



U.S. Commission on Civil Rights

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Bioterrorism and Health Care Disparities

March 8, 2002

This briefing paper was prepared by the Commission's Office of Civil Rights Evaluation for the information of the Commissioners. The findings and recommendations are those of the staff.

The recent cases of anthrax contamination have raised numerous questions regarding the nation's health care system, especially as it relates to the prompt emergency medical treatment of hundreds or perhaps thousands of individuals. Of special concern to the U.S. Commission on Civil Rights is equitable treatment for all groups regardless of socioeconomic status, English-language proficiency, ethnicity, or race.¹[1]

With this review, the Commission's interest, focusing on the rights of protected classes, is that all Americans receive medical treatment that is equally prompt, sufficient, and systematic in the event of a biological attack on the United States. The U.S. Commission on Civil Rights has long been concerned with health care disparities, and recent events serve to make the urgency of the problem more stark. The following discussion incorporates some of the Commission's main concerns.

1. How is the federal government making sure that all Americans are served fairly and equitably by the health care system and receive medication and treatment without class distinction?

[1] The U.S. Commission on Civil Rights is an independent, bipartisan fact-finding federal agency established in 1957 to monitor and report on the status of civil rights in the nation. As the nation's conscience on matters of civil rights, the Commission strives to keep the President, the Congress, and the public informed about civil rights issues that deserve concentrated attention. In so doing, it continually reminds all Americans why vigorous civil rights enforcement is in the national interest.

In testimony before Congress in May 2001, Assistant Secretary for Health and Surgeon General Dr. David Satcher stated that “disparities in the burden of illness and death” continue to exist for African Americans, Hispanics, American Indians, Alaska Natives, and Asian Pacific Islanders when compared with the U.S. population as a whole. According to Dr. Satcher, the infant mortality rate for African Americans is more than double that of white citizens. The rate of death due to heart disease is 40 percent higher for African Americans than for whites, while for all cancers it is 30 percent higher. Lastly, the death rate among African Americans due to HIV/AIDS is more than seven times that for whites, just slightly higher than the homicide rate of six times. Mortality rates for other minorities mirror these disturbing trends.²[2]

A report by the Institute of Medicine (IOM) argues that “[d]espite the nation’s vast riches and enormous resources, certain populations continue to fall outside the medical and economic mainstream and have little or no access to stable health care coverage.”³[3] “These populations include the more than 44 million people without health care coverage (an increase of 11 million over the past decade), low-income underinsured individuals, Medicaid beneficiaries, and patients with special health care needs who rely on safety net providers for their care. . . . New studies forecast that, absent major reform, the number of uninsured will continue to grow substantially.”⁴[4]

A second report by IOM found that racial and ethnic minorities in the United States frequently receive lower quality health care than nonwhites. Although other studies have shown that lack of health insurance and lower income levels contribute to disparate treatment, this study demonstrates that racial and ethnic minorities receive less care despite having equivalent insurance and income. The report establishes that these disparities have historically existed and continue to exist. Factors that may contribute to unequal treatment are stereotyping, biases, and “uncertainty on the part of health care providers.” In the last instance, a health care provider is not culturally knowledgeable about what a patient may find acceptable in that social encounter. Also possibly contributing to inadequate health care for minorities are the “conditions in which many clinical encounters take place.” Contemporary clinical encounters are “characterized by high time pressure, cognitive complexity and pressures for cost-containment,” according

[2] U.S. Department of Health and Human Services, “Testimony of David Satcher, Assistant Secretary of Health and Surgeon General, U.S. Public Health Service, U.S. Department of Health and Human Services, Before the House Commerce Committee, Subcommittee on Health and Environment, May 11, 2000,” <<http://www.hhs.gov/as1/testify/t000511a.html>> (Feb. 28, 2002).

[3] Marion Ein Levin and Stuart Altman, eds., “America’s Health Care Safety Net: Intact but Endangered,” 2000, <<http://books.nap.edu/books/030906497X/html1.html/#pagetop>> (Nov. 29, 2001).

[4] U.S. Commission on Civil Rights, “Bioterrorism and Civil Rights,” briefing paper for submission to the commissioners, draft, November 2001, p. 2 (hereafter cited as USCCR, “Bioterrorism and Civil Rights”).

to the study. These factors and numerous others create an environment designed to provide disparate treatment.⁵[5]

Proposals by the federal government to eradicate disparate health care include the Department of Health and Human Services' (HHS) coordinated effort to eliminate gaps in six areas contributing to this disparity by the year 2010. The six areas identified by HHS are diabetes, HIV/AIDS, infant mortality, immunizations, cancer screening and management, and cardiovascular disease. To reach this goal, HHS in its 2001 budget included \$5.5 billion in subsidies for measures that focus on improving the health of minorities, a net increase of \$720 million from the previous fiscal year.⁶[6] Another stated initiative of the federal government is to improve the health care infrastructure and remove obstacles preventing minority populations from accessing health care. A third initiative is Healthy People 2010, a program promoting wellness and disease prevention on a national scale, which includes a primary goal of eliminating health disparities.⁷[7] Additionally, in December 2000, culturally and linguistically based discrepancies in health care were addressed by HHS' Office of Minority Health via the publication of recommended national service standards on these issues.⁸[8]

Despite the very real threat of biological attack on the United States, HHS has not established which population groups will be the first to be treated when supplies are limited.⁹[9] However, the General Accounting Office (GAO) does not believe that individuals lacking health insurance will be denied treatment if a biological attack occurs. The critical determinants for providing treatment will be whether an individual has been exposed to a biological contaminant. Furthermore, the needed drugs will be provided

[5] Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, eds., "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," 2002, <<http://www.nap.edu/books/030908265X/html>> (March 22, 2002), pp. 1-2.

[6] U.S. Department of Health and Human Services, "HHS Reshaping the Health of Minority Communities and Underserved Populations," fact sheet, Jan. 18, 2001, <<http://www.hhs.gov/press/2001press/01fsminhlth.html>> (Nov. 26, 2001) (hereafter cited as HHS, "Reshaping Minority Health").

[7] U.S. Department of Health and Human Services, "Testimony on Health Disparities: Bridging the Gap by Ruth L. Kirschstein, M.D., Acting Director, National Institutes of Health, U.S. Department of Health and Human Services, Before the Senate Subcommittee on Public Health Committee on Health, Education, Labor and Pensions, July 26, 2001," <<http://www.hhs.gov/asl/testify/t000726b.html>> (Nov. 26, 2001).

[8] HHS, "Reshaping Minority Health."

[9] U.S. General Accounting Office, "Bioterrorism: The Centers for Disease Control and Prevention's Role in Public Health Protection," Testimony Before the Committee on Energy and Commerce, House of Representatives, Nov. 15, 2001, <<http://www.gao.gov>> (Nov. 19, 2001), p. 15 (hereafter cited as GAO, "Bioterrorism and CDC's Role").

from a national pharmaceutical stockpile maintained by the federal government and not via normal health insurance coverage.¹⁰[10]

2. How is the federal government making sure that there is access to public health care in rural or underserved urban areas?

A 1999 study by the U.S. Commission on Civil Rights reported that “[r]acial and ethnic minorities are more likely than whites to live in areas [whether rural or urban] that are medically underserved.”¹¹[11] This study further stated that disparate treatment in the health care system could be viewed in “the adverse effects of hospital closures and relocations to suburban communities on the minority population.”¹²[12]

A report by the Urban Institute states that numerous proposals over the last several years have argued for a “limited service” model for rural hospitals. That is, rural hospitals will play a complimentary role to urban ones by limiting the services they provide. The various problems created by the limited service model include an increase in the percentage of uninsured or publicly insured patients for rural hospitals as wealthier, insured individuals seek medical attention in urban hospitals providing more thorough service. The report also establishes that rural hospitals treat a larger number of underinsured patients, because rural areas typically include more self-employed, thus self-insured, individuals (e.g., farmers). Finally, the institute reports that, like the uninsured who live in urban areas, the rural uninsured seek medical attention at “community health centers, hospital emergency rooms, local health departments, and private providers.” However, since rural areas typically have fewer health care providers than urban areas, “the safety net in rural areas generally includes almost all providers in the community; that is, the health care infrastructure in a rural community is the safety net.”¹³[13]

The federal government has undertaken several efforts to improve health care for underserved populations. For example, HHS’ State Office of Rural Health program is providing matching grants to the state health offices of all 50 states for the treatment of rural populations. Its Rural Outreach and Network Development programs “help rural

[10] Janet Heinrich, Deborah Miller, and Marcia Crosse, interview in Washington, D.C., Nov. 28, 2001 (hereafter cited as GAO Interview).

[11] USCCR, “Bioterrorism and Civil Rights,” p. 1; U.S. Commission on Civil Rights, *The Health Care Challenge: Acknowledging Disparity, Confronting Discrimination, and Ensuring Equality, vol. I: The Role of Government and Private Health Care Programs and Initiatives*, September 1999, p. 3 (hereafter cited as USCCR, *Health Care*, vol. I).

[12] U.S. Commission on Civil Rights, *The Health Care Challenge: Acknowledging Disparity, Confronting Discrimination, and Ensuring Equality, vol. II: The Role of Federal Civil Rights Enforcement Efforts*, September 1999, p. 6.

[13] The Urban Institute, “Supporting the Rural Health Care Safety Net,” *Occasional Paper Number 36*, March 2000, <<http://newfederalism.urban.org/pdf/occa36.pdf>> (Nov. 26, 2001), pp. 2–5.

communities find innovative ways to stretch and coordinate their scarce health care dollars.” HHS also supports five rural health research centers around the country. Additionally, HHS is conducting numerous other programs that bring services to rural areas, such as Community Health Centers.¹⁴[14]

Regarding Native Americans, many of whom live on reservations in rural areas, HHS received a \$214 million increase for the Indian Health Service (IHS) in fiscal 2001, thus increasing IHS’ budget to \$2.6 billion. The increase was allocated for “more comprehensive clinical and environmental health activities, stronger injury prevention programs, increased mental health and more opportunities for Native Americans to visit doctors and dentists.”¹⁵[15]

For minority populations, both in rural and urban settings, HHS’ National Cancer Institute (NCI), for example, spent nearly \$125 million on minority research programs addressing cancer in 1997. However, the Institute of Medicine found a lack of strategic planning at NCI, thus calling into question the effectiveness of its programs.¹⁶[16]

Lastly, the National Association of Counties (NACo) conducted a nationwide survey of counties with “functioning county level governments” to determine their ability to respond to emergency situations.¹⁷[17] Of the 3,066 counties that fit this definition, approximately 34 percent provided a response. The percentage of respondents was highest (28 percent) among counties with between 10 and 24,999 residents, while lowest (2 percent) among those with 500,000 or more residents. Naturally, counties with 500,000-plus residents are fewer in number to begin with.

The survey results paint a bleak scenario, as less than 10 percent of respondents stated they were “fully prepared” to respond to a biological attack. Even worse, less than 5 percent were confident they could adequately respond to a chemical attack.¹⁸[18]

[14] U.S. Department of Health and Human Services, “Testimony on Effects of Public Financing on Public Health Care Infrastructure by Wayne Myers, M.D., Director Office of Rural Health Policies, Health Resources and Services Administration, U.S. Department of Health and Human Services, Before the Senate Subcommittee on Public Health, Field Hearing in Wichita, KS, July 7, 1999,” <<http://www.hhs.gov/asl/testify/t990707b.html>> (Nov. 27, 2001).

[15] HHS, “Reshaping Minority Health.”

[16] U.S. Department of Health and Human Services, “Testimony on the Unequal Burden of Cancer: NCI Response to a Report by the Institute of Medicine by Richard D. Klausner, M.D., Director, National Cancer Institute, U.S. Department of Health and Human Services, Before the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies, Jan. 21, 1999,” <<http://www.hhs.gov/asl/testify/t990707b.html>> (Nov. 27, 2001).

[17] National Association of Counties, “Counties Secure America: A Survey of Emergency Preparedness of the Nation’s Counties,” October 2001, <<http://www.naco.org/programs/homesecurity/emerpprep.pdf>> (Jan. 30, 2002) (hereafter cited as NACo, “Counties Secure America”).

[18] Beverly Schlotterbeck, “Gonzalez Unveils NACo Homeland Security Plan,” *County News Online*, Jan. 28, 2002, <<http://www.naco.org/pubs/cnews/current/Articles/Gonzalez.html>> (Jan. 30, 2002).

Furthermore, although 94 percent of respondents have plans for dealing with natural disasters, only 49 percent have plans addressing possible terrorist activities. As may be expected, 80 percent of counties with one million or more residents have instituted plans to deal with a chemical attack, while only 22 percent of counties with fewer than 10,000 inhabitants, typically in the most rural areas of the country, have plans to deal with all possible terrorist activities. It must be noted that the 80 percent arrived at for counties with a million or more inhabitants is solely applicable to a chemical attack; no data are available concerning a biological attack, and the percentage of those “fully prepared” for either possibility is nominal. Finally, 21 percent of respondents have no preparations for a biological attack, while 43 percent have no response plans for a chemical attack.¹⁹[19]

As is evident, the nation’s counties are not prepared to adequately, if at all, respond to biological or chemical attacks. NACo has sought the aid of Congress and the Bush administration in drastically improving this situation.²⁰[20]

3. After the anthrax attacks in 2001, officials seemed to advise members of the public to call their private doctors. What should an American do if he or she doesn’t have a regular doctor or health insurance?

Examining the number of minority individuals lacking health insurance in the United States, a national study found that roughly 11 percent of non-Hispanic whites were uninsured in 1999, compared with 33 percent of Hispanics and 21 percent of African Americans. Additionally, compared with 10 years ago fewer African American and Latino working adults are provided health insurance by their employers.²¹[21] As noted by a Commission researcher, “[t]he nation’s health care safety net has, by default, cared for many of the uninsured.” However, as the number of uninsured grows, this safety net is being strained beyond endurance.²²[22]

In the event of a mass anthrax attack, the federal government, through the efforts of HHS, will respond by providing “appropriate antibiotics from its stockpile to wherever they are needed.” Furthermore, the government advises against asking one’s doctor in advance for antibiotics, because these will be made available by the government when needed.²³[23] Reiterating this point, the GAO states that the needed drugs will be provided from a national pharmaceutical stockpile provided by the federal government and not via normal

[19] Bill Miller, “Survey Finds Counties Unready for Bioterrorism,” *Washington Post*, Jan. 29, 2002, p. A2.

[20] Schlotterbeck, “Gonzalez Unveils NACo Homeland Security Plan.”

[21] Kate N. Grossman, “Health Disparities Rooted in Poverty,” *Chicago Sun-Times*, Nov. 11, 2001, p. 15.

[22] USCCR, “Bioterrorism and Civil Rights,” p. 2.

[23] U.S. Department of Health and Human Services, “Questions and Answers About Anthrax Prevention and Treatment,” *HHS News*, Oct. 10, 2001, <<http://www.hhs.gov/news/press/2001/pres/20011010a.html>> (Nov. 27, 2001).

health insurance coverage. Additionally, the Centers for Disease Control and Prevention's (CDC) policy is to vaccinate only those individuals who have been exposed to a contaminant, not the universal populace, regardless of the quantity of vaccine available, according to the GAO.²⁴[24] One HHS official states that HHS' policy of selective vaccination may change once enough vaccine becomes available.²⁵[25]

Lastly, the distribution of pharmaceuticals and treatment of affected individuals is, apparently, a multilevel process including the federal, state, and local governments. At the federal level, HHS' Office of Emergency Preparedness (OEP) is developing the Metropolitan Medical Response Systems (MMRS). MMRS encompasses public contractual relationships permitting the use of "existing emergency response systems emergency management, medical and mental health providers, public health departments, law enforcement, fire departments, EMS and the National Guard to provide a unified response to a mass casualty event." To date, OEP has contractual agreements to develop MMRS with 97 municipalities. Furthering its distribution and treatment abilities,

OEP also coordinates the National Disaster Medical System (NDMS), a group of more than 7,000 volunteer health and support professionals who can be deployed anywhere in the country to assist communities in which local response systems are overwhelmed or incapacitated.

In the event of a biological attack, 44 Disaster Medical Assistance Teams (DMATs) consisting of these volunteers would be responsible for providing "on-site medical triage, patient care and transportation to medical facilities." In addition to DMATs, there are four National Medical Response Teams (NMRTs) that possess their own pharmaceuticals and the ability to detect biological contaminants, "decontaminate victims, provide medical care and remove victims from the scene." Three NMRTs respond nationally, while the fourth is permanently situated in Washington, D.C.²⁶[26]

At the state and local levels, the procedures for distribution of pharmaceuticals and treatment of affected individuals, as well as the general level of readiness, vary among localities. The state of Illinois currently appears to have the most organized system. Illinois has contracted with pharmaceutical packagers and distributors so that the drugs it receives from the national pharmaceutical stockpile can be redistributed into 1.5 million individual doses within 24 hours. It took the National Guard in Colorado several days to accomplish this feat during a trial run. To date, Illinois is the only state to have

[24] GAO Interview.

[25] Dr. Nathan Stinson, interview in Washington, D.C., Dec. 3, 2001 (hereafter cited as Stinson Interview).

[26] Federal Document Clearing House, Inc., "Homeland Security," Dec. 5, 2001 (hereafter cited as Federal Clearing House, "Homeland Security").

implemented this system.²⁷[27] On a local level, Chicago has enacted a system in which pharmaceuticals will be distributed at hundreds of schools and clinics as opposed to more centralized and less numerous locations, such as hospitals. By distributing drugs from these more localized and numerous facilities, Chicago officials believe the public will be less liable to panic in the event of an emergency.²⁸[28] Conversely, the state of New Hampshire is one which needs to improve its plan for dealing with a biological or chemical attack. A state commission that examined New Hampshire's preparedness recommended that the state increase its ability to treat individuals at public health labs and hospitals, increase its statewide distribution of emergency medical supplies, and establish a "statewide hospital mutual-aid agreement." Additionally, it was recommended that the state's ability to distribute medications from national stockpiles and treat affected individuals with these drugs be enhanced.²⁹[29]

4. Initially, officials seemed to minimize the anthrax incidents as isolated, not related to terrorism, the result of anthrax occurring naturally in the environment, and not a threat to postal workers. Events proved that none of this was the case. What is the government now doing to more accurately forecast and establish a clear plan to respond to bioterrorist attacks?

An examination of the government's efforts in the first days of the outbreaks highlights several problems. When the initial case of anthrax appeared, federal officials failed to realize that it was the first indication of a serious public health threat, as can be seen from the following timeline:

- *October 9.* After the CDC confirmed the first case of anthrax in a Florida man, Secretary of Health and Human Services Tommy Thompson suggested that he most likely contracted the disease through outdoor activities. This theory proved to be untrue when the origin was traced to a letter sent to his place of employment, American Media.
- *October 12.* NBC announced that news anchor Tom Brokaw's assistant tested positive for anthrax after receiving a suspicious letter.
- *October 13.* Two doctors notified New Jersey state health officials that their patients, both postal workers undergoing treatment for skin lesions, likely handled the letter.
- *October 14.* Another postal worker at the Hamilton plant that processed the NBC letter developed flu-like symptoms.

[27] *The Associated Press State & Local Wire*, "Lumpkin Preparing the State for Bioterrorism," Dec. 11, 2001 (hereafter cited as AP, "Lumpkin Preparing the State").

[28] Shawn Tully, "The Mayor, His Troops, and the Health of a City; Chicago is Better Prepared than any Other Large City to Protect its Citizens Against Bioterror. Here's its Detailed Plan for Fighting America's Newest War," *Fortune*, Nov. 26, 2001, p. 138 (hereafter cited as Tully, "Chicago is Better Prepared").

[29] Tom Fahey, "NH Needs Training, Equipment," *The Union Ledger*, Nov. 28, 2001, p. 1.

- *October 15.* Anthrax spores were found at a post office that handled mail for American Media. This discovery did not prompt the testing of any other postal facility. Anthrax also was found in a letter sent to Senate Majority Leader Tom Daschle. Public health officials acted quickly and decisively to address the contamination of the U.S. Senate. Forty members of Senator Daschle's staff were tested immediately; over the next two days, hundreds of members of Congress and Hill staffers were offered testing and medication.
- *October 18.* Test results from two New Jersey postal workers with skin lesions came back positive for skin anthrax. The FBI and CDC began environmental testing at the plant at which they worked. The assumption was still that only those who touched a contaminated letter were at risk. Neither the state nor federal government assumed any responsibility for the medical treatment of the postal employees, indicating that they should seek treatment from their own doctors.
- *October 19.* The State of New Jersey Department of Health became increasingly concerned because of the outbreak at the Capitol and changed its recommendations. It urged all postal employees at the Hamilton and West Trenton facilities to take antibiotics. But the department persisted in stating that postal employees should seek treatment from their own private doctors or a nearby hospital.
- *October 20.* Anthrax was discovered in the mailroom of another office building on Capitol Hill.
- *October 21.* Officials confirmed that one employee of the Brentwood post office in Northeast Washington, D.C., had been diagnosed with inhalation anthrax. In New Jersey, 13 of 23 samples taken by federal officials at the Hamilton facility tested positive for anthrax contamination.
- *October 22.* Officials announced that two postal workers from the Brentwood facility died of inhalation anthrax. The government abandoned its position that only those who touched mail would likely become sick.
- *October 23.* Federal health officials said that in the future they would more aggressively test and treat postal workers who may have come in contact with contaminated letters or packages. Finally, testing of thousands of postal workers was ordered.

The government, in order to enhance the nation's ability to detect and respond to a biological attack, has announced some new initiatives. For example, the CDC is "upgrading the nation's public health laboratory and epidemiological capacity," and HHS via its Office of Emergency Preparedness is "expanding its efforts to develop medical response capabilities at local and national levels."³⁰[30]

However, the slow response toward testing and treating workers at the postal processing facilities in New Jersey and Washington, D.C., raises questions of equitable treatment and appropriate response. Some have argued that "officials . . . acted less swiftly to

[30] U.S. Department of Health and Human Services, "HHS Initiative Prepares for Possible Bioterrorism Threat," fact sheet, Oct. 6, 2001, <<http://www.hhs.gov/news/press/2001/pres/01fsbioterrorism.html>> (Nov. 27, 2001).

defend the blue-collar, often minority workers of the Postal Service than they had the white-collar, mainly white world of Capitol Hill.” Officials have countered that the government honestly believed no contamination had occurred at Brentwood.³¹[31] Furthermore, Tom Ridge, director of the Office of Homeland Security, states:

[S]oon after the first case of anthrax surfaced [at the Brentwood facility], CDC placed its medical surveillance team on the highest alert. This medical survey team monitors emergency room logs every day all across the country. The purpose of the service is to track potential trends. When we put them on alert, we wanted them to track trends dealing with anthrax-like symptoms.³²[32]

Finally, when it is determined that a biological attack has occurred, the CDC states that it will rapidly deploy pharmaceuticals to the affected population. Once a determination has been made as to the specific biological or chemical agent, subsequent deployment of pharmaceuticals will be geared toward treatment of this specific agent.³³[33]

5. Now that the government knows such attacks are possible, is there a national emergency plan in place for health care delivery? If so, what is the plan? Who is responsible for it? Which agency has the lead role? What other agencies have major roles? What is the command-and-control structure? Has the government made sure that one agency is responsible for coordinating the efforts of all other agencies? What authority resides with the newly established Office of Homeland Security? Are the responsibilities transferred from other agencies, or new? Are the authority and responsibility for combating bioterrorism clearly designated at the federal level? If not, by when will these be established?

According to the GAO, “under the Federal Response Plan, CDC is the lead [HHS] agency providing assistance to state and local governments for five functions: (1) health surveillance, (2) worker health and safety, (3) radiological, chemical, and biological hazard consultation, (4) public health information, and (5) vector control.”³⁴[34] In this capacity, the CDC has established a process to prepare public health agencies for a biological attack. The steps in this process are:

- Enhance epidemiologic capacity to detect and respond to biological attacks.
- Supply diagnostic reagents to state and local public health agencies.

[31] Steve Twomey and Justin Blum, “How the Experts Missed Anthrax; Brentwood Cases Defied Assumptions About Risks,” *Washington Post*, Nov. 19, 2001, p. A1.

[32] The White House, “Director Ridge Discusses Anthrax Situation,” news release, Oct. 22, 2001, <<http://www.whitehouse.gov/news/releases/2001/10/20011023-1.html>> (Dec. 3, 2001).

[33] U.S. Department of Health and Human Services, “Testimony on Combating Terrorism: Management of Medical Stockpiles by Stephen M. Ostroff, M.D.,” Mar. 8, 2000, <<http://www.hhs.gov/asl/testify/000308a/html>> (Nov. 21, 2001) (hereafter cited as Ostroff Testimony).

[34] GAO, “Bioterrorism and CDC’s Role,” p. 3.

- Establish communication programs to ensure delivery of accurate information.
- Enhance bioterrorism-related education and training for health care professionals.
- Prepare educational materials that will inform and reassure the public during and after a biological attack.
- Stockpile appropriate vaccines and drugs.
- Establish molecular surveillance for microbial strains, including unusual or drug-resistant strains.
- Support the development of diagnostic tests.
- Encourage research on antiviral drugs and vaccines.³⁵[35]

For responding to a biological attack, the CDC has issued broad plans in its biological and chemical terrorism preparedness and response report indicating it will:

Assist state and local health agencies in organizing response capacities to rapidly deploy in the event of an overt attack or a suspicious outbreak that might be the result of a covert attack.

Ensure that procedures are in place for rapid mobilization of CDC terrorism response teams that will provide on-site assistance to local health workers, security agents and law enforcement officers.

Establish a national pharmaceutical stockpile to provide medical supplies in the event of a terrorist attack that involved biological or chemical agents.³⁶[36]

The CDC report recommended that this plan be refined and implemented by 2004.³⁷[37]

CDC responded to the anthrax crisis with the following, among other efforts: “CDC has established a secured web-based system for states to report weekly summaries of their bioterrorism-related activities [with] eight to 30 full-time personnel [engaged] in . . . responses in each state” conducting investigations of bioterrorism threats. Furthermore,

[35] Centers for Disease Control and Prevention, “Biological and Chemical Terrorism: Strategic Plan for Preparedness and Response, Recommendations of the CDC Strategic Planning Workshop,” *Morbidity and Mortality Weekly Report*, vol. 49, no. RR-4, Apr. 21, 2000, <<http://www.cdc.gov/mmwr/pdf/rr/rr4904.pdf>> (Nov. 19, 2001), p. 5 (hereafter cited as CDC, *Morbidity and Mortality*, vol. 49).

[36] *Ibid.*, p. 12.

[37] *Ibid.*, p. 13. According to GAO’s “Bioterrorism and CDC’s Role,” p. 4: “HHS is currently leading an effort to work with governmental and nongovernmental partners to upgrade the nation’s public health infrastructure and capacities to respond to bioterrorism. As part of this effort, several CDC centers, institutes, and offices work together in the agency’s Bioterrorism Preparedness and Response Program.”

“CDC and state and local public health agencies are continuing epidemiologic and laboratory investigations of bioterrorism-related anthrax.”³⁸[38]

Despite the CDC’s expertise and existing role in responding to a biological attack upon the United States, under Presidential Decision Directive 39 “the Federal Bureau of Investigation [FBI] [is] the lead agency for the crisis plan [while] . . . the Federal Emergency Management Agency [FEMA] [is responsible for] ensuring that the federal response management is adequate to respond to the consequences of terrorism.”³⁹[39] The crisis aspect, directed by the FBI, is not addressed in this paper, because it pertains to criminal investigations and not medical treatment after an attack. FEMA’s role is that of consequence management, which encompasses “efforts to provide medical treatment and emergency services, [evacuating] people from dangerous areas, and [restoring] government services.” Primary responsibility for providing consequence management falls to state and local authorities, with FEMA playing a supporting role. However, the FBI is the agency charged with principal authority in case of biological attack and must be supported by “[a]ll federal agencies and departments, as needed. . . .”⁴⁰[40]

The newly created Office of Homeland Security is charged with developing and coordinating “the implementation of a comprehensive national strategy to secure the United States from terrorist threats or attacks.” Inclusive in this mandate is the responsibility to “coordinate development of monitoring protocols for use in detecting the release of biological, chemical, and radiological hazards. . . .”⁴¹[41] Additionally, this office is collaborating with “the CDC, the Food and Drug Administration and the National Institutes of Health . . . to support and encourage research to address scientific issues related to bioterrorism.”⁴²[42]

Despite all these efforts, the federal government’s current state of preparedness led GAO to conclude that the federal response to a biological attack operates “under an umbrella of various policies and contingency plans.”⁴³[43] Echoing the GAO’s concerns are

[38] Centers for Disease Control and Prevention, “Update: Investigations of Bioterrorism-Related Anthrax and Adverse Events from Antimicrobial Prophylaxis,” *Morbidity and Mortality Weekly Report*, vol. 50, no. 44, Nov. 9, 2001, <<http://www.cdc.gov/mmwr/pdf/rr/rr4904.pdf>> (Nov. 20, 2001), pp. 974–75.

[39] CDC, *Morbidity and Mortality*, vol. 49, p. 9.

[40] U.S. General Accounting Office, “Combating Terrorism: Consideration for Investing Resources in Chemical and Biological Preparedness,” Testimony Before the Committee on Government Affairs, U.S. Senate, Oct. 17, 2001, <<http://www.gao.gov>> (Nov. 19, 2001), pp. 2–3 (hereafter cited as GAO, “Combating Terrorism”).

[41] The White House, “The Office of Homeland Security,” news release, October 2001, <<http://www.whitehouse.gov/news/releases/2001/10/2001/1008.html>> (Nov. 27, 2001) (hereafter cited as the White House, “Homeland Security”).

[42] U.S. Department of Health and Human Services, “Restoring Hope, Rebuilding Lives,” Nov. 5, 2001, <<http://www.hhs.gov/news/speech/2001/011105.html>> (Nov. 27, 2001).

[43] GAO, “Combating Terrorism,” pp. 2–3.

numerous other individuals. Dr. Victor Sidel, professor of social medicine at Albert Einstein College of Medicine in New York, for example, believes that the United States “may place too much control over public health matters in the hands of military and law enforcement officials.”⁴⁴[44] One federal official states that as far as he is aware, the federal government has no master emergency plan established to deal with a biological attack.⁴⁵[45]

However, it must be noted that the federal government will not be directing the distribution of vaccines in the wake of a biological attack unless the Secretary of HHS declares a public health emergency. Responsibility for distribution of pharmaceuticals falls to state and local officials.⁴⁶[46] As previously discussed, the system currently in place appears to be a multilevel one.⁴⁷[47] At the federal level, HHS’ Office of Emergency Preparedness (OEP) is establishing a system that will unite federal, state, and local entities in responding to a biological or chemical attack.⁴⁸[48] However, the choice of locations for the distribution of pharmaceutical supplies to the affected population appears to reside with individual states and, more specifically, local governments. In Chicago, for example, city officials have decided to distribute drugs from the more localized and numerous schools and clinics as opposed to more centralized and less numerous locations, such as hospitals.⁴⁹[49] Finally, as GAO explained, the responsibility for distributing pharmaceuticals has been left to state and local officials, but the vaccination policy rests with CDC. Currently, CDC’s policy is to vaccinate only those individuals who have been exposed to a contaminant, not the universal populace, regardless of the quantity of vaccine available.⁵⁰[50] However, one HHS official states that HHS’ policy of selective vaccination may change once enough vaccine becomes available.⁵¹[51]

Turning to fiscal matters, the Bush administration’s fiscal year 2003 budget requests \$5.8 billion for the CDC. This is a decrease of \$1 billion (or 15 percent) from fiscal 2002 and is primarily due to a major one-time purchase of vaccines and other pharmaceuticals to

[44] Jeff Nesmith, “Biological Attack a Small, But Real Threat in Terrorism ‘War,’” *Cox News Service*, Sept. 20, 2001.

[45] Stinson Interview.

[46] GAO Interview.

[47] *See* Federal Clearing House, “Homeland Security”; AP, “Lumpkin Preparing the State”; and Tully, “Chicago is Better Prepared.”

[48] Federal Clearing House, “Homeland Security.”

[49] Tully, “Chicago is Better Prepared.”

[50] GAO Interview.

[51] Stinson Interview.

combat bioterrorist threats in fiscal 2002. A total of \$1.6 billion will be directed at CDC bioterrorism preparedness, “a net decrease of \$661 million” from fiscal 2002. Furthermore, the budget “reflects a one-time decrease of \$757 million in the costs associated with the procurement of vaccines and pharmaceuticals in fiscal year 2002.” Of the \$1.6 billion for bioterrorism preparedness, \$940 million is for state and local bioterrorism preparedness, the same as in fiscal 2002. The amount of \$159 million is aimed at upgrading CDC’s scientific response ability through the “acquisition of additional equipment and personnel, including the Rapid Response and Advanced Technology (RRAT) Lab at the National Center for Infectious Diseases.” RRAT “specializes in the triage and analysis of biological specimens as potential agents of terrorism.” A proposed \$400 million of the \$1.6 billion is for the addition of 286 million doses of smallpox vaccine, to be available by the end of fiscal 2002, to the National Pharmaceutical Stockpile. To assist states in distributing stockpile supplies, \$65 million will be made available. CDC’s budget also includes \$18 million for continued research evaluations of the “anthrax vaccine used to inoculate military personnel, and offered to postal workers and congressional staff.”⁵²[52]

The administration’s budget also includes \$1.8 billion for the National Institutes of Health (NIH). This money will fund countermeasures developed by NIH, in coordination with the Office of Homeland Security and the Office of Public Health Preparedness (OPHP), aimed at neutralizing bioterrorist threats from micro-organisms such as smallpox, anthrax, tularemia, and plague.⁵³[53]

Lastly, the budget includes \$37.7 billion for the Office of Homeland Security, an increase of \$19.5 billion from fiscal 2002. Of that amount, \$3.5 billion is for the nation’s “first responders,” who include police, firefighters, and Emergency Medical Teams. A total of \$11 billion is for border security, an increase of \$2 billion, while nearly \$6 billion will be directed at defending against bioterrorism. Efforts geared toward intelligence-gathering and improved coordination between agencies will receive \$700 million in funding. And \$200 million will be used to create Citizens Corps, which will help communities to “be better prepared for terrorist” attacks.⁵⁴[54]

6. Has the CDC named a new assistant secretary for bioterrorism, as has been discussed in media accounts? If so, what is that office’s role?

On July 10, 2001, HHS Secretary Tommy Thompson introduced Dr. Scott Lillibridge as his special assistant for bioterrorism. The department’s news release said, “Lillibridge

[52] U.S. Department of Health and Human Services, “FY 2003 President’s Budget for HHS,” <<http://www.hhs.gov/budget/pdf/hhs2003bib.pdf>> (Feb. 20, 2002), p. 31.

[53] Ibid., p. 41.

[54] The White House, “The President’s Plan to Strengthen Our Homeland Security,” news release, February 2002, <<http://www.whitehouse.gov/news/releases/2002/02/20020204-2.html>> (Feb. 20, 2002), p. 1.

will coordinate anti-bioterrorism efforts across the department and will report directly to Secretary Thompson.” Dr. Lillibridge previously coordinated CDC’s bioterrorism response effort.⁵⁵[55] On November 1, 2001, Dr. Lillibridge began reporting to Dr. Donald A. Henderson, who was selected as director of the newly created OPHP. This office will work with all HHS agencies to “enhance the response to anthrax attacks,” and any other biological attacks that may occur.⁵⁶[56] Finally, one HHS official states that to the best of his knowledge there is no proposal to create an assistant secretary for bioterrorism position because OPHP could possibly serve the same purpose.⁵⁷[57]

7. How will the problem of articulation between civilian and military organizations be resolved? For example, which agency will stockpile medication? Which agency will distribute it?

Under the National Pharmaceutical Stockpile Program “a repository of life-saving pharmaceuticals, antidotes, and medical supplies, known as 12-Hour Push Packages” are maintained. These packages are suitable for use in any emergency, including a bioterrorist attack. The CDC and the OEP both maintain stockpiles.⁵⁸[58] The stockpiles maintained by CDC will “take up to 12 hours to deploy. . . .” OEP’s stockpiles will deploy simultaneously with its National Disaster Medical System (NDMS), and the three NDMS teams “can be at an airport (commercial or military) and be ready to board within five hours of notification.”⁵⁹[59] As concerns the military, the Marine Corps Chemical and Biological Incident Response Force, for example, “may be deployed to assist civilian communities. . . .”⁶⁰[60] However, regarding the small pox vaccine, Dr. Nathan Stinson, director of HHS’ Office of Minority Health, states that while both HHS and the military

[55] U.S. Department of Health and Human Services, “HHS Names Physician to Coordinate Anti-Bioterrorism Initiatives,” *HHS News*, July 10, 2001, <<http://www.hhs.gov/news/press/2001pres/20010710a.htm>> (Nov. 20, 2001). The Commission is in the process of contacting Dr. Henderson and Dr. Lillibridge, or a designated spokesperson, in order to set up an interview to establish the parameters in coordinating HHS’ anti-bioterrorism initiatives.

[56] U.S. Department of Health and Human Services, “Secretary Thompson Names Henderson to Head Office of Public Health Preparedness,” *HHS News*, Nov. 1, 2001, <<http://www.hhs.gov/news/press/2001pres/2001101a.htm>> (Nov. 30, 2001).

[57] Stinson Interview.

[58] GAO, “Bioterrorism and CDC’s Role,” p. 11.

[59] U.S. Department of Health and Human Services, “Testimony on Combating Terrorism: Management of Medical Stockpiles by Robert F. Knouss, M.D.,” Office of Emergency Preparedness, Public Health Service, U.S. Department of Health and Human Services, Before the House Committee on Government Reform, Subcommittee on National Security, Veteran’s Affairs and International Relations, February 23, 1999,” <<http://www.hhs.gov/asl/testify/t00038d.html>> (Nov. 27, 2001) (hereafter cited as Knouss Testimony).

[60] Ostroff Testimony; *see also* Knouss Testimony. According to Dr. Nathan Stinson, director of HHS’ Office of Minority Health, information on military stockpiles is confidential.

are stockpiling it, the Department of Defense would limit the use of the military stockpile to the armed forces.⁶¹[61] Still, according to the White House and the Office of Homeland Security, “[t]he U.S. Government has [a total of] eight stockpiles or push packages containing 50 tons of medical supplies that can be anywhere in the United States within 12 hours or less. It takes nine semi-trucks to haul the supplies.”⁶²[62] Lastly, many states are developing independent pharmaceutical stockpiles. In states where this is occurring, the state health department will be “responsible for keeping the stockpiles of vaccines.” Management of these stockpiles is at the discretion of the particular state.⁶³[63]

8. What role and responsibility does HHS’ Office for Civil Rights (OCR) bear?

The Commission’s Office of Civil Rights Evaluation submitted questions to HHS/OCR regarding OCR’s role in preparing for and responding to a biological attack. The questions were forwarded to Dr. Donald A. Henderson.⁶⁴[64] However, one HHS official states that HHS/OCR is currently fulfilling its mission.⁶⁵[65] A review of OCR’s Web site on March 13, 2002, did not provide any information regarding efforts to prevent unequal treatment in the delivery of medical services in the wake of a biological attack. Of course, if one considers OCR’s mission statement it is readily clear that this office should ensure that unequal treatment does not occur. This statement reads:

The Department of Health and Human Services, through the Office for Civil Rights, promotes and ensures that people have equal access to and opportunity to participate in and receive services in all HHS programs without facing unlawful discrimination. Through prevention and elimination of unlawful discrimination, the Office for Civil Rights helps HHS carry out its overall mission of improving the health and well-being of all people affected by its many programs.

This mission is communicated throughout the Department and is reflected in the customer service nondiscrimination objectives that have been developed in the Department’s strategic plan. Ensuring the nondiscriminatory provision of services funded by or provided directly by the Department is a continuing challenge to all of the Department’s employees.

[61] Stinson Interview.

[62] The White House, “Homeland Security.”

[63] GAO Interview.

[64] The Commission’s Office of Civil Rights Evaluation (OCRE) was notified that its questions were forwarded in an e-mail from Steve Melov, director of the Resource Management Division, dated Nov. 27, 2001, 3:35 p.m. OCRE never received a response.

[65] Stinson Interview.

STAFF FINDINGS

1. The stated goal of the CDC's Federal Response Plan is to provide "comprehensive, integrated training designed to ensure core competency in public health preparedness and the highest levels of scientific expertise among local, state, and federal partners."⁶⁶[66] It was recommended that the plan be implemented by 2004.⁶⁷[67] The Commission finds that the plan is oriented to administrative processes and not to the active provision of health care to the American population. Details about how the plan will be implemented have been nonexistent. The plan makes no provisions for low-income Americans, those living in rural areas, or those who may require language assistance. Furthermore, the 2004 timeframe for implementation is inadequate, since recent events have proven that the need for a plan is present.
2. Many within the public and private sectors find that our nation's public health system is deeply flawed, perpetually underfunded, lacking political support, and encumbered by antiquated laws.⁶⁸[68] The Commission finds no evidence substantially refuting this impression. Simply stated, more funding and political support—especially as underserved populations are concerned—are required. A crisis exists that has left a vast number of Americans, primarily the poor, women, and language, racial, and ethnic minorities, unprotected and uncared for by our nation's medical system. The current and very real threat of a biological attack has brought this crisis to the forefront of public issues necessitating immediate action.
3. As concluded by the Commission, "[d]iscrimination in health care delivery, financing and research continues to exist."⁶⁹[69] Disparate treatment links the poor, the limited-English proficient, the non-English speaking, and certain ethnic and racial groups in a system that does not provide them adequate health care and, quite often, fair consideration during nonemergency periods. Our review finds that the government does not have a plan to ensure that all groups, be they economic, language, ethnic, or racial, will receive prompt, sufficient, and systematic treatment following a biological attack.
4. The federal government must take immediate steps to correct its biological terrorism response plan, which GAO found in disarray. Specifically, GAO

[66] CDC, *Morbidity and Mortality*, vol. 49, p. 5.

[67] *Ibid.*, p. 13. However, according to GAO's "Bioterrorism and CDC's Role," p. 4: "HHS is currently leading an effort to work with governmental and nongovernmental partners to upgrade the nation's public health infrastructure and capacities to respond to bioterrorism. As part of this effort, several CDC centers, institutes, and offices work together in the agency's Bioterrorism Preparedness and Response Program."

[68] M. Gregg Bloche and Lawrence O. Gostin, "Public Health in Spotlight," *The Desert News*, Nov. 11, 2001, p. AA01.

[69] USCCR, *Health Care*, vol. I, p. 189.

established the existence of an uncoordinated, redundant system that requires streamlining and clear responsibilities and authority. From its mission statement, the Office of Homeland Security “will coordinate the executive’s branch efforts to detect, prepare for, prevent, protect against, respond to, and recover from terrorist attacks within the United States.”⁷⁰ Still, it is not clear from our review which agency will serve as the coordinating body for the numerous independent efforts directed at treating individuals exposed to biological contaminants. Moreover, it is doubtful that government initiatives announced thus far will resolve the problem of redundancy and haphazard coordination.

5. Government officials have not demonstrated the existence of a comprehensive plan for delivering treatment into all segments of the nation’s population in the event of widespread bioterrorism. Although state and local entities will have decision-making authority as to the dispersal of vaccines, unless the Secretary of HHS declares a public health emergency, the question remains whether those often ignored by society (the homeless, the socially underserved, the least economically viable) will be provided with adequate treatment and treated like all other segments of society.
6. The National Association of Counties (NACo) reports that counties throughout the nation are unprepared to respond to a biological or chemical attack. In a national survey of counties with “functioning county level governments,” to determine their ability to respond to emergency situations, NACo found that 21 percent of the counties that responded had no preparation for a biological attack, while 43 percent were unprepared for a chemical attack.⁷¹

STAFF RECOMMENDATIONS

1. Government officials must act swiftly to develop a plan for stockpiling and distributing medicine, and delivering treatment to all Americans. Such a plan must be developed and announced through the mass media to ensure public confidence and that appropriate actions are taken by health care providers and the public in the event of an emergency. This recommendation also applies to those states developing pharmaceutical stockpiles.
2. HHS through its Office of Public Health Preparedness must keep the public informed about its efforts to enhance HHS’ response to anthrax and other biological threats. This can be done via public service announcements on television, radio, and the print media, via HHS’ Web site, through mass mailings and billboards, and as a specific request to news agencies to provide this information. A national toll-free desk must be established to field questions and respond to the public’s requests for information about health care threats.

[70] The White House, “Homeland Security.”

[71] NACo, “Counties Secure America.”

3. HHS must ensure that states and localities are adequately prepared to deal with a biological or chemical attack. A valid assurance would include a detailed and sufficient plan of action for quickly locating and treating an affected population in the wake of a biological or chemical attack. Inclusive in this plan would be specific locations for distribution of pharmaceutical supplies and the active notification of the public regarding these locations. Adequate plans must be subjected to a national review and confirmation from HHS on a scale of one to five, with five being the highest rating, and recertification would be required on a yearly basis. Plans receiving a rating of less than five, or failing to receive any rating, would be provided a six-month period in which to improve one scale rating or achieve a rating of one, and a year to achieve a five rating. Ratings would be tailored to the needs of individual states and localities depending on their characteristics.
4. An underlying weakness of the nation's health care system is that it ignores the nexus between population group membership and the receipt of health care. Health care disparities exist between various population groups. Past failures to take disparities into account give rise to questions about the government's readiness to treat all Americans if bioterrorism escalates. The federal government must take minority health disparities into consideration and immediately alter the nation's health care infrastructure accordingly.
5. The CDC should develop model emergency response plans for state and local jurisdictions that take into account variations in resources and infrastructures. Additionally, partnerships must be created between well-prepared states (such as Illinois) and others (such as New Hampshire) to help jurisdictions found lacking increase their competency levels.
6. Federal, state, and local governments must identify, recruit, and train a network of multilingual volunteers and personnel who can be deployed to assist with limited-English-proficient populations in the event of a biological attack.
7. Following a bioterrorist attack, the federal government must ensure that everyone, regardless of race, ethnicity, and socioeconomic class, is provided with long-term medical care. To accomplish this it is necessary that federal, state, and local governments and health care providers develop relationships and the mechanisms to communicate with and inform racial and ethnic minorities.⁷²[72]
8. Protocols for responding to a bioterrorist attack must be established by federal, state, and local governments and health care professionals. These protocols must clearly state, among other points, how everyone in a city will be notified following a bioterrorist attack and that everyone will receive the same treatment regardless of race, ethnicity, and socioeconomic class.⁷³[73]

[72] Dr. Mohammad Akhter, testimony before the U.S. Commission on Civil Rights, briefing, Washington, D.C., Mar. 8, 2002.

[73] Ibid.

9. The deterioration of the health care “safety net” over many years demands that the number of trained health care volunteers be increased. More health care volunteers are not only required in the event of a bioterrorist attack, but are also needed to combat the long-term reduction of health care financing disproportionately affecting minorities.⁷⁴[74]

U.S. Commission on Civil Rights

Briefing on Bioterrorism and Health Care Disparities

March 8, 2002

Presentation by Dr. Mohammad Akhter, Executive Director of the American Public Health Association

Proceedings

CHAIRPERSON BERRY: Now we have our guest with us. And the staff extended an invitation to the American Public Health Association and their executive director, Dr. Mohammad Akhter.

Would you please come forward, Dr. Akhter. And welcome, and thank you very much for coming.

Dr. Akhter’s biography is in the material that you were given. But I’ll note that he is executive director of the American Public Health Association. He previously was a senior advisor at the U.S. Department of Health and Human Services. And in addition to his position at the APHA, he is a physician with board certification in preventive medicine.

⁷⁴[74] Ibid.

He's a clinical professor at Georgetown University Medical School. He is also an adjunct professor of international public health at George Washington University, School of Public Health. He has held many public health leadership positions, including director of the Missouri State Department of Health and health commissioner here in the District of Columbia. And that had to be a tough job.

Dr. Akhter, the Commission has long been concerned about issues of health care disparities in general. And then with the recent issues around bioterrorism that is perpetrated or might be perpetrated against the United States, we had some discussion about the urgency of this problem and about inadequacies that may be there in our health systems and whether underserved communities in particular would be appropriately served if there were a massive bioterrorist attack.

So we're pleased that you were willing to come and have this brief discussion with us. Then we will have some questions, perhaps, and some exchanges as we proceed to try to understand this issue. So thank you very much for coming.

DR. AKHTER: Thank you for inviting me. Good morning. Indeed, a pleasure to be here this morning, to be speaking to you all, to provide you with some information and some ideas that might lead to prevention of potential abuses of the civil rights for the people.

The threat of bioterrorism is real. And I say this from the information that I have been discussing with the various government agencies, with the public health community.

I'm a member of a professional organization. Just like there's an American Bar Association, American Medical Association, there's an American Public Health Association, about 55,000 members working in the federal government, state government, and the local government, providing services to the people to ensure that the water that you drink is clean, that the air you breathe is safe, and that food you eat is not contaminated, and the children will go to school and have immunizations done.

And so I speak from very ground-level information, as well as information from our federal government agencies. And what we know at the moment is the threat is real for bioterrorism. There are several reasons for that.

The first one is that we are at war against the terrorists. And our President tells us it's going to be a long war. And the terrorists can any time strike back at us. And this is one of their ways of, really, attacking our population centers.

The second reason for the threat being real is that there are at least 15 or 16 countries around the world that have, or potentially have, the access to bioterrorism agents—former states of the Soviet Union, for one; the Iraqi people. We know for sure the Iraqi government had tons of anthrax, and they weaponize it. And many of those states are not really keeping a good tab on these weapons or this anthrax. And they could just fall into the hands of the terrorist.

The third reason for us being concerned is the terrorists of today have a lot of money and a lot of connections. And there are 1,000 labs around the world, about half of them in the United States, the other half around the world, that are capable of maintaining and growing these organisms. And there are very few controls—checks and balances—on those labs and people who work in those labs. And finally, we have still not caught the culprits who were responsible for the anthrax attack. Those folks are still out there.

And so recognizing the threat is real, there's been a bipartisan effort in the United States government to prepare our nation against any eventuality that if there is an attack, that we are fully prepared.

And of all other potential disasters that might happen, the bioterrorism disaster is a very separate and different kind of category for a variety of reasons. If there's an earthquake, if there's a bomb blast, there's a sound, there's smoke, there's dust, there's lightening. But in a bioterrorist attack there is none of those. It's a silent attack. The first time you find out is when somebody gets sick, and we find out, oh, yes, anthrax attack. Because we can't see it; it's invisible.

The second thing is that, in any other attack, the attack takes place at one time, and it's over. They hit our buildings September 11. We knew "this is it." We need to really take care of it. We need to do what we need to do. In a bioterrorist attack, every single case that takes place is a separate attack. It keeps taking place from time to time. Where next? We just don't know. And particularly, if they use an infectious agent where disease can spread from one person to another, it then becomes many attacks that continue to take place time after time. And so that's really a concern.

The reason I'm saying this is that for dealing with bioterrorist attacks, you need to have long-term medical care and follow-up for the folks. And that's why it becomes so important. And we need to have it all around the country for all people. Because with bioterrorism, people could attack anywhere, and they can do anything they may choose. They can pick the time, they can pick the agent, they can pick the place. It's up to them, so we need to be prepared.

I'm very pleased to tell you that our government has done a terrific job since September 11, at all levels, in preparing ourselves and dealing with this eventuality—the President, the Congress. The federal agencies have allocated resources. Our intelligence today is much better. We have monies going from the federal government to state and local governments to really prepare themselves and start developing their plans.

But there are some inherent problems within our system as we enter this new century that we need to be aware of and need to be careful.

The first issue that I want to bring to your attention is the issue of a safety net. There are 40 million Americans who are uninsured; there are many who are underinsured. They don't have access to care. So we cannot simply say in a bioterrorist attack, "Go to your private doctor and get your Cipro." It just will not happen. And even if you provide them

the Cipro, like the government has planned on doing—that we give them the push pack and say, everybody get a pack of Cipro, and we deliver it to you, how about if they have a reaction? How about if that Cipro is not good for them? How about if they have another complication? Where should they go? So we need to have that mechanism in place.

It's not only the issue of not having health insurance; it's also the issue of not having services available. There are many areas that our government has identified as underserved areas, many of them in rural America, but many of them in the inner-city areas, where there is no facility available. Physically there's not many doctors, private health commissioners in Washington, the nation's capital. Not long ago, in '91, for 78,000 children living east of the river, there were only four pediatricians who would take Medicaid. Now, how do you suppose those people will get the service?

And so it's the issue of not having the insurance and also not having the access to care. And I think somewhere we need to prepare for this, because if they don't have a good safety net today when there's peace, tranquility, what would happen if, God forbid, there's a big disaster? That safety net is going to be torn to shreds because demand on services will be so great. So that's my first point to you.

My second point today deals with our state and local public health infrastructure. These are the people at the state and local level. These are the county health directors, the city health departments, the state health departments.

For many years, the United States has been a country where we've been very fortunate to have no epidemic, no major outbreaks, there have been small outbreaks. So over a period of time, we have sort of taken the money away from those health departments to do other things. And so as we entered the century, we find we have the shells of health departments. For example, New York City would have 100-plus public health nurses. You'll find that now there are a handful of them there because the need wasn't there. But with a bioterrorist attack and seeing these consequences, it becomes important that we rebuild these health departments and really do them well. We can rebuild them or build what's there already. But we need to make sure that we do it in such a way that the people in underserved areas and minorities living in the inner city get the service.

The effectiveness of the health department is very evident. We have made tremendous progress in improving the infant mortality rate and the death rate from heart disease and other areas. Our people are healthier today than they've ever been in the history of the United States of America. But yet, because we're a land of immigrants—there are a lot of minorities, today 25 percent of all Americans are of racial and ethnic descent—by 2030, 40 percent; and by 2050, half of all Americans are going to be of racial and ethnic descent—Asian Americans, Chinese Americans, African Americans, Hispanic Americans. And the public health system has not been able to reach these people because their experience with disease and death is very different today. There are disparities in health status.

The infant mortality rate for the African Americans, for example. If you start to look at it in one of our best states in the United States—Minnesota—infant mortality rate in that state for the entire state is the lowest in the nation, very good. But the infant mortality rate for the African American is the highest in the same state.

And similarly, you look at the heart disease rates, cancer rates, and diabetes rates, they are all higher among the minority populations. The highest infant mortality rate is among the Native Americans in the United States.

Let me just put it the other way. The life expectancy for Americans is 77 years right now, as a nation as a whole. When you come to African American women, it's five years less. When you come to African American men, it's eight years less. When you come to the Native Americans, it's 10 or 12 years less than the other folks.

We live in the same country, we pay the same taxes, we breathe the same air, and we enjoy the same food, but here there are these disparities that exist. And there has been a little disconnect between the public health departments' ability to reach into these populations with culturally sensitive ways of providing them the service—how they could live healthy, how they could grow up to be healthy, what to do in terms of other services that they need to have access to. And so we will always have the struggle as a state health commissioner in Missouri. As a state health commissioner here in the nation's capital, you always have the struggle with reaching out to these folks.

In a time of emergency, it becomes even more important that we have an ability to reach out to these people so that folks don't just simply stay home and not get the care that they need, that we have the access to. And I think we need to make sure that as we build up the capacity of the health department, that we build up this capacity of outreach, the ability to be able to communicate with the minority population so that they will not disproportionately suffer in view of the bioterrorist attacks.

And my last point this morning deals with the states that are now considering new legislation that will give the states the authority to quarantine people, to take other people's property in time of a bioterrorist attack. This is something that every state felt that we just need to strengthen our existing rules and regulations. And therein lies the problem, how do you balance the need of the state, the need of the country, and need of the people who will be quarantined? How do you make that decision of which population to quarantine, which population not to quarantine?

And our view is that what we should have, Madam Chairperson of the Commission, is that the quarantine be the last resort, the option that's available, to manage that population, whether it's providing treatment to that population, whether it deals with vaccinating that population, we should try that to contain the disease; that the quarantine be the last resort. But if there's nothing else that's available—this is really the only way that we can contain the disease—sure enough we should do that. And when we provide the treatment to the people, that we should not do things differently; that we treat a certain group of people differently, or certain people have preference over the others, but

the management of a disaster and the provision of treatment should be based upon the needs of the individual, not the position or the economic status, or the authority of the individual, and that that be really made part of their plans.

And I present this to you today because every state is now required by the federal government to submit a plan, a plan that's medically correct, that's administratively sound to deal with the terrorism. And that plan will then come to the federal government, the federal government will review that plan, and will provide the funding to the states.

Every state has been given 20 percent of their share of the funding for bioterrorism. Eighty percent will be given to them when they submit their plan. And as we speak today, the date for submission of the plan is May 15, that every state must submit their plan by that date. And as the federal government starts to review that plan—and the federal government has said that they will make their decision within 30 days of receiving the plan—they must look at not only the expediency and the medical effectiveness of the plan, but also the potential that the civil rights of any individual or group are not violated in the process. Their assurance is that every effort will be made to really make that happen. And one of the ways to make that happen is to bring representatives and such people to the table to really be part of the planning process.

Madam Chair, I stop here. And thank you and members of the Commission for this opportunity this morning. And if there are any questions or comments, I'd be delighted to answer them for you. Thank you again.

COMMISSIONER MEEKS: Thank you very much.

CHAIRPERSON BERRY: That was wonderful. That was the clearest expression I've heard of these issues.

Commissioner Meeks, and then Commissioner Edley, and then Commissioner Thernstrom.

COMMISSIONER MEEKS: I'm from Pine Ridge Indian Reservation, so this really brings up a lot of questions to me. One, the tribes don't usually have a relationship with the state, and the state doesn't have jurisdiction over the tribes. It's a government-to-government relationship which the tribes have with the federal government.

Do you know how the tribes are included in this plan?

DR. AKHTER: At the moment, the way the resources have been provided, it is the federal government providing resources to the states. There are few large cities that the federal government is giving special attention to. To my knowledge, there's not a special allocation, if you will, for the tribes to prepare for this major event.

COMMISSIONER MEEKS: Do you know if the Indian Health Service is included in this plan? Has it been to the table on this?

DR. AKHTER: I'm not aware of the fact, whether they are on the table or not. I'm sure they are involved at some level, but I don't know what level. This has been, basically, taking the resources and giving it to the states, and saying, states, you prepare the plan for the people in your state.

CHAIRPERSON BERRY: Elsie, I read in the—just to intervene, I read in the newspaper somewhere that some of the tribes were complaining about this, because they didn't think they should have to go through the state. And somebody was trying to figure out how to fix it.

Commissioner Edley?

COMMISSIONER EDLEY: Thank you. Great. I mean, really. Great.

I guess I want to focus on the last sort of issues that you were talking about, the issues of treatment, quarantine, etc. And here's the dilemma as I see it.

I think from a civil rights perspective, we're used to the problem that political processes may not work to protect the interests of minorities and disadvantaged populations. On the other hand, the literature is full of studies demonstrating not just disparities but disparate treatment by medical professionals of minorities, discrimination.

So when an event breaks out, I'm not quite sure who to trust to make these decisions about who gets quarantined, or what institution, or how the shredded safety nets get repaired, and what the priorities are going to be.

Do you see my problem? If you trust the politics, then you worry about the people with little political power getting the short end of the stick. If you trust the health care professionals, who are not really accountable to anybody, then you may see in this crisis situation what the literature tells us happens in emergency rooms—namely, minorities getting the short end of the stick or not getting the same kind of treatment that middle-class Anglos would get.

So I'm puzzled about how in this time of crisis one creates a decision-making mechanism in which we can have confidence from a civil rights perspective. Because, otherwise, you—remember all the suspicions about whether the black postal workers, because they were minorities, were going to be treated the same way as the largely white Capitol Hill staff.

COMMISSIONER BRACERAS: Well, they weren't.

COMMISSIONER EDLEY: And there's a question of whether they will be, and then there's just a question of whether, whatever the facts may be, whether the public is going to have confidence that the decision making is fair.

DR. AKHTER: Commissioner Edley, this is the crux of the matter. This is a wonderful question. It is not only whether they are treated, but also what kind of perception people develop in the process. And here is what I would recommend or suggest.

There need to be protocols developed in a very public way. We are never going to be able to deal with bioterrorist agents if we leave the decision making to the politicians, or to the medical people, or to the public health people, or to the police, or whoever else. There has to be a great amount of cooperation and collaboration between the people and their government in the time of crisis. We need people to operate, we need public education, we need to work with the people. We need to bring them to the table, and it has to be done very transparently.

We say, “Folks if there is an outbreak, here is a protocol. This is how everybody living in the city will be notified.” And so this same process. This is how those people where the impact is will be treated. “Here are the protocols. This is where you will go get your medication. It will be the same medication.” So that we make this for our nation a very transparent way. I need to have this transparency to be able to get the support of the people. Without the support of the people, I can have all the medicine, I can have all the knowledge, I will not be able to work this thing through. And gaining the confidence of the people is by having the transparency, having these protocols, having people’s participation into the process so that everything is open.

The public knows. I think everybody living in Washington D.C.—Dr. Walks and I spoke about this. Everybody should know living in Washington, D.C., that in case of crisis what will happen, how will they be notified, where should they go to get the treatment, and how the follow-up will be done, so that it’s the same. We are prepared. It doesn’t matter what color you are, it doesn’t matter what race you are, it doesn’t matter what part of the city you live—that we have prepared for our city a plan. We will go down and just sort of implement that plan.

Would we make some mistakes? Yes, sir. Surely. There always will be. But if we can make this very transparent up front, I think the likelihood of us making a mistake will be very small.

CHAIRPERSON BERRY: Commissioner Thernstrom?

COMMISSIONER THERNSTROM: Well, I doubt that there’s any disagreement on this Commission that too many people are uninsured in this country. I know in New York, if you’re self-employed and you want, not decent, but half-way decent health insurance, you have to pay more than \$500 a month, which is an extraordinary amount for most people. And all of us are concerned, of course, about infant mortality rate disparities and so forth.

But it seems to me that access to health care and health insurance and so forth is really a separate question, or largely separate question, in general, from access in the context of an emergency, when hospitals will obviously be open to everybody—and hospitals are

open. I mean, what Commissioner Edley is suggesting is open hospitals don't solve the problem because there's disparate treatment. But, obviously, in an emergency, hospitals are open to everybody needing emergency care.

And if there is discrimination in the emergency rooms once people arrive—and I agree, by the way, that there need to be plans. And I would hope that the federal government and the state governments are engaged in that kind of planning. But if there is discrimination in the emergency room, which I hope is not true—but if it's true, I'm not sure what the answer to that is in the way of regulations or anything that is a piece of paper that doesn't really respond to the problem.

DR. AKHTER: Very good question, very fundamental question.

As I said earlier, if the issue was one-time care you give somebody, you're done with. I would feel very comfortable saying, "Oh, yes, you could go, you could get the care, it's done with." The issue in bioterrorism is long-term follow-up. Even in anthrax, a 60-day follow-up. People are going to be taking the Cipro for 60 days. In other infections, maybe longer. Sometimes the people who have nightmares and mental health problems tend to suffer two years' long follow-up.

And so the issue for me—I separate the issues of having universal coverage in our nation. But the issue to me is some kind of pronouncement that tells the population, that tells the health care providers that, "Folks, in the case of an emergency, somebody's going to pay for it. It will be taken care of. You go to the hospital emergency room, you go to a private doctor. If it is related to this emergency, this disaster, long term it will be paid for."

Hospitals are wonderful institutions. They would love to serve the people for a day or for two days. But once you have a long-term commitment where there's no money coming in, they're also business institutions. And I've spoken to the hospitals, spoken to managed care organizations. If their institutions are going to be filled with people who are not going to be paying, then their own survival is also at stake.

So what I'm saying in this is that one of the ways to maintain and to assure that everybody's taken care of is to really give these assurances. And the only people who can do that is the federal government who says, "Folks, in case of emergency, it doesn't matter whether you have insurance or not, whether you're covered by HMO or by somebody else, you will be taken care of." And I think that will go a long way in allaying the fears.

COMMISSIONER THERNSTROM: So what you're saying is suppose we have a terrible bioterrorism threat in this country—anthrax, whatever, there are other possibilities, obviously, a whole range of them—you could imagine masses of people being affected by this, and the federal government ignoring the need to respond by taking care of these people in a sustained way?

DR. AKHTER: Yes, it is very true. As we speak today, it is true. I'll tell you this. If there are people who have mental health problems because of the 9/11 incident, and they don't have health insurance, who is taking care of them? Who has provided the insurance, that, yes, it will be paid; they can go to a mental health professional to get the service? We know that from our members and from our leaders. We've spoken with the providers of the service—the doctors, the hospitals—and there is this concern at the bottom of all of this. They're willing to serve their community to the best of their ability. And they will do a great job. But to sustain providing services without having any way of, really, up-front assurance that they'll be compensated is a very important thing.

COMMISSIONER THERNSTROM: But mental health would be very different than a smallpox epidemic. I mean, surely, nobody would say, we're going to let smallpox spread throughout the nation. I mean, it's just not possible.

DR. AKHTER: I know. This sort of seems to you the hypothetical thing that nobody will do—I think logically that is very true. But in realistic terms, if you don't have health insurance, as we speak today, you are three times less likely to seek care when you're sick versus if you have health insurance. So if a person doesn't have the health insurance, and he feels bad, and he has little hives, and he has this fever coming on, he stays home, spreads the disease to others.

On the other hand, if you have the assurance—this is truly—the issue of this is, can we assure our people and our providers that in case of disaster that there's a mechanism for which you'll be taken care of. And I think we need to say that up front, not leave it in some suspense that maybe somebody will, maybe somebody won't.

CHAIRPERSON BERRY: Vice Chair, and then Commissioner Meeks.

VICE CHAIRPERSON REYNOSO: First of all, I thought that your suggestion of a protocol is really very good, because it would bring everybody in to make those decisions. And somebody would have to at least violate the protocol if they're going to not be treating people equally.

But I have sort of a present type question. Out in California, we have two crises right now in California. One is the closing of emergency rooms in hospitals, and the other is the lack of a sufficient number of nurses. They've just moved some legislation to try to increase the number of nurses in California. But I've seen nothing that's been done in terms of the emergency rooms. I've just read an article about all of the emergency rooms that have closed down for economic reasons in California.

To me, emergency rooms and nurses seem to be such a vital part of what to do in case there's a bioterrorism attack. So we're concerned about a bioterrorism attack, and yet, at least for now, at least as I hear in California, we're allowing some of the structure that would be necessary to be weakened.

Is California exceptional or are those things happening throughout the country?

DR. AKHTER: Commissioner, California is a little bit ahead than the rest of the country.

VICE CHAIRPERSON REYNOSO: Don't tell me that.

DR. AKHTER: But it is happening to some degree in other places too. The emergency rooms are overcrowded. I mean, we know that we close emergency rooms many times. We divert patients to the other places because we're too busy in one place or the other. But certainly the federal government—our President, our Congress—has done a great job in making the funds available to create additional capacity.

VICE CHAIRPERSON REYNOSO: To reverse those trends.

DR. AKHTER: To reverse those trends and say, here is the money to create the hospital capacity, and we're working with the hospital association to really look at and say we need to have the capacity. And that's two types of capacity. One is the emergency rooms themselves, that you have the capacity, in a community there's enough capacity to be expended in time of emergency to be able to take care of the folks. The second one is inpatient capacity in the hospital. That's also the same situation, where people wait in the emergency room because they can't find a bed up on the floor to be admitted in the hospital. And so that's in the works. It will be taken care of.

CHAIRPERSON BERRY: Commissioner Meeks?

COMMISSIONER MEEKS: Your point is well taken about people that are not insured. In the public health system they're so understaffed. I can give you just an example from a couple of weeks ago. And this is a rural area, reservation. She drove 50 miles to get a pap smear. Got there, they had a shortage of nurses, and they closed the clinic for the day. So people really do not go unless they—I mean, that's why the death rate on reservations is so much higher.

So how is this going to address this staffing issue? Are these public health—I mean, because that's where people are used to going to if they don't have insurance.

DR. AKHTER: Yes. There are two issues here. One is having the staff—nursing shortage, for example. The President has done a great job putting money in his budget, saying here is the money, provide incentive, get more people to become nurses. Let's start this pipeline going. So one is the creating of manpower. So that's one issue.

But there's another issue that's equally important. If we want to distribute today in Washington, D.C., Cipro to the entire city, all the doctors, all the nurses, all the staff will not be enough. We need to train volunteers. And that's part of the process; that we train volunteers who become the extension from the public, who become the extension of the public health system so they can go out and provide the service in case of an emergency. God forbid, in a major disaster, there will not be enough people to do the work at a level that we do today in the hospitals or in the clinics. We will need to rely on a lot of volunteers to be able to tie ourselves over.

CHAIRPERSON BERRY: Commissioner Wilson?

COMMISSIONER WILSON: Thank you, Madam Chair.

First of all, I just want to thank you very much for your very lucid and thorough talk today. It's been very illuminating. Just a couple of points before I ask you the actual question.

In relation to what Commissioner Thernstrom was pointing out, what you're really saying is that it's not just the government that has to have the structure; it's if people don't have insurance, they're not going to move towards helping themselves, which I think is a very important point.

My question is, you were just talking about volunteers. Are these people being trained now? Is there a program to call up volunteers or to enlist the help of volunteers?

DR. AKHTER: Many hospitals, many medical institutions already have volunteers working. If you go down there, people doing the transport are volunteers. Sometimes people manning the front desks are volunteers. There's now money being made available through the federal government to the states and the local jurisdictions to formally do public education and to train volunteers to be able to have those people available in the community, and that they be done in such a way that could be identified in time of disaster, that they have a special cap after they complete their training or a special jersey they wear so that we can recognize they're part of the team and not somebody just going to interrupt the flow. So, yes, those plans are in the works.

COMMISSIONER WILSON: Because I'm assuming that the number of volunteers who are working in hospitals now wouldn't begin to be effective. I mean, you would need a massive number of volunteers.

DR. AKHTER: This is absolutely correct.

COMMISSIONER WILSON: It would seem to me that a large-scale campaign should be in the works for that now.

DR. AKHTER: Yes.

COMMISSIONER WILSON: But my central question that I had was that you passed over this quickly, and I would like you to talk a little bit more about it. I was somewhat alarmed at this. When you were talking about the issue of quarantining and some states—I don't know if I heard you correctly—taking property.

DR. AKHTER: Yes.

COMMISSIONER WILSON: Do you want to elaborate on that a little bit?

DR. AKHTER: Yes. We are a nation where the civil rights have been very much important as our nation's correcter, saying we just need to maintain people's civil rights, we need to have really minimum intrusion into the lives of the people. And the kind of authority that you have—for example, I as health commissioner will have the authority to take an individual who is not taking his or her medication for tuberculosis and is dangerous to the other people.

I will take them and put them at the D.C. General Hospital for treatment. But as soon as they become noninfectious and they're no longer spreading the disease, which is in a month or six weeks, then I could not hold them any more. I need to let them go so that they could go back in the community, they will not take their medication again. They'll get back on their other drugs, alcohol, whatever their personal situation was. Then I will sometimes again take these people back in again and do that.

Now, there are folks in our society—homeless people, mentally ill people who are out there—where we maintain their rights as much as anybody else's rights. And the same is true of the properties. There may be a danger because something has happened in their property. We want to keep the property completely clean and ensure that it poses no threat to the community or to the nation as a whole.

And so the states are looking at their laws, and for the first time strengthening those laws so there's a clear-cut authority; that in a time of national emergency that the state has a clearly defined law to quarantine a group of people or to take over a property that will be in the best interest of the people.

And I think the issue here is to create a balance, that there is an appropriate decision-making process by which you will do this and not be done by fear, and not be done differently in the state of Missouri compared with the nation's capital; that we have a mechanism in place where we do this thing in some recognized, pre-agreed manner. Let's put it this way.

COMMISSIONER WILSON: But let me ask you this. If you follow this line of reasoning, that if people do not have insurance, and for the most part, then, would not be compelled, or would not feel the need, or would not feel the entitlement to go and get help for themselves, those are the people who are basically poor in this country. And not to say that those are the people who would have property. But supposing they did have property, it would seem to me that those would be the people who would more likely have their property seized.

DR. AKHTER: I don't think the property's being seized because they're not cooperating. I think the property's being seized because something has happened in that building. There's anthrax exposure in the building. And right now we don't have such clearly defined authority that we can take over the building. The post office building, yes. The government building, you can shut it down. But if it's a private building, what do you do? You want to make sure that it's clean, and you want to make sure it's safe for the public that is going to be doing business there, but also for the community.

COMMISSIONER WILSON: So once they seize it, they come in and, basically, decontaminate it?

DR. AKHTER: That's correct. So they will do the cleaning, and have that authority to be able to do that, without going through a lengthy court process.

CHAIRPERSON BERRY: Commissioner Thernstrom?

COMMISSIONER THERNSTROM: So if you were to pose these concerns to Tom Ridge, the Homeland director, to members of his staff, what would he say? Wouldn't he say, we agree that—sorry about that. Since the mic was not on, I'll repeat the question.

If you were to pose these concerns—articulate these concerns—to Governor Ridge, Homeland director, to his staff, wouldn't he say, we agree that there absolutely has to be plans in place, and that is precisely what we're doing?

I mean, I raised the smallpox before because, obviously, anthrax is not an easily communicable disease, but smallpox is. And if there wasn't a proper response on the part of government public authorities as well as physicians and the health community—this is a disease that could have devastating effects spreading throughout the population.

Isn't this something that is on Ridge's plate already? And are you saying, yes, but I don't really have confidence in this operation?

DR. AKHTER: No. I have all the confidence in Tom Ridge. But his plate is too big. There are too many things on the plate. The first thing is survival of our nation on the plate. Okay? That's the first part of the plate. Then there are other things as you go along the line—the port security, the business security, and other things. And then finally you get down to it. It is a little bit further down the plate. And he's not the only one who really would be responsible. It's the state governments, the governors, the local governments.

And what happens is, that if there are other people who are watching, we just don't make the mistakes that we might otherwise make, not intentionally—sometimes unintentionally, things happen—that we put something together because this is what it is. So we believe that when these plans are being developed at the state and local levels, that if they're done in such a way that's transparent, there's participation of the people, there are the right protocols, that we will have a much better way of really protecting all of this. And ultimately, the plans are reviewed not only in terms of their medical effectiveness, their administrative efficiency, but also in terms of their ability to balance the need of the state or jurisdiction and the need of the people.

CHAIRPERSON BERRY: Dr. Akhter, we are very grateful to you for being here to have this discussion. And I was most interested in all the points you made, but one of them, which is that the bioterrorism issue is a subset of concern about the access to health care generally—whether there are facilities, or the people are served, all those points you

made. Which fits in with the concern the Commission has had a long time about what is the reason for disparities in health care—race, class? Is it anything? What is it? And maybe we can have at some point another discussion about the general issue of health care disparities.

But I want to very much thank you for coming and appreciate it very much.

DR. AKHTER: My pleasure. Anytime. If there's any question I could answer for you, I'd be delighted. Thank you again very much.

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