THE CSTE WASHINGTON REPORT

Marcia S. Mabee, MPH, PhD
Editor
11479 Waterview
Reston, Virginia 20190
mmabee@ix.netcom.com
703-709-3001

November 3, 2005 Volume 9, Number 21

INSIDE THIS ISSUE

… SENATE FINSHES LABOR-HHS-APPROPRIATIONS

… PANDEMIC FLU UPDATE

… HHS BUYS ADDITIONAL VACCINE AS PREPARATIONS FOR POTENTIAL INFLUENZA PANDEMIC CONTINUE

…NUMBER OF AMERICANS WITH DIABETES CONTINUES TO INCREASE

… HEART ATTACK DEATH RATES FOUND HIGHER FOR ALL PATIENTS IN HOSPITALS TREATING LARGER SHARE OF AFRICAN AMERICANS

EDITOR'S NOTE: Diabetes now affects nearly 21 million Americans – or 7 percent of the U.S. population – and more than 6 million of those people do not know they have diabetes, according to the latest prevalence data released today by the Centers for Disease Control and Prevention (CDC). This number represents an additional 2.6 million people with diabetes since 2002. Another 41 million people are estimated to have pre-diabetes, a condition that increases the risk of developing type 2 diabetes – the most common form of the disease – as well as heart disease and stroke. "Diabetes is a leading cause of adult blindness, lower-limb amputation, kidney disease and nerve damage. Two-thirds of people with diabetes die from a heart attack or stroke," said Dr. Frank Vinicor, director of CDC's diabetes program. -- 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

SENATE FINSHES LABOR-HHS-APPROPRIATIONS – The Senate finished work on its FY 2006 Labor-HHS-Education Appropriations bill last week. While several amendments were adopted, chief among them an amendment offered by Sen. Tom Harkin (D-IA) to provide $7.9 billion in emergency funding for pandemic flu preparedness, there are no changes from the July 14th Committee-passed bill for CDC programs or NIH. A conference to resolve differences between funding levels provided in the respective House and Senate bills will convene next week and expects to conclude deliberations by November 14th. This is the first time in several years that there has been a formal conferencing of the Labor-HHS-Education Appropriations bill. Usually the bill languishes and must be wrapped into an omnibus measure. While the Senate bill has a slightly lower discretionary spending allocation than the House bill ($141.7 billion v. $142.5 billion). Both are slightly lower than the FY 2005 level. However, the Senate bill includes a budget maneuver that frees up nearly $3 billion of spending by forward funding a mandatory spending program by 24 hours into the next Fiscal Year. Most of the freed up money is used for education spending in the bill, but it also supports a $1 billion increase (3.7 percent) for NIH. Last year the House, with strong Administration support, rejected the same maneuver in the omnibus bill. Rejection again could imperil health programs. In addition, House fiscal conservatives are pushing for across-the-board cuts in all discretionary spending to pay for hurricane disaster spending. Appropriators are currently balking at including defense spending in those cuts which may cause a heavier blow to fall on remaining domestic programs.

CSTE sent a letter to conferees in September urging adoption of the higher Senate or House numbers for priority programs and restoration of FY 2005 funding for the Preventive Health-Health Services Block Grant. Both House and Senate bills provide $100 million for the PHHS Block Grant which is $31 million below the FY 2005 level. The principal difference in funding between the House and Senate bills is the State and Local Terrorism Preparedness Grant program. The House cuts funding by $67 million (7 percent), the Senate by $130 million (14 percent).

PANDEMIC FLU UPDATE – The Bush Administration released its updated pandemic flu plan yesterday, November 2nd. The Administration has set up a new website specific to pandemic flu acitvities: http://www.pandemicflu.gov/ Accompanying the plan was a budget amendment providing $7.1 billion in emergency spending that does not require budget cuts (or tax increases) to offset the amount. Of the total, $6.7 billion is provided to the Department of Health and Human Services, with about $600 million of that committed for state and local preparedness. However, because the plan requires state and local health departments that wish to stockpile Tamiflu, or other antivirals, to pay 75 percent of the costs of doing so, only $100 million of the $600 million is available for state and local planning and infrastructure support. This amount does not restore the President's FY 2006 proposed cut to CDC State and Local Terrorism Preparedness grants of $130 million. As noted in the appropriations update above, the Senate FY 2006 Labor-HHS-Education Appropriations bill concurs with the President's budget, while the House reduces the proposed cut by one-half.

Yesterday, Congress held hearings on the Administration's Pandemic Flu Plan. During a Senate Labor-HHS-Education Appropriations Subcommittee hearing, several Senators expressed disappointment with aspects of the plan, with Sen. Tom Harkin (D-IA) stating

that he did not feel the plan did enough to support the preparedness needs of state and local health departments. His successful amendment to the FY 2006 Senate Labor-HHS-Education Appropriations bill (H.R. 3010) provided the following amounts for pandemic flu preparedness: $3.3 billion for vaccine development; $3.1 billion to stockpile antiviral drugs, such as Tamiflu; $600 million for state and local public health agencies; $750 million to manage a possible patient surge at hospitals in the event of a pandemic; $185 million for the Centers for Disease Control and Prevention to boost surveillance and detection; and $60 million for global surveillance efforts. Consideration of Harkin's amendment to H.R. 3010 would likely supercede a successful amendment earlier this month to the FY 2006 Department of Defense Appropriations bill. That amendment provides $3.9 billion for pandemic flu preparedness, including $600 million for state and local public health agencies. But the Harkin H.R. 3010 amendment must be negotiated in conference with the House appropriators who tend to follow the Administration's wishes. Fiscal conservatives in the House are also expressing their interest in having the emergency spending designation removed from proposed pandemic flu spending and are requesting that spending be fully offset with budget cuts in other program areas.

HHS BUYS ADDITIONAL VACCINE AS PREPARATIONS FOR POTENTIAL INFLUENZA PANDEMIC CONTINUE -- HHS Secretary Mike Leavitt October 27 announced the purchase of additional vaccine that could be used in the event of a potential influenza pandemic.

The department has awarded a $62.5 million contract to Chiron Corporation to manufacture an avian influenza vaccine designed to protect against the H5N1 influenza virus strain, which has caused an epidemic of avian flu in Asia and has recently spread to Europe. The number of individuals who could be protected by the newly contracted vaccine is still to be determined by ongoing clinical studies.

"An influenza vaccine effective against the H5N1 virus is our best hope of protecting the American people from a virus for which they have no immunity," Secretary Leavitt said. "This contract will increase our stockpile of the vaccine and is a continuation of our aggressive multi-pronged approach to a potentially critical public health challenge."

This purchase builds on the department's current plans to buy enough H5N1 influenza vaccine for 20 million people and enough influenza antivirals for another 20 million people. These supplies of vaccine and antiviral treatment will be placed in the nation's Strategic National Stockpile where they will be available for use should an influenza pandemic occur. Last month, HHS awarded a $100 million contract to sanofi pasteur, the vaccines business of the sanofi-aventis Group, for avian flu vaccine.

Developing an effective avian influenza vaccine is a key element of a comprehensive U.S. approach to prepare for an influenza pandemic that includes improved vaccine production methods and stockpiling of antivirals.

Earlier this year, Secretary Leavitt established an HHS-wide Influenza Task Force to coordinate all HHS activities affecting the public health preparedness for seasonal

influenza outbreaks and an influenza pandemic. Long-term objectives include an effective and efficient global surveillance network for outbreaks of influenza-like illness in humans and animals, and interoperable local, state, and federal government response plans for influenza outbreaks within the United States. The task force is also developing strategies to effectively coordinate with response partners, both public and private and insure timely communication with the public.

NUMBER OF AMERICANS WITH DIABETES CONTINUES TO INCREASE -- Diabetes now affects nearly 21 million Americans – or 7 percent of the U.S. population – and more than 6 million of those people do not know they have diabetes, according to the latest prevalence data released today by the Centers for Disease Control and Prevention (CDC). This number represents an additional 2.6 million people with diabetes since 2002. Another 41 million people are estimated to have pre-diabetes, a condition that increases the risk of developing type 2 diabetes – the most common form of the disease – as well as heart disease and stroke.

“Diabetes is a leading cause of adult blindness, lower-limb amputation, kidney disease and nerve damage. Two-thirds of people with diabetes die from a heart attack or stroke,” said Dr. Frank Vinicor, director of CDC’s diabetes program.

Highlights of the fact sheet:

* Diabetes continues to be the sixth leading cause of death in the United States.

* In 2005, 1.5 million people aged 20 years or older will be newly diagnosed with diabetes.

* Compared to non-Hispanic whites, diabetes continues to be more common (1.7 to 2.2 times more common) among American Indians and Alaska Natives, non-Hispanic blacks, Hispanic/Latino Americans, and Asian Americans and Pacific Islanders.

* The risk of diabetes increases with age. About 21 percent of Americans aged 60 years or older have diabetes. This compares to approximately 2 percent for people 20 to 39 years old and about 10 percent for those aged 40-59 years.

* The United States spends approximately $132 billion each year on diabetes – $92 billion in direct medical costs and another $40 billion each year in indirect costs because of missed work days or other losses in productivity.

The 2005 National Diabetes Fact Sheet – a report that summarizes the latest estimates of Americans with both diagnosed and undiagnosed diabetes – is being issued to coincide with National Diabetes Month in November. The fact sheet is a collaborative effort involving CDC and the National Diabetes Education Program and other organizations in the U.S. Department of Health and Human Services, including the Agency for Health Research and Quality, the Centers for Medicare and Medicaid Services, the Health Resources and Services Administration, the Indian Health Service, the National Institute

of Diabetes and Digestive and Kidney Diseases and the Office of Minority Health. The American Diabetes Association, the American Association of Diabetes Educators, Juvenile Diabetes Research Foundation International, and U.S. Department of Veterans Affairs are also partners in the National Diabetes Fact Sheet.

The data in the updated 2005 National Diabetes Fact Sheet will help national, state, and local health officials understand the health and economic burden of diabetes and better direct efforts to reach populations hardest hit by the disease.

"Recent studies have shown that people with pre-diabetes can successfully prevent or delay the onset of diabetes by losing 5 percent to 7 percent of their body weight. This can be accomplished through 30 minutes or more of physical activity most days of the week and by following a low calorie, low fat eating plan, including a diet rich in whole grains and fruits and vegetables," Dr. Vinicor said.

The 2005 National Diabetes Fact Sheet is available at www.cdc.gov/diabetes.

HEART ATTACK DEATH RATES FOUND HIGHER FOR ALL PATIENTS IN HOSPITALS TREATING LARGER SHARE OF AFRICAN AMERICANS -- Ninety days after acute myocardial infarction (AMI) — or heart attack — death rates for African Americans and white patients were found to be significantly higher in hospitals that disproportionately serve African-American patients than in hospitals that serve mainly white patients, according to a major new study led by researchers at Dartmouth Medical School. The researchers suggest that quality of care, more than racial differences per se, determines AMI outcomes.

Based on the study findings, the investigators assert that targeted quality improvements at hospitals serving large shares of African Americans could enhance AMI care for all patients in those hospitals as well as potentially reduce black-white differences in AMI outcomes overall.

The analysis, published in the October 25, 2005, edition of *Circulation: Journal of the American Heart Association*, is one of the first to look at the association between the racial composition of a hospital's patients and health outcomes. The study was funded in part by the National Institute on Aging (NIA), a component of the National Institutes of Health, U.S. Department of Health and Human Services. Additional funding was provided by the Robert Wood Johnson Foundation.

"We know that disparities exist in the health and health care of African Americans and whites," explains Richard Suzman, Ph.D., Associate Director of the NIA for Behavioral and Social Research. "Some researchers focus on doctor-patient interactions as the major factor, while others give more weight to hospital quality. Potential remedies are quite different, depending on which set of factors predominates. This study sheds light on the mechanisms that may be at work in the case of hospital care and heart attacks."

Led by Jonathan Skinner, Ph.D., of Dartmouth Medical School, the research team analyzed the records of nearly all fee-for-service Medicare patients who were treated for AMI at U.S. hospitals between January 1, 1997, and September 30, 2001. More than 1.13 million older adults treated at 4,289 non-Federal hospitals were included in the study.

“Our research is consistent with the view that African Americans tend to go to hospitals where everyone gets lower quality care,” Dr. Skinner says. “Targeting quality improvements for all patients at hospitals that disproportionately serve African Americans can improve overall survival, but also deliver an extra dividend by helping to shrink health disparities at the national level.”

Skinner and colleagues classified hospitals that treated Medicare beneficiaries with AMI into 10 groups, depending on the extent to which they served African Americans. The 10 hospital groups ranged from those that admitted no African-American AMI patients to those where more than one-third (33.6 percent) of AMI patients were African American.

After adjusting for age, race, sex, and concurrent health problems such as diabetes, the risk-adjusted 90-day mortality after AMI was 20.1 percent in hospitals serving no African Americans and 23.7 percent in hospitals with the greatest share of black AMI patients — a 19 percent higher rate. Heart attack patients treated at largely minority-serving hospitals were not sicker and did not have more severe heart attacks than patients at other hospitals, the study showed. In fact, the data show that AMI patients treated in hospitals with no African-American AMI patients were the sickest, as measured by an index of comorbidities, but had the lowest risk-adjusted mortality rates.

The differences in risk-adjusted hospital mortality outcomes also were not explained by patients’ income, type of hospital ownership, the hospitals’ annual AMI patient volume, region of the country, or urban status.

“We suspected that these differences could have been caused by the higher rates of poverty among the elderly African-American population, but this was not the case,” Skinner notes. Moreover, he notes, the differences could not be attributed to the likelihood of the hospital providing certain post-AMI surgical interventions, such as coronary artery bypass grafting.

The researchers point out that in this study, 21 percent of the hospitals treated 69 percent of the elderly African-American AMI patients. The average Medicare AMI patient was treated in a hospital where 6.9 percent of AMI patients were African American. Relative to the hospital where the average AMI patient was treated, hospitals that disproportionately treated African Americans were more likely to be teaching facilities, more likely to be government-run (non-Federal), and less likely to be not-for-profit.

The researchers further suggest that, because many African-American Medicare beneficiaries live in urban areas with more than one hospital, disparities might be reduced by directing patients toward hospitals known to provide high-quality care.