Disease Control and Prevention (CDC), shows a significant decline in exposure to secondhand smoke and continued decreases in children's blood lead levels. The report also suggests the need for more research into health effects of exposure to low levels of cadmium.

"This is the most extensive assessment ever of Americans' exposure to environmental chemicals; it shows we're making tremendous progress, and that's good news," said CDC Director Dr. Julie Gerberding. "Exposure to secondhand smoke continues to plummet and blood lead levels in children are way down. However, many challenges remain. CDC is steadfast in its commitment to health protection, including protection from environmental threats."

Exposure to Environmental Tobacco Smoke Decreases

Levels of a chemical called cotinine, which is a marker of exposure to secondhand smoke in nonsmokers, have dropped significantly since levels were first measured from 1988 to 1991. Compared with median levels for 1988-1991, median cotinine levels measured from 1999-2002 have decreased 68 percent in children, 69 percent in adolescents, and about 75 percent in adults. Still, some populations remain at greater risk; the third report shows that non-Hispanic blacks have levels twice as high as those of non-Hispanic whites or Mexican Americans, and children's levels are twice as high as adults' levels.

Children's Blood Lead Levels Continue to Decline

New data on blood lead levels in children aged 1—5 years show that for 1999—2002, 1.6 percent of children aged 1—5 years had elevated blood lead levels (levels of 10 micrograms per deciliter or greater – the CDC blood lead level of concern). This percentage has decreased from 4.4 percent in the early 1990s.

"Lowering blood lead levels in children is one of the major environmental health accomplishments of the past 30 years; however, CDC is still concerned about exposure to lead from lead-based paint and lead-contaminated house dust, soil and consumer products," said Dr. Jim Pirkle, Deputy Director for Science at CDC's Environmental Health Laboratory. "There is no safe blood lead level in children. Children are best protected by controlling or eliminating lead sources before they are exposed."

Exposure to Cadmium Merits Monitoring

Recent studies have shown that urine levels of the metal cadmium as low as 1 microgram per gram of creatinine may be associated with subtle kidney injury and an increased risk for low bone mineral density. The report shows that about 5 percent of the U.S. population aged 20 years and older had urinary cadmium at or near these levels. Cigarette smoking is the likely source for these higher cadmium levels. More research is needed on the public health consequences of these levels in people in this age group.

For this year's report, CDC's Environmental Health Laboratory measured 148 chemicals – 38 of which have never been measured in the U.S. population – or their breakdown products (metabolites) in blood or urine. The samples were collected from approximately 2400 people who participated in CDC's National Health and Nutrition Examination Survey (NHANES) from 1999 -2002. NHANES is an ongoing national health survey of the general U.S. population. The report provides exposure data on the U.S. population by age, sex, and race or ethnicity.

In addition to lead and cadmium, the report includes extensive data for such chemicals as mercury, lead, cadmium, and other metals; phthalates; organochlorine pesticides; organophosphate pesticides; pyrethroid insecticides; herbicides; polycyclic aromatic hydrocarbons; dioxins and furans; polychlorinated biphenyls; and phytoestrogens.

CDC conducts this research to learn more about the effectiveness of public health interventions and better understand the health risks of exposure to chemicals in the

environment. Research separate from the report's findings is needed to determine the relationship between levels of chemicals in the blood or urine and health effects. The results presented in this and future reports will help set priorities for research on human health risks resulting from exposure to environmental chemicals.

The *Third National Report on Human Exposure to Environmental Chemicals* and an executive summary are available online at the following Web site: http://www.cdc.gov/exposurereport.

AHRQ STUDY FINDS WEIGHT-LOSS SURGERIES QUADRUPLED IN FIVE YEARS -- The number of Americans having weight-loss surgery more than quadrupled between 1998 and 2002—from 13,386 to 71,733—with part of the increase driven by a 900 percent rise in operations on patients between the ages of 55 and 64, according to a new study by HHS' Agency for Healthcare Research and Quality. The study was published in the July 12 issue of *Health Affairs*.

During the same period, hospital costs for treating patients who underwent weight-loss surgery increased by more than six times—from $157 million a year to $948 million a year—and the average cost per surgery increased by roughly 13 percent, from $11,705 to $13,215.

To be considered medically eligible for weight-loss surgery, known technically as bariatric surgery, a patient must have a Body Mass Index greater than 40 (or greater than 35 with serious obesity-related complications such as type 2 diabetes or obstructive sleep apnea). Approximately 395,000 Americans between 65 and 69 years of age will be medically eligible to have weight-loss surgery this year, and this number could increase by approximately 20 percent, to 475,000, in 2010, which would have important cost implications for the Medicare program, according to the study authors.

The authors estimate that future demand for weight-loss surgery could rise even more sharply as safety concerns diminish. To date, only a small fraction of people who are medically eligible for weight-loss surgery have actually had the procedure; in 2002, for example, only 0.6 percent of an estimated 11.5 million morbidly obese patients underwent weight-loss surgery. Meanwhile, in-hospital death rates among weight-loss surgery patients as a whole fell by 64 percent—from 0.89 percent to 0.32 percent between 1998 and 2002. In spite of the overall decline, the death rate for men, which dropped from 2.76 percent to 0.79 percent, was still three times higher than the 0.24 death rate for women.

"This study clearly shows another side of the challenge that America's obesity epidemic poses to the Nation's health care system. In the absence of more effective means of preventing obesity, the demand for surgery and its costs will continue to increase," said AHRQ Director Carolyn M. Clancy, M.D. "These findings provide valuable national estimates for the present and future for Medicare, Medicaid and private health plans."

The authors further suggest that future use and costs of prescription weight-loss drugs also could increase significantly. While 63 million Americans were medically eligible for weight-loss drugs in 2002, less than 2.4 percent were prescribed them. The average spending on weight-loss drugs that year was $304 per patient, with health plans paying roughly three-fourths of the expense and patients paying the balance.

According to lead study author William E. Encinosa, Ph.D., newer, more effective drugs now under development to block cravings or appetite will likely increase the demand for prescription weight-loss medications.

The authors based their estimates on data from the Nationwide Inpatient Sample, a database of the Healthcare Cost and Utilization Project sponsored by AHRQ in partnership with data organizations in 37 states. The Nationwide Inpatient Sample is the largest all-payer inpatient care database in the United States from which national estimates of inpatient care can be derived. Data are also from the Medstat 2002 MarketScan Commercial Claims and Encounter Database. The MarketScan database contains claims for inpatient hospital care, outpatient care, and prescription drugs for enrollees under age 65 in employer-sponsored benefit plans for 45 large employers across the United States.

For more findings, see "Use and Costs of Bariatric Surgery and Prescription Weight-Loss Medications," in the July 12 issue of *Health Affairs*.

TEEN BIRTH RATE CONTINUES DECLINE, FEWER CHILDHOOD DEATHS, MORE CHILDREN IMMUNIZED CHILDREN MORE LIKELY TO LIVE IN POVERTY, BE INVOLVED IN VIOLENT CRIME -- The adolescent birth rate has reached another record low, the death rate for children between ages 1 and 4 is the lowest ever, young children are more likely to receive their recommended immunizations, and fourth graders are scoring better in math, according to a yearly compendium of statistics from federal agencies concerned with children.

Children also are more likely to live in poverty, infants are more likely to be of low birthweight, youth are more likely to commit or be a victim of a violent crime, and reading scores of older children have declined slightly.

These findings are described in *America's Children: Key National Indicators of Well-Being 2005*, the U.S. government's 9th annual monitoring report on the well-being of the Nation's children and youth. The report was compiled by the Federal Interagency Forum on Child and Family Statistics and presents a comprehensive look at critical areas of child well-being, including health status, behavior and social environment, economic security, and education.

Health

The report said that the adolescent birth rate for 2003 was 22 for every 1,000 girls ages 15 to 17, down from 23 in 2002. Since 1991, the adolescent birth rate dropped by more

than two-fifths, from 39 births for every 1,000 girls. The decline followed a one-fourth increase in the teen birth rate from 1986 to 1991.

"For the sixth consecutive year, the adolescent birth rate has reached a record low," said Duane Alexander, M.D., Director of the National Institute of Child Health and Human Development of the National Institutes of Health. "We welcome this trend and hope it continues."

Dr. Alexander noted that teen mothers face a number of problems unique to their age. Teen mothers are much less likely to finish high school or to graduate from college than are other girls their age. Infants born to teen mothers are more likely to be of low birthweight, which increases their chances for infant death and for blindness, deafness, mental retardation, mental illness, and cerebral palsy.

Adolescent birth rates varied by racial and ethnic group. The rate for Black, non-Hispanic adolescents dropped by more than half since the 1991 peak of 86 births for every 1,000 girls, to 39 for every 1,000 girls in 2003. The birth rate was at 9 for every 1,000 Asian/Pacific Islanders girls in 2003, 12 for White, non-Hispanics, 30 for American Indians/Alaska Natives, and 50 for Hispanics.

The report's health indicators showed two other strong gains for children as well. The percentage of young children receiving the recommended series of immunizations—the 4:3:1:3 combined series to protect against diphtheria, tetanus and pertussis; polio; measles; and *Haemophilus influenzae* type b (Hib) vaccine—has increased. In 2003, 81 percent of children ages 19-35 months had received the 4:3:1:3 series, up from 78 percent in 2002. Children living below the poverty level were less likely to receive the immunization series (76 percent) than were children above the poverty line (83 percent).

"Immunizations are one of the most important ways to protect our children against serious disease," said Dr. Edward J. Sondik, Director of the National Center for Health Statistics. "We need to continue efforts to monitor immunization rates as an important health indicator."

Another indicator, child mortality, showed that children from ages 1 to 4 years were less likely to die than in recent years. In 2002, there were 31 deaths for every 100,000 children in this age group, down from 33 deaths per 100,000 in 2001. The report noted that death rates for this age group had been declining in the last two decades, dropping by more than half between 1980 and 2002. This decline reflects the drop in injuries—the leading cause of death in children—and, in particular, the drop in these deaths due to motor vehicle crashes.

Dr. Sondik explained that increased use of safety seats and other child restraint systems could greatly reduce early childhood deaths.

The death rate for children from 5 to 14 years of age did not change between 2001 and 2002. However, the death rate for children in this age group, 17 deaths per every 100,000 children, had dropped by approximately 45 percent since 1980.

The percentage of infants born at low birthweight increased, from 7.8 in 2002, to 7.9 in 2003. The report stated that the percentage of low birthweight infants has increased slowly and steadily since 1984, when it was 6.7 percent. Low birthweight infants are those weighing less than 2,500 grams, or 5 lb. 8 oz. Low birthweight results from an infant's being born preterm (less than 37 weeks) or from being small for his or her gestational age.

The report attributes part of the increase to a rise in the number of twin and other multiple pregnancies, because multiples are more likely than singletons to be born prematurely. The report added, however, that low birthweight had also increased among singletons. Changes in obstetric practices have also contributed to the rise in low birthweight and preterm delivery, particularly the increased rates of Cesarean delivery and induced labor. Both procedures may be undertaken preterm, because the fetus is in distress.

This year's report also includes special features related to health. The first special feature, on asthma, points out that at some point in their lives, about 13 percent of children had been diagnosed with asthma. In 2003 about 9 percent of children were reported to currently have asthma and two-thirds of these children had one or more asthma attacks in the previous 12 months. In some cases, asthma can seriously limit a child's activities, cause visits to hospitals and emergency rooms, and even result in death.

Another special feature, on lead in the blood of children, reported that, in 1999-2002, about 2 percent of children from ages 1 to 5 had elevated blood lead levels (greater than or equal to 10 micrograms per deciliter). This figure decreased substantially from 1976-1980 when 88 percent of children had elevated blood lead levels.

Behavior and Social Environment

The percentage of eighth graders who had used any illicit drugs in the past 30 days declined, from 10 percent in 2003 to 8 percent in 2004. The report noted that rates for illicit drug use in the past 30 days for tenth and twelfth graders had not changed during the same time period.

The rate at which youths were victims of serious violent crimes went up, from 10 per 1,000 youth ages 12 to 17 in 2002, to 18 per 1,000 in 2003. However, this rate was lower than the peak of 44 victims per 1,000 youth in 1993. The report noted that the rate of serious violent crime against youth decreased by 60 percent from 1993 to 2003.

In 2003, males were more likely to be victims of serious violent crime than were females, with 25 males per 1,000 male youth, compared with 10 females for every 1,000 female youth.

The rate at which youth committed serious violent crimes also increased, from 11 youth offenders of serious violent crimes per 1,000 youth ages 12 to 17 in 2002 to 15 per 1,000 in 2003. Although the 2003 rate is higher than the 2002 rate, the 2003 rate is 71 percent lower than the 1993 peak of 52 violent crimes committed per 1,000 youth.

Economic Security

The percentage of all children ages 0 to 17 living below the poverty threshold was 18 percent in 2003, up from 17 percent in 2002. According to the report, in 2003, the official poverty threshold for a family of four was an annual income of $18,810. The percentage of children living in households below the poverty threshold has fluctuated since the 1980s, reaching a high of 23 percent in 1993, and dropping to 16 percent in 2000. The poverty rate was higher for Black-alone children (34 percent) and Hispanic children (30 percent) than for White-alone, non-Hispanic children (10 percent).

About 13 million children (18 percent) lived in households that were classified as food insecure by the USDA in 2003, unchanged from 2002. Households are classified as food insecure based on survey reports of difficulty obtaining enough food, reduced diet quality, and anxiety about the household's food supply. Eighteen percent of children lived in food-insecure households, and 0.6 percent of children lived in households classified as food-insecure with hunger among children and adults.

In 2003, 89 percent of children had health insurance coverage at some point during the year. The report noted that the number of children who had no health insurance coverage at any time during 2003 was estimated to be 8.4 million (11 percent of all children), which was unchanged from 2002.

Education

The average mathematics score increased for fourth graders, from 226 in 2000 to 235 in 2003, on the National Assessment of Educational Progress, the Nation's Report Card on elementary and secondary school performance. Similarly, the average mathematics score for eighth graders rose from 273 to 278 over the same period. In 2003, the percentages of fourth and eighth graders scoring at or above the Proficient achievement level in math were higher than in all previous assessments. Twelfth-graders were not tested in reading or mathematics in 2003, but twelfth grade mathematics scores had not changed significantly from 1996 to 2000.

The average reading score for fourth graders did not change from 1992 to 2003. Eighth graders' reading score changed only from 264 in 2002 to 263 in 2003; the 2003 score was higher than in 1992. The reading score of twelfth graders was lower in 2002 than in 1992 or 1998.

Girls had higher reading scores than did boys in grades 4 and 8 in 2003 and in grade 12 in 2002. However, boys had higher math scores than did girls in grades 4 and 8 in 2003, and in grade 12 in 2000.

In 2003, 87 percent of young adults ages 18-24 had completed high school with a diploma or an alternative credential, such as a General Education Development certificate. The high school completion rate has increased slightly since 1980, when it was 84 percent.

The proportion of Black-alone, non-Hispanic youth (ages 16 to 19) who were neither in school nor working was 10 percent in 2004, down from 12 percent in 2003. More Black-alone, non-Hispanic youth moved from the category "not enrolled in school and not working" into the category of "enrolled in school and not working" in 2004. The report categorizes people who responded to a question on race by indicating only one race as a "race-alone" population. For example, those who indicated their race as only "Black" and no other race are referred to as "Black-alone."

Population and Family Characteristics

The number of children under age 18 living in America increased, from 72.8 million in 2002 to 73.0 million in 2003. Children have decreased as a proportion of the population, from a peak of 36 percent in 1964, to 25 percent in 2003.

The report noted that the racial and ethnic diversity of the nation's children has increased over time. In 2003, 60 percent of American children were White-alone, non-Hispanic, 16 percent were Black-alone, and 4 percent were Asian-alone. From 2002 to 2003, the percentage of children who were Hispanic increased from 18 percent to 19 percent. The percentage of children who are Hispanic has increased faster than that of any other racial and ethnic group, from 9 percent of the child population in 1980, to 19 percent in 2003.

In 2004, 20.3 percent of American children lived with at least one foreign-born parent, up from 19.6 percent in 2002. The report stated that the foreign-born population has grown since 1970, and that this increase has largely been from Latin America and Asia.

The proportion of births to unmarried women also increased, from 34 percent in 2002 to 35 percent in 2003. The sharpest increase in the proportion of births to unmarried women occurred between 1980, when 18 percent of all births were to unmarried women, and 1994, when births to unmarried women reached 33 percent.

Accompanying backgrounders describe an additional special feature, on parental reports of emotional and behavioral difficulties, and a special section on family structure and children's well-being.

As in previous years, not all statistics are collected on an annual basis and, for this reason, some data in the report may be unchanged from last year's brief.

The 2005 *America's Children* report appears in its full-length version. The Forum publishes a condensed version of the report in alternate years.

Members of the public may access the report at http://childstats.gov. While supplies last, members of the public also may obtain printed copies from the Health Resources and Services Administration, Information Center, P.O. Box 2910, Merrifield, VA 22116, by calling 1-888-Ask-HRSA (1-888-275-4772), or by e-mailing ask@hrsa.gov