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January 28, 1999

\$100M Sought for Child Health Care

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Filed at 2:39 a.m. EST**By The Associated Press**

WASHINGTON (AP) -- The Clinton administration wants to spend more than \$100 million helping children's hospitals and fighting childhood asthma.

Both initiatives will be included in the budget President Clinton submits to Congress next week for the fiscal year starting Oct. 1, said a White House official, speaking on the condition of anonymity.

The \$68 million asthma plan, which first lady Hillary Rodham Clinton is announcing this afternoon at the White House, was billed as the "first-ever comprehensive, administration-wide strategy" to fight the disease. Most of the money -- \$50 million -- would be used for competitive state grants to identify and treat poor children served by Medicaid who have asthma.

Mrs. Clinton also was scheduled to unveil proposed new subsidies for training pediatricians in speech at the National Press Club.

The government now helps pay for training doctors by reimbursing hospitals through the Medicare program for the elderly. But that system is based on the number of Medicare patients a hospital sees, which creates a disadvantage for hospitals that treat mainly children.

Children's hospitals lose money each year, more than other teaching hospitals, partly because of this inequity, the administration contends. The \$40 million would come through an existing grant programs and amount to about \$9,380 per resident. The average hospital would see \$689,000.

The asthma initiative would help schools educate children and parents on how to avoid attacks, support research into environmental hazards and pay for a public information campaign. It would be administered by the Department of Health and Human Services and the Environmental Protection Agency and was developed in part by Vice President Al Gore.

Over the last 15 years, the number of children with asthma has doubled to about 6 million, with an even steeper increase -- about 160 percent -- among children under age 5. More than 100,000 children are hospitalized with the ailment each year.

Black children suffer the most. Their risk of contracting the disease is only slightly higher than it is for other children, but they are more than four times as likely to die from it.

The initiative would provide:

--\$8.4 million for schools to teach parents and children the importance of asthma medication and how to identify and avoid materials that trigger attacks. The administration estimates this initiative will reach more than 2 million children.

--\$2 million for new research into the role chemicals, pesticides and cigarette smoke play in the onset of asthma. Another \$1 million would be used by EPA to monitor air pollution in two communities to examine its relation to asthma.

--\$5.2 million for a public information campaign, including posters, flyers and brochures, to reduce children's exposure to tobacco smoke and other asthma triggers.

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FIRST LADY HILLARY CLINTON UNVEILS NEW, \$68 MILLION INITIATIVE TO FIGHT ASTHMA

January 28, 1999

Today, First Lady Hillary Rodham Clinton unveiled a new, \$68 million initiative to fight childhood asthma through a comprehensive national strategy that includes new efforts to: (1) implement school based programs that teach children how to effectively manage their asthma; (2) invest in research to determine environmental causes of asthma and to develop new strategies to reduce children's exposure to asthma triggers; (3) provide funds to states and providers to help them implement effective disease management strategies that will insure we lower hospitalizations, emergency room visits and deaths from asthma; and (4) conduct a new public information campaign to reduce exposure to asthma triggers and dust mites.

MILLIONS OF CHILDREN SUFFER FROM ASTHMA

Over the past 15 years, the number of children afflicted with asthma has doubled to total about 6 million. The most rapid increase in prevalence over this time period has occurred in children under the age of 5, with rates increasing over 160 percent. Over 100,000 children are hospitalized each year because of asthma, making it the leading cause of hospitalization due to chronic illness for children at a cost of \$1.9 billion in medical expenses annually. Asthma is also one of the leading causes of school absenteeism, resulting in over 10 million missed school days each year. Minority children are disproportionately affected by asthma. Although African American children under the age of 18 have only a slightly higher risk of actually having asthma than non-Hispanic white children, they experience a disproportionately higher rate of death from asthma attacks, over four times the rate for white children. Many children with asthma remain chronically impaired because they lack support systems that enable them to effectively manage their own disease or access sufficient medications or equipment.

DEVELOPMENT OF A NEW NATIONAL STRATEGY

Today, the First Lady will release "Asthma and the Environment: A Strategy to Protect Children," authored by the Environmental Task Force on Environmental Health Risks and Safety Risks to Children, which is co-chaired by the Environmental Protection Agency and the Department of Health and Human Services. This report outlines the first-ever comprehensive, Administration-wide strategy to fight childhood asthma. The Task Force makes four recommendations for asthma that will reduce the incidents of asthma in children, as well as hospitalizations, and emergency room visits for asthma. The four steps for federal action are: strengthening and accelerating research efforts to better understand the environmental factors that exacerbate childhood asthma, expanding school based programs that reduce environmental exposures to asthma, collecting better data at the local level to track asthma incidents, and educating health care providers serving low income children about the most effective course of treatment for asthma.

LARGEST EVER FEDERAL INVESTMENT TO FIGHT CHILDHOOD ASTHMA

Today, the First Lady announced a new \$68 million initiative to address asthma. This package of investments responds to Task Force recommendations and includes:

- **IMPLEMENTING SCHOOL-BASED ASTHMA PROGRAMS.** The Environmental Protection Agency (EPA), together with the Department of Education, will invest \$8.4 million to expand school-based programs that teach parents and children how to identify and avoid allergens that trigger an asthma attack, as well as why it is important to use their asthma medication and their inhalers. EPA will also expand programs that educate teachers and school staff to help them eliminate potential triggers from the school environment. With this investment, over 2 million children will be able to breathe easier in their classrooms.
- **INVESTING IN NEW RESEARCH TO REDUCE CHILDREN'S EXPOSURE TO ASTHMA TRIGGERS.** The Environmental Protection Agency will invest \$2 million to expand its research into the role that environmental hazards (including chemicals, particles, ozone, diesel exhaust, pesticides, tobacco smoke and allergens) play in the onset of childhood asthma. The Environmental Protection Agency will also invest \$1 million to conduct a pilot program to expand air pollution monitoring in up to two communities downwind of industrialized urban centers to better understand the relationship between air pollution and asthma. These new investments builds on the Administration's long-standing commitment to asthma research. This year, the National Institutes of Health will invest over \$110 million dollars in research to explore the cause of asthma and develop strategies to better manage the disease, and plans to continue this significant investment in FY2000.
- **IMPLEMENTING NEW DISEASE MANAGEMENT STRATEGIES TO TARGET LOW INCOME CHILDREN.** The Department of Health and Human Services will provide \$50 million in competitive grant funds to States who identify and treat asthmatic children enrolled in the Medicaid program in accordance with the new disease management guidelines developed by the National Institutes of Health. These guidelines will help to ensure that children receive the appropriate medication and are taught how to effectively manage their illness. Through this initiative, participating states will collect data on asthma incidents so we can better understand asthma and effects. In addition, HHS will invest almost \$2 million to work with State officials and other providers nationwide to help them integrate these new strategies into their current patterns of practice.
- **CREATING A NEW NATIONAL PUBLIC INFORMATION CAMPAIGN.** The Environmental Protection Agency and the Department of Health and Human Services will invest \$5.2 million in a national public information campaign to reduce children's exposure to environmental tobacco smoke and other indoor asthma triggers through a national public service campaign that uses posters, flyers, and brochures that identify common asthma triggers, such as pet hair or tobacco smoke, and simple solutions for eliminating or avoiding them; expands existing in-home education networks, such as community based lead prevention programs, and utilizes Americorps and VISTA volunteers to provide direct assistance to parents in identifying asthma triggers and implementing intervention strategies; and using health care providers and managed care organizations to help parents reduce their children's exposure to asthma triggers.

Clinton Targets Childhood Asthma

Associated Press

President Clinton will ask Congress for \$68 million to attack childhood asthma and \$40 million to subsidize the training of pediatricians by children's hospitals, according to the White House.

Both initiatives will be included in the proposed fiscal 2000 federal budget Clinton will submit next week, said the official, speaking on the condition of anonymity.

The asthma plan, to be announced today at the White House,

was billed as the "first-ever comprehensive, administration-wide strategy" to fight the disease. Most of the money—\$50 million—would be used for competitive state grants to identify and treat poor children who have asthma and are served by Medicaid.

First lady Hillary Rodham Clinton was scheduled to unveil the proposed new subsidies for training pediatricians in a speech at the National Press Club.

The government helps pay for the training doctors receive by reim-

bursing hospitals through the Medicare program for the elderly. But that system is based on the number of Medicare patients a hospital sees, creating a disadvantage for hospitals that mainly treat children.

Children's hospitals lose money each year, more so than other teaching hospitals partly because of this inequity, the administration contends. The \$40 million would come through an existing grant program and would amount to about \$9,380 per resident. The average hospital would receive \$689,000.

Light Linked to Gamma Ray Burst

Eruption Originated About 10 Billion Light-Years Away

Associated Press

For the first time, astronomers have recorded visible light from the source of a gamma ray burst, a mysterious deep space eruption more powerful than the energy of 10 million billion stars, researchers report.

The gamma ray burst was detected at 4:47 a.m. EST Saturday by two orbiting observatories. News of the event was relayed through a network to astronomers. Ground-based telescopes were able to capture optical light from the fading afterglow that followed the 110-second peak of the burst.

Gamma ray bursts are common, happening several times a week. But they come and go so swiftly that astronomers have never before been able to link optical observations with the gamma ray detection.

Officials said the stellar eruption originated about 10 billion light-years away but was so powerful in visible light that it could have been sighted from the ground with binoculars if, by chance, someone had been looking.

NASA said that the burst appeared to originate from near the constellation Corona Borealis, visible in the predawn northern sky.

The gamma ray burst phenomenon was discovered in 1967. They occur randomly across the sky several hundred times a year, with the peak of each burst lasting from a few milliseconds to a few minutes. Astronomers do not know their origin or precise cause; some speculate that the bursts originate from black holes. Since gamma rays are invisible to the eye, the eruptions were unknown until the development of gamma ray detectors.

The burst last Saturday was detected by NASA's Compton Gamma Ray Observatory and by the Italian-Dutch satellite BeppoSAX. Both satellite observatories regularly monitor the sky in search of such stellar events.

The satellites pinpointed the sky location of the burst, and the data were relayed quickly to other observers. Visible light was then detected by teams from the California Institute of Technology using a telescope at the Mount Palomar Observatory in California and by observers from Washington's Carnegie Institute, using the Keck II telescope in Hawaii.

Based on the measured intensities of the light and the gamma rays, experts estimated energy released from the explosion could have been equal to the energy of 10 million billion stars like the sun.

The Washington Post

THURSDAY, JANUARY 28, 1999

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Los Angeles Times

POLITICS & GOVERNMENT

HELP?

Thursday, January 28, 1999

Nation IN BRIEF / WASHINGTON, D.C.

Asthma Sufferers May Get Some Relief

From Times Wire Reports



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President Clinton will ask Congress for \$68 million to attack childhood asthma and \$40 million to subsidize training of pediatricians by children's hospitals, a White House official said. Both initiatives will be included in the proposed fiscal 2000 federal budget that Clinton will submit next week. The asthma plan, to be announced today at the White House, was billed as the "first-ever comprehensive, administration-wide strategy" to fight the disease. Most of the money--\$50 million--would be used for competitive state grants to identify and treat poor children served by **Medicaid** who have asthma.

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ASTHMA Qs and As
January 27, 1999 (2 PM)

Consolidated DRAFT DHHS and EPA Qs and A's. Department/Agency that prepared each response is identified in () following each question..

Q: What is asthma? (DHHS)

A: Asthma is a chronic lung disease characterized by recurrent episodes of breathlessness, wheezing, coughing, and chest tightness. The severity of asthma attacks can range from mild to life threatening.

Q: What causes asthma? (DHHS)

A: Why some people develop the chronic airway inflammation that is the hallmark of asthma is not well understood. Genetic factors seem to play a strong role, as do events early in life - such as respiratory infections, exposures to allergens and tobacco smoke - and other factors such as the diets of mother and child and the child's exercise level. Among those who incur the chronic airway inflammation, environmental triggers and life style have a material influence on how frequently the attacks occur, how severe they are, and how readily they can be suppressed by medication.

Q: What can asthma sufferers do about it? (DHHS)

A: Health care professionals do not know how to prevent asthma from developing. But both the frequency and severity of symptoms can be reduced by the use of medications and by reducing environmental and behavioral triggers of asthma attacks.

Q: Why does asthma warrant attention by the federal government? (DHHS)

A: Three reasons:

1. Asthma has reached epidemic proportions in the United States. Over the past fifteen years, the number of Americans afflicted with asthma has doubled to about 15 million - including over 5 million children. The fastest growing group of asthma sufferers is children under five years old. Asthma affects Americans of all ages, races, and ethnic groups - with low income and minority populations experiencing significantly higher rates of fatalities, hospital admissions, and emergency room visits due to asthma.

2. Asthma's secondary effects are wide ranging. It is a leading cause of school absenteeism, accounting for over 10 million missed school days. Asthma symptoms not severe enough to require a visit to the emergency room or to a physician can still substantially restrict the activities and impair the quality of life. Asthma results in many lost nights of sleep, limitation of activity, and disruption of family and care giver routines, with additional social and economic consequences including lost work days.

3. Asthma care is a huge financial burden. In 1990, the cost of asthma to the U.S. economy was estimated to be \$6.2 billion, with the majority of the expense attributed to medical care. A 1996 analysis found the annual cost to be \$14 billion.

Q: Where do we stand in countering this epidemic? (DHHS)

A: Critical breakthroughs in science in the last decade have generated a body of information that, when effectively translated to patients, enables most people with asthma to live fully active lives. The National Asthma Education and Prevention Program, co-sponsored by the National Heart, Lung and Blood Institute, developed Guidelines for the Diagnosis and Management of Asthma, which translate the scientific findings into recommendations for patient care. By implementing these Guidelines, health care providers, care-givers, and most patients with asthma can work together successfully to control the disease.

The Guidelines contain advice about appropriate medical care, self-monitoring of symptoms, control of allergens and other environmental triggers in the indoor environment, avoidance of triggers that cannot be controlled, and abstention from behaviors that exacerbate asthma symptoms. The Guidelines present a set of practices that, in combination, can reduce the frequency and severity of asthma attacks. However, more research is needed to further refine these guidelines. In particular, better strategies for environmental interventions are needed as well as concerted research efforts to learn enough about the causes of asthma to establish primary prevention guidelines.

Many asthma patients remain unnecessarily ill because of a complex interplay of factors that prevent the Guidelines from being fully implemented. Many health care professionals, teachers, day-care workers, workplace monitors, and others in a position to apply the guidelines are not sufficiently familiar with them. Many people lack access to quality medical care or resources to obtain sufficient medications or equipment. Furthermore, even with high quality care, some patients' asthma is not readily controlled; and others experience adverse side effects for the currently available medications.

Q. What is the relationship between asthma and the environment? (EPA)

Our understanding of the relationship between environmental exposures and the development (i.e., onset) of asthma in non-asthmatic children is limited.

However, the environmental triggers of asthma attacks have become increasingly well-understood. There is strong and convincing evidence that particulate matter and ozone are associated with exacerbation of asthma-related symptoms, increases in hospitalization for respiratory causes for persons with asthma, decrements in lung function and increased medication use. Air pollution also might act synergistically with other environmental factors to worsen asthma and some evidence suggests that exposure to ozone can enhance a person's responsiveness to inhaled allergens.

House dust mites, cockroaches, mold and animal dander have been identified as the principal allergens that trigger asthma symptoms. Reducing exposure to these allergens has been shown not only to reduce asthma symptoms and the need for medication, but also to improve lung function. Environmental tobacco smoke (also called secondhand smoke) is an important irritant that can trigger an asthma episode and possibly worsen the effects of allergens.

Q: In emphasizing environmental triggers, are you suggesting that people could avoid asthma if they simply cleaned their houses better? (DHHS)

A. Of course not. This is not a matter of blaming the victim. The issue is to help people understand and deal with those things in their day-to-day living environments such as animal dander and tobacco smoke that trigger asthma attacks.

Q. What has the Clinton Administration done to combat asthma? (DHHS & EPA)

A. Although a great deal of work is still ahead of us in the fight against asthma, the Administration is proud of the work it has accomplished to date:

Major Accomplishments of the Department of Health and Human Services (DHHS)

The Department of Health and Human Services supports research, health services delivery, and public health practice to address the growing problem of asthma.

Research. This year, enhancing its investments of recent years, HHS will invest over \$100 million in asthma research. HHS-supported grantees have been responsible for many of the scientific breakthroughs that helped shape the Guidelines for the Diagnosis and Management of Asthma.

Health Services Delivery. Medicaid and Medicare expenditures for treatment of asthma are estimated to exceed one billion dollars per year. In addition, thousands of people each year receive care for their asthma at HHS-funded facilities such as community health centers and hospitals of the Indian Health Service.

Public Health Practice. Current spending on public health programs, apart from direct patient care, is approximately \$5 million. The Department supports model programs and partnerships that convey information about asthma management to public health officials, health care providers, patients, and their family members.

Major EPA Accomplishments

Air Pollution. In July 1997, EPA updated the public health standards for smog (ozone) and particulate matter (soot). These standards were based on protecting sensitive populations such as children. These standards will prevent approximately 15,000 premature deaths, about 350,000 cases of aggravated asthma and nearly a million cases of significantly decreased lung function in children.

Research. In August 1998, EPA and DHHS established the first-ever federal research centers dedicated solely to studying children's environmental health hazards. Jointly funded by EPA and DHHS, these Centers for Children's Environmental Health Research were created at eight leading research institutions. Five of these centers are focusing on asthma. They will better our understanding of the link between secondhand smoke, smog, and other pollutants and the rise in asthma rates.

Secondhand Smoke. EPA completed a landmark risk assessment in 1993 on the health effects of secondhand smoke on adults and young children, including strong conclusions on the relationship between secondhand smoke and the frequency and severity of asthma attacks. This report has led to major public policy changes resulting in substantial reductions in exposure of children and adults to secondhand smoke.

Public Health Education. EPA has led the effort to provide practical solutions to problems associated with indoor air pollution and has published extensive guidance for the public and building managers to help reduce exposure to asthma triggers in schools, homes, and day care facilities.

Q: What are DHHS' priorities in countering asthma? (DHHS)

A: The Department has four priorities:

- to determine the causes of asthma and develop interventions to prevent it from developing in the first place;
- to reduce the burden of asthma for people with the disease;
- to eliminate the disproportionate health burden of asthma in minority populations and those living in poverty; and
- to track the disease and assess the effectiveness of asthma programs.

Q: What will DHHS do to reduce the burden of asthma? (DHHS)

A: The Department, in collaboration with public and private partners, will continue to foster public health programs that improve access to quality medical care and foster widespread use of current medical and scientific knowledge to prevent and/or reduce the severity of asthma attacks. The Department also will expand research with a view to discovering and developing improved means of managing asthma, including determining more about the triggers of asthma attacks and the variability among patients with respect to their response to these triggers.

Q. What are EPA's priorities in countering asthma? (EPA)

The President's FY2000 budget includes \$22 million for the U.S. Environmental Protection Agency to address environmental factors that contribute to the rising rates of asthma. These funds will help reduce children's exposure in the home, schools, and day care facilities to known asthma triggers such as secondhand smoke and indoor allergens (e.g. dust mites, animal dander, insects, and mold) by:

- *Implementing School-based Programs:* EPA will invest \$8.4 million to expand outreach and educational programs to inform parents, teachers, and children about how to improve indoor air quality for children with asthma and manage potential asthma triggers. With this investment, 2 million children across the nation will breathe cleaner air in their classrooms.
- *Creating a New National Public Information Campaign:* EPA and DHHS will work together to develop and implement a national public information campaign to reduce children's exposure to secondhand smoke and other indoor asthma triggers. This campaign will include: a \$4 million dollar national public service campaign and expanded community-based outreach programs; a \$1 million dollar expansion of existing in-home education networks to provide direct in-home assistance to help parents identify asthma triggers and implement effective strategies to reduce health risks; and \$1.2 million dollars to better equip health care providers to educate children and their parents about ways to reduce exposure to asthma triggers.
- *Researching the Link Between Environmental Factors and Asthma:* EPA will spend \$5 million to expand its research into the role that environmental hazards (including chemicals, particles, ozone, diesel exhaust, pesticides, tobacco smoke and allergens) play in the onset of childhood asthma and to develop better and more practical strategies for improving the quality of life of children with asthma. EPA will also invest \$1 million to conduct a pilot program to expand air pollution monitoring in up to two communities downwind of industrialized urban centers to better understand the relationship between air pollution and asthma.

Q: What will DHHS do to reduce the disproportionate burden of asthma upon racial and ethnic minorities and disadvantaged populations? (DHHS)

A: The Department will foster research and other activities toward

understanding of the causes of the disproportionate impact of asthma; for example, distinguishing the roles in asthma incidence and prevalence of location-specific, and, in cooperation with EPA, environmental factors (e.g., air pollution, occupational exposures) from those of ethnicity, cultural variables, and genetics;

assessing the impact of managed care on Medicaid children and adults with asthma; and

determining the relative influences of poverty, race, and ethnicity on the use of emergency room services for asthma.

Q: How will DHHS track the asthma epidemic to determine the effectiveness of its programs? (DHHS)

A: Current surveillance capability permits the Centers for Disease Control and Prevention to track asthma prevalence, asthma physician office visits, asthma emergency room visits, asthma hospitalizations, and asthma mortality at a national level and in four geographic regions. Except for mortality data, this type of information generally is unavailable at the state or local level. In future years, the Department will be seeking to improve the scope and depth of asthma surveillance. The Department also will seek to complement surveillance – e.g., with studies designed to identify populations with high or low asthma prevalence that might shed light on factors that influence the development of asthma. EPA will also utilize data available through DHHS programs to the extent possible to help it evaluate the effectiveness of environmental interventions in reducing the impact of childhood asthma.

Q. What will the Children's Asthma and the Environment strategy accomplish? (EPA)

This strategy is important for several reasons:

- It consolidates federal resources and expertise to focus on this epidemic.
- It establishes four principles for Federal efforts in this area:

A focus on efforts to:

--eliminate the disproportionate impact of asthma in minority populations and those living in poverty;

--emphasize partnerships and community based programs;

--commit to setting measurable and consistent goals for childhood asthma under the Healthy People 2010 program;

--invest in evaluation to identify those strategies that are most effective in reducing the burden of asthma so that they may be replicated.

- The strategy also calls for action in four areas:

Research: Research will be conducted to understand the role environmental pollutants (including chemicals, fine particles, ozone, diesel exhaust, pesticides, tobacco smoke and allergens) play in the onset of asthma episodes in children and what causes asthma. This research will help us develop practical strategies for improving the quality of life of children with asthma.

Public Health Programs: Using our current scientific knowledge, DHHS and EPA will implement public health programs that reduce environmental exposures to asthma triggers to prevent and reduce the severity of asthma attacks. This will include: promoting national guidelines to reduce environmental factors that worsen asthma; expanding support for state and local public health action; establishing school-based asthma programs in communities to help reduce and eliminate allergens and other environmental risk factors in schools; and reduce children's exposure to environmental tobacco smoke and other indoor asthma triggers in their homes.

Surveillance: Establish a coordinated, integrated, systematic nationwide asthma surveillance system for collecting and analyzing health outcome and risk factor data at the state, regional and local levels.

Addressing disproportionate impacts on the poor and minorities: We plan to eliminate the disproportionate burden of asthma among different racial groups and those living in poverty. We will conduct research and surveillance to better understand the scope of the problem and implement activities designed to reduce and eventually eliminate this disproportionate impact.

Q. What is the initiative on disease management? (DHHS)

DHHS proposes to conduct a demonstration to test the use of innovative disease management techniques for children enrolled in the Medicaid fee-for-service program. The Department will provide \$50 million for competitive start-up grants to states that submit meritorious disease management programs to identify and treat children with asthma using the most appropriate care - the NHLBI guidelines for Diagnosis and Management of Asthma. Participating states would be required to measure the success of the program.

Q. What is Disease Management? (DHHS)

Disease management combines the use of the most-up-to-date treatment protocols ("best practices") with a prevention component -i.e., disease-specific education programs and health screening; an intensive case management component -i.e., close monitoring of patient care and treatment compliance; and a self-care component -i.e., empowering patients and their families to identify symptoms and care for their own chronic disease.

Asthma and the Environment:

A Strategy to Protect Children



President's Task Force on Environmental Health
Risks and Safety Risks to Children

ABOUT THE PRESIDENT'S TASK FORCE ON ENVIRONMENTAL HEALTH RISKS AND SAFETY RISKS TO CHILDREN

In recognition of the growing body of scientific information demonstrating that America's children suffer disproportionately from environmental health risks and safety risks, President Clinton issued Executive Order 13045 on April 21, 1997, directing each Federal Agency to make it a high priority to identify, assess, and address those risks. In issuing this order, the President also created the Task Force on Environmental Health Risks and Safety Risks to Children, co-chaired by Donna Shalala, Secretary of the Department of Health and Human Services, and Carol M. Browner, Administrator of the Environmental Protection Agency. The



Task Force was charged with recommending strategies for protecting children's environmental health and safety. Two subcommittees were established in the Executive Order to carry out this directive: a subcommittee directed to review and foster public access to federal government sponsored research on environmental health and safety risks to children, and a subcommittee directed to identify priority public outreach activities related to protecting children's environmental health and safety.

In April 1998, the Task Force identified four priority areas for immediate attention: childhood asthma, unintentional injuries, developmental disorders, and childhood cancer. The Task Force created and charged the Asthma Priority Area Workgroup, co-chaired by EPA and DHHS, with reviewing current Federal efforts to address the many facets of the issue and, most importantly, to make appropriate recommendations for action by the Federal government. This strategy is the result of that effort.

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MEMBERS OF THE PRESIDENT'S TASK FORCE ON ENVIRONMENTAL HEALTH RISKS AND SAFETY RISKS TO CHILDREN

Honorable Donna E. Shalala
Co-chair
Secretary
Department of Health and Human Services

Honorable Carol M. Browner
Co-chair
Administrator
Environmental Protection Agency

Honorable Alexis Herman
Secretary
Department of Labor

Honorable Janet Reno
Attorney General
Department of Justice

Honorable Andrew Cuomo
Secretary
Department of Housing and Urban
Development

Honorable Bill Richardson
Secretary
Department of Energy

Honorable Richard Riley
Secretary
Department of Education

Honorable Dan Glickman
Secretary
Department of Agriculture

Honorable Rodney Slater
Secretary
Department of Transportation

Honorable Jacob J. Lew, Director
Office of Management and Budget

Honorable George Frampton, Acting Chair
Council on Environmental Quality

Honorable Ann Brown
Chairman
Consumer Product Safety Commission

Honorable Janet Yellen
Chair
Council of Economic Advisors

Honorable Neal Lane, Director
Office of Science and Technology Policy

Honorable Gene Sperling
Assistant to the President for Economic Policy

Honorable Bruce Reed
Assistant to the President for Domestic Policy

ASTHMA PRIORITY AREA WORKGROUP MEMBERS

Stephen Redd, MD (Co-chair)
National Center for Environmental Health
Centers for Disease Control and Prevention

Robert Axelrad (Co-chair)
Office of Children's Health Protection
Environmental Protection Agency

Mary White, Sc.D
Division of Health Studies
Agency for Toxic Substances and Disease Registry

John Talbott
Office of Building Technologies
Department of Energy

Ron Ashford
Department of Housing and Urban Development

Warren Friedman, Ph.D, CIH
Office of Lead Hazard Control
Department of Housing and Urban Development

Tracey Mitchell
Indoor Environments Division
Environmental Protection Agency

Marshall Plaut, M.D.
National Institute of Allergy and Infectious Diseases
National Institutes of Health

Jerry Phelps
National Institute of Environmental Health Sciences
National Institutes of Health

Virginia Taggart, M.P.H.
National Heart, Lung, and Blood Institute
National Institutes of Health

Hillel Koren, Ph.D.
National Health and Environmental Effects Laboratory
Office of Research and Development
Environmental Protection Agency

Caroline Freeman
Occupational Safety and Health Administration
Department of Labor

George Malindzak, Ph.D
National Institute of Environmental Health Sciences
National Institutes of Health

Lucas Neas, Ph.D
National Health and Environmental Effects Laboratory
Office of Research and Development
Environmental Protection Agency

Edward Chu
Office of Children's Health Protection
Environmental Protection Agency

Marilyn Wind
Consumer Product Safety Commission

Stacey Katz
Office of Science Policy
Department of Health and Human Services

Polly Hoppin, Sc.D
Office of Science Policy
Department of Health and Human Services

EXECUTIVE SUMMARY

An epidemic of asthma is occurring in the United States. While the epidemic affects people of all ages, children are particularly affected. Nearly 1 in 13 school-aged children has asthma, and the percentage of children with asthma (i.e., prevalence rate) is rising more rapidly in preschool-aged children than in any other age group.

There is no national system to collect data from states specifically on asthma, although several states are developing systems to collect such data. Although national data do not provide the resolution necessary to identify particular geographic areas hardest hit by the asthma epidemic, surveys undertaken in a number of large cities in the United States indicate that the prevalence and severity of asthma are greatest in the large, urban inner cities.

**An epidemic
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States.**

Asthma is one of the leading causes of school absenteeism, accounting for over 10 million missed school days per year. Asthma also accounts for many nights of interrupted sleep, limitation of activity, and disruptions of family and care-giver routines. Asthma symptoms that are not severe enough to require a visit to an emergency room or to a physician can still be severe enough to prevent a child with asthma from living a fully active life.

In 1990, the cost of asthma to the U.S. economy was estimated to be \$6.2 billion, with the majority of the expense attributed to direct medical expenses. A 1996 analysis found the cost of asthma to be \$14 billion, indicating a rapidly increasing financial burden. These estimates, which are not limited to the costs of childhood asthma, indicate that the direct medical costs of asthma account for between 1% and 3% of all health care expenditures in the United States.

Asthma is a particularly important disease to consider in the context of environmental hazards to which children are exposed. Children breathe more air, eat more food, and drink more liquid in proportion to their body weight than do adults, and their developing respiratory, immunological, and digestive systems may be more susceptible to environmental exposures than those of adults. In a typical day, children may be exposed to a wide array of environmental agents at home, in day care centers, schools and while playing outdoors. There is substantial evidence that environmental exposures, including viruses and allergens, play a major role in triggering asthma symptoms. Indoor airborne allergens include those from house dust mites, cockroaches, mold and animal dander. In addition, exposure to environmental tobacco smoke (ETS), also known as secondhand smoke, has been shown to be a major determinant of asthma symptoms. Elevated levels of outdoor air pollutants, particularly ozone and exposure to outdoor allergens (e.g. pollens, molds), are associated with increased symptoms and an increased risk of emergency department visits for asthma, as well.

In addition, environmental factors such as airborne allergens and environmental tobacco smoke may play a major role in the onset of asthma. Other pollutants may also play a role, although the scientific data are inadequate to offer firm conclusions. Genetic predisposition is the strongest known risk factor for developing asthma, but the rapidly rising number of cases of childhood asthma cannot be solely genetic because the genetic composition of the population changes slowly. Rather, some interaction between genetic predisposition and environmental exposures, and possibly other factors such as diet, increased body weight, or lack of exercise are likely to be responsible for the increase. Further work is essential to clarify how genetic susceptibility and environmental exposures interact to cause asthma.

Reducing exposures of children with asthma to airborne allergens and pollutants will reduce the health burden of asthma and significantly improve their quality of life. It is not yet certain, but it is possible that reducing the exposure of infants and young children at risk of developing asthma may prevent its onset. Environmental control methods and asthma treatments are available now that can help children and their families control asthma and lead healthy, active lives. Yet not all children have access to these measures. Too many children miss school, limit their physical activity, and are seriously ill because of asthma. A child ill with asthma also has an impact on the entire family.



This strategy, prepared by the Task Force, is aimed at developing a further understanding of the role of environmental factors associated with the:

- onset of asthma; and
- triggers of asthma attacks

The efforts of the Task Force resulted in four recommendations for Federal action for addressing childhood asthma, which are presented in this strategy. The strategy also sets forth guiding principles that were used to develop the four recommendations.

GUIDING PRINCIPLES

Federal agency actions can provide leadership and direction in reducing environmental risks to protect children who have asthma or are at risk of developing it. Recommendations for action put forward in this initiative are predicated on the principles that federal action must have:

- A focus on efforts to *eliminate the disproportionate impact of asthma in minority populations and those living in poverty.*
- An emphasis on *partnerships and community based programs.*
- A commitment to setting *measurable and consistent goals* for childhood asthma under the Healthy People 2010 program.

- *An investment in evaluation* to identify those strategies that are most effective in reducing the burden of asthma so that they may be replicated.

RECOMMENDATIONS

RESEARCH

Strengthen and accelerate focused research into the environmental factors that cause or worsen childhood asthma.

⇒ Strengthen and accelerate research into the environmental factors that may contribute to the onset of asthma in children.

⇒ Expand and accelerate research to develop and evaluate environmental strategies that will improve the quality of life of people with asthma.

This initiative is about protecting children from environmental risks that either cause or worsen asthma...

PUBLIC HEALTH PROGRAMS

Implement public health programs that foster improved use of current scientific knowledge to reduce environmental exposures to prevent and reduce the severity of symptoms for those with asthma.

⇒ Promote clinician and patient implementation of national guidelines for reducing environmental risks that worsen asthma.

⇒ Expand support for state and local public health action.

⇒ Reduce children's exposure to environmental tobacco smoke and other indoor triggers in their homes.

⇒ Establish school based asthma programs that help reduce or eliminate allergens and irritants and that promote student's self management of asthma and full participation in school activities.

⇒ Continue to reduce outdoor air pollution.

SURVEILLANCE

Establish a coordinated, integrated, and systematic nationwide asthma surveillance system for collecting and analyzing health outcome and risk factor data at the state, regional and local levels.

DISPROPORTIONATE IMPACT ON THE POOR AND MINORITIES

Identify the reasons for and eliminate the disproportionate burden of asthma among different racial and ethnic groups and those living in poverty.

⇒ Improve asthma management for children within the medicaid program.



INTRODUCTION

The Growing Problem of Asthma in Children

Asthma is a chronic inflammatory lung disease characterized by recurrent episodes of breathlessness, wheezing, coughing, and chest tightness; these episodes are also known as exacerbations or attacks. The severity of exacerbations can range from mild to life threatening. Both the frequency and severity of asthma symptoms can be reduced by the use of medications and by reducing exposure to the environmental triggers of asthma attacks.

For the past 15 years, an epidemic of asthma has occurred in the United States. By all indications, this epidemic is continuing. Although asthma has become a major public health problem affecting Americans of all ages, races and ethnic groups, children have been particularly severely affected.



National survey data indicate that the number of children with asthma in the United States has more than doubled in the past 15 years. In 1980, 2.3 million American children had asthma. In 1995, the most recent year for which data are available, the number of affected children had risen to 5.5 million. Based on these trends, it is estimated that in 1998 more than 6 million children in the United States have asthma. Prevalence rates of asthma are highest in boys and are increasing in both boys and girls, and in all race and ethnic groups. The prevalence of asthma in children under age 18 is 7.3%. The most rapid increase has occurred in children under 5 years old, with rates increasing over 160% over the past 15 years.

The number of deaths attributed to asthma in children has also increased. In 1977, 84 deaths in children 18 and younger were recorded; the number of deaths has risen to 280 in 1995, a more than 3-fold increase. Although the death rate due to asthma has increased in all racial and ethnic groups, minority populations experience a disproportionately higher death rate from asthma. In 1995, the death rate from asthma in African-American children, 11.5 per million, was over four times the rate in white American children, 2.6 per million. The higher death rates among African-American children are especially troubling.

The number of hospitalizations and emergency room visits for asthma have increased in all population groups. Asthma accounts for one-third of all pediatric emergency room visits and is the fourth most common cause for physician office visits. The variation in the impact of asthma across racial and ethnic groups is significant. African-American children have an annual rate of hospitalization of 74 per 10,000, over 3 times that for white children, 21 per 10,000. In addition, African-American children are approximately 4 times more likely than white children to seek care at an emergency room. In short, African-American children have a slightly higher risk of getting asthma, but have a much higher risk of hospitalization or death due to the disease.

At the present time, surveillance for asthma in children is limited to analyses of ongoing surveys and data systems on health events such as mortality, hospitalization, and outpatient visits. Other than for African Americans, such information is extremely limited for most ethnic groups.

There is no national system to collect data from states specifically on asthma, although several states are developing systems to collect such data. Although national data do not provide the

resolution necessary to identify particular geographic areas hardest hit by the asthma epidemic, surveys undertaken in a number of large cities in the United States indicate that the prevalence and severity of asthma are greatest in the large, urban inner cities.

There is no national system to collect data from states specifically on asthma, although several states are developing systems to collect such data.

These measures, particularly for death, hospitalization, and emergency room visits, give an incomplete picture of the true burden of asthma in the United States. For example, one follow-up study of children with asthma in inner city areas found a nearly 10 times higher likelihood of a child suffering symptoms of asthma on a given day than visiting an emergency room. Asthma is one of the leading causes of school absenteeism, accounting for over 10 million missed school days per year. Asthma also accounts for many nights of interrupted sleep, limitation of activity, and disruptions of family and care-giver routines. Asthma symptoms that are not severe enough to require a visit to an emergency room or to a physician can still be severe enough to prevent a child with asthma from living a fully active life.

Estimating the costs of asthma is an indirect way to measure its health burden. In 1990, the cost of asthma to the U.S. economy was estimated to be \$6.2 billion (Weiss, 1992), with the majority of the expense attributed to direct medical expenses. A 1996 analysis (Farquhar, et al, 1998) found the cost of asthma to be \$14 billion, indicating a rapidly increasing financial burden. These estimates indicate that the direct medical costs of asthma for all ages account for between 1% and 3% of all health care expenditures in the United States.

What We Know About Childhood Asthma

Over the past 15 years, there have been major advances in the scientific understanding of asthma. Asthma is now known to be a disease of airway inflammation resulting from a complex interplay between environmental exposures and genetic and other factors. This has implications for the medical treatment and for the environmental management of asthma.

In contrast to the limited understanding of the relationship of environmental exposures to the onset of asthma, the environmental triggers of asthma attacks for children with asthma have become increasingly well characterized. House dust mites, cockroaches, mold and animal dander have been identified as the principal allergens that trigger asthma symptoms. Reducing exposure to these allergens has been shown not only to reduce asthma symptoms and the need for medication, but also to improve lung function. Environmental tobacco smoke is an important irritant that can trigger an asthma episode and possibly worsen the effects of allergens. Upper respiratory viral infections are also recognized as important triggers for asthma episodes.

Children with asthma have long been recognized as particularly sensitive to outdoor air pollution. Many common air pollutants, such as ozone, sulfur dioxide, and particulate matter are respiratory irritants and can exacerbate asthma. Air pollution also might act synergistically with other environmental factors to worsen asthma. For example, some evidence suggests that exposure to ozone can enhance a person's responsiveness to inhaled allergens. Whether long term exposure to these pollutants can actually contribute to the development of asthma is not known. To date, little research has examined the role of other hazardous air pollutants (e.g., metals and volatile chemicals) in the development or exacerbation of asthma, although this is an issue of increasing public concern.

Children with asthma have long been recognized as particularly sensitive to outdoor air pollution.

In addition to improved understanding of appropriate environmental management of asthma, the medical management of asthma has changed significantly. Inhaled anti-inflammatory medications have become the mainstay of medical management to prevent asthma episodes and lessen chronic symptoms of asthma. In addition, improvements in monitoring techniques now permit objective measures of lung function that are easy for patients and physicians to use in assessing asthma severity and monitoring changes in the disease. In a disease like asthma that varies considerably over time and where changes in lung function can occur before symptoms develop, these objective measures are essential tools for making management decisions.

As a result of these advances, the medical and environmental management of asthma is better defined and the knowledge exists to manage asthma better than ever before. One especially important finding is that patient education has been documented to be cost effective. Teaching patients and their families specific management skills improves asthma management, reduces the use of emergency services, and improves quality of life. This is particularly important for asthma management, since the environmental management of asthma requires knowledge of asthma triggers and specific actions that can be undertaken to reduce exposure to these triggers. The treatment goal for almost all individuals with asthma should be for that person to lead a life unrestricted because of asthma.

Reducing exposure to environmental allergens and pollutants will reduce the frequency and severity of attacks for children with asthma, reduce their need for medicine, and improve their lung function. Children are exposed to many environmental agents that could trigger asthma attacks. For example, 25% of children in America live in areas that regularly exceed EPA limits for ozone. Approximately 29% of households still permit exposure of children to secondhand smoke in the home on a regular basis and exposure to environmental tobacco smoke is so widespread that approximately 88% of all children have some level of documented exposure (Pirkle, 1996). A high proportion of children living in the inner city are exposed to high levels of cockroach antigen.

Why Has Asthma Reached Epidemic Proportions in Children?

The causes of the increasing rate of asthma over the past 15 years and the particular role that environmental exposures play are not known, but there are some clues. Atopy, the genetically inherited susceptibility to become allergic, is the most important predictor of a child developing asthma. A substantial research effort is underway to identify the genes that are responsible for susceptibility to asthma. Because the genetic make-up of the population changes slowly, genetic susceptibility alone cannot be responsible for the epidemic of asthma that has occurred in the United States over the past 15 years. Further work is essential to clarify how genetic susceptibility and environmental exposures interact to cause asthma. Factors such as the intensity of environmental exposure and the age of the person being exposed are likely to be important.

Exposure to allergens found indoors is a strong risk factor for developing asthma. Children are spending increasing amounts of time indoors, thus increasing their exposure to indoor allergens.

The causes of the increasing rate of asthma over the past 15 years and the particular role that environmental exposures play are not known

The environmental exposures most strongly suspected of causing asthma to develop include environmental tobacco smoke and allergens such as house dust mites, cockroaches, mold, and animal dander. Exposures that stimulate the immune system may also be significant, such as diet during the prenatal period and early infancy, the pattern of respiratory infections early in life, and even decreasing rates of exercise have all been suggested as risk factors for the development of asthma.

Scope of the Strategy

This strategy is about protecting children from the environmental risk factors that make their asthma worse. Environmental action may also help prevent asthma. To accomplish this goal, the environmental aspects of asthma must be considered in the context of other aspects of asthma prevention and management, such as access to quality medical care and efforts to understand the disproportionate health impact of asthma among minority populations. Childhood asthma is a multi-factorial disease, and efforts to improve its management and to prevent it will require multi-dimensional, multi-disciplinary efforts that must occur simultaneously. This Asthma and the Environment strategy focuses on improving the environment in which children with asthma live, learn, play and work. Environmental action, along with medical care, will help children with asthma live productive, active lives and may spare future generations of children from the disease altogether. The Task Force has prepared the following four goals to be accomplished in the next ten years, guided by the vision that in the 21st century, every child in America will live, learn, work, and play in environments that do not cause or worsen asthma.

GOALS OF THE ASTHMA AND THE ENVIRONMENT STRATEGY

BY THE YEAR 2005, THE NUMBER OF HOUSEHOLDS IN WHICH CHILDREN ARE REGULARLY EXPOSED TO SECONDHAND SMOKE WILL BE REDUCED TO 15%.¹

BY THE YEAR 2010, ASTHMA HOSPITALIZATION RATES IN CHILDREN WILL HAVE FALLEN TO NO MORE THAN 10 HOSPITALIZATIONS PER 10,000 PEOPLE.² (Healthy People 2010 DRAFT)

BY THE YEAR 2010, EMERGENCY DEPARTMENT VISITS WILL BE REDUCED TO NO MORE THAN 46 PER 10,000 PEOPLE.³
(Healthy People 2010 DRAFT)

BY THE YEAR 2010, NO MORE THAN 10% OF CHILDREN WITH ASTHMA WILL EXPERIENCE ACTIVITY LIMITATIONS.⁴
(Healthy People 2010 DRAFT)

1 Baseline: 29% in 1994. Source: Biennial Radon and ETS Survey of the Conference of Radiation Control Program Directors and EPA.

2 Baseline: Hospitalization rate per 10,000 population in 1993-94: 18 for total population; 50 for children 0-4 yrs of age and 18 for children 5-14 yrs. Source: Healthy People 2010 Draft

3 Baseline: Emergency room visits 71 per 10,000 population for total population in 1992-94; 121 for children 0-4 yrs of age and 81 for children 5-14 yrs. Source: Healthy People 2010 Draft

4 Baseline: Activity limitation for persons with asthma; 22 percent for overall population in 1992-94. No children-specific data available. Source: Healthy People 2010 Draft

VISION FOR THE 21ST CENTURY

Every child in America will
live, learn, work, and play
in environments that do
not cause or worsen
asthma.

GUIDING PRINCIPLES

Federal agency actions can provide leadership and direction in reducing environmental risks to protect children who have asthma or are at risk of developing it. Recommendations put forward in this strategy are predicated on the principles that federal action must have:

1. A focus on efforts to better understand and eliminate the disproportionate impact of asthma in minority populations and those living in poverty.

Poor and minority children are much more likely than white, non-Hispanic children to visit an emergency room, to be hospitalized, or to die from asthma, although the rising prevalence of asthma has affected all populations. The reasons for this disparity are not known, although environmental exposures and limited access to quality medical care may all play a role.

The focus on eliminating disparities across racial and ethnic groups has to be considered in all efforts to prevent asthma and its health impact; however, because of the importance of this issue the Task Force has included a specific recommendation in this strategy to examine, understand, and ultimately eliminate disparities.

2. An emphasis on partnerships and community based programs.

A successful effort to reduce childhood asthma will depend in part on the level of success achieved in enlisting all sectors of society in efforts to implement effective programs to prevent and manage the disease. Federal agencies have already forged effective partnerships with many health and professional organizations, corporations, and foundations to conduct training, educate health care providers and the public, and to implement a wide range of prevention activities at the national, state, and local levels.

Expanded partnerships both within government and between government and the private sector are needed. With increasing knowledge about the primary causes of asthma and triggers of asthma attacks, the challenge for the 21st century will be to integrate new research findings into effective environmental, medical and educational programs. Partnerships will be critical to implementing this broad vision of asthma control. In particular, community-based programs should integrate asthma control activities into existing systems such as schools, child care, youth programs, workplaces, primary health, and job training programs.

The challenge for the 21st century will be to integrate new research findings into effective environmental, medical and educational programs.

3. A commitment to setting measurable and consistent goals for childhood asthma under the Healthy People 2010 program.

Health objectives are now being developed for the year 2010 and represent a significant revision of the goals set for the year 2000. These objectives will set the nation's health agenda for increasing years of healthy life and reducing disparities among the entire American population. Draft objectives currently encompass an expanded set of asthma-related objectives for improved clinical management as well as a series of environmental objectives addressing known asthma triggers such as indoor allergens, secondhand smoke and outdoor air pollution. The goals embodied in the final Healthy People 2010 document will serve as the tools to measure progress towards control of asthma.

4. Investment in evaluation of programs to identify those strategies that are most effective in reducing the burden of asthma so that they may be replicated.

Asthma intervention programs and related activities need to be fully evaluated to determine those techniques which are successful and should be replicated. Evaluation should be incorporated in the planning of all programs and should include:

- identification of desired health outcomes of the program;
- measurement of effectiveness of the intervention activities and processes used to implement them;
- identification of unforeseen obstacles;
- assessment of the cost-effectiveness of the program;
- a prediction of long term sustainability of the program.

RECOMMENDATIONS

I. RESEARCH

Strengthen and accelerate focused research into the environmental factors that cause or worsen childhood asthma.

EXPAND RESEARCH INTO THE ENVIRONMENTAL FACTORS THAT CONTRIBUTE TO THE ONSET OF ASTHMA IN CHILDREN.

Though progress has been made in understanding what causes asthma, there is currently insufficient scientific information to establish specific guidelines and recommendations for public health practices to prevent the onset of asthma in children (i.e. primary prevention).

In order to establish primary prevention guidelines, the top priority for research is to determine the causes of asthma in children and particularly the role of the environment. To understand what causes asthma, research must identify the basic cellular and molecular mechanisms that cause airway inflammation and sensitization and, in particular, the interaction of environmental exposures and genetic susceptibility. In addition, clinical and epidemiologic studies are needed to examine the relationship between environmental exposures and the onset of asthma.



Because of promising preliminary work on the relationship of indoor allergens and asthma onset, as well as the much greater proportion of time that children spend indoors, greater emphasis on examining the relationship of indoor exposures to the development of asthma is warranted. Exposures to high levels of allergens in the indoor environment have been shown in some studies to be associated with the subsequent development of asthma. However, few studies have examined the importance, by geography, of particular allergens. In studies evaluating the role of indoor allergens on exacerbations of asthma, different allergens, such as those associated with cockroaches, dust mites, and mold, have been implicated in different cities. This suggests that different allergens can exacerbate asthma, and that different allergens may be capable of inducing the new onset of asthma.

In one study (Hyde, et al, 1997) avoiding exposure to dust mite and food allergens early in life was found to reduce the risk of developing asthma in the first year of life. However, this effect was not statistically significant at 2 to 4 years of age. Whether such allergen avoidance strategies are feasible and effective in reducing the development of asthma is not known.

The complex interactions between outdoor air pollutants and allergens and the development of asthma have not been adequately evaluated. Some epidemiologic studies have suggested a relationship between exposure to volatile organic compounds and prevalence rates of childhood asthma. Because adult-onset asthma is known to be associated with occupational exposures to volatile organic compounds including formaldehyde, ethylene oxide, and isocyanates, further work to assess the possible etiologic role of specific pollutants in childhood asthma is appropriate.

EXPAND AND ACCELERATE RESEARCH TO DEVELOP AND EVALUATE ENVIRONMENTAL STRATEGIES THAT WILL IMPROVE THE QUALITY OF LIFE FOR CHILDREN WITH ASTHMA.

It is well established that inhaled allergens and irritants and outdoor pollutants provoke asthma symptoms. Research is needed to identify if other environmental exposures are significant. Further, the relative importance of various exposures is not well understood. Cost effective strategies for reducing exposures are not well developed.

Patient education strategies in certain populations have profound impacts on reducing the frequency and severity of exacerbations and improving the quality of life for children. But many of these programs are not responsive to the cultural, ethnic, and economic diversity of the American population. Innovative strategies are urgently needed for reaching a wide range of children and their families, for tailoring recommendations for reducing environmental exposures to their needs, and for providing support to follow the recommendations.

2. PROGRAMS TO IMPROVE PUBLIC HEALTH

Implement public health programs that improve use of scientific knowledge to prevent and reduce the severity of asthma symptoms by reducing environmental exposures.

PROMOTE CLINICIAN AND PATIENT IMPLEMENTATION OF NATIONAL GUIDELINES FOR REDUCING ENVIRONMENTAL RISKS THAT WORSEN ASTHMA.

Despite uncertainty about the causes of the increase in asthma prevalence rates, much can and should be done to prevent severe illness and death from asthma and improve the quality of life of persons with asthma. Experts convened by the National Asthma Education and Prevention Program (NAEPP) coordinated by the National Institutes of Health (NIH) have reviewed the

scientific literature and produced guidelines for managing asthma. These include specific recommendations for controlling environmental factors that contribute to asthma severity.

While there is consensus that NAEPP guidelines define the best diagnosis and management practices for asthma, dissemination of the guidelines must be expanded and adoption improved. Many clinicians do not include advice about environmental control in their patient education. Among families who do receive recommendations, adherence is generally low. Asthma is highly variable, and families need help establishing priorities for environmental control measures that will be suitable for their individual child's asthma and their family circumstances. Effective public health programs can provide this education and support.

For children without access to quality health care, appropriate instruction on the environmental triggers of asthma is impossible or severely limited. Emergency rooms or urgent care facilities may serve as the only source of primary care for such children. These settings should be recruited to provide the kind of education and links to chronic disease management services that are essential to reducing the severity and frequency of asthma attacks.

EXPAND SUPPORT FOR STATE AND LOCAL PUBLIC HEALTH ACTION.

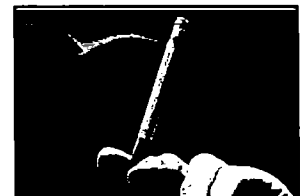
Recent advances in the treatment of asthma and in identifying the environmental triggers of asthma attacks make it possible to control and prevent symptoms at a level unheard of just ten years ago. But these gains have not been realized by many of our children. Public health agencies have a critical role in helping to reduce environmental factors affecting asthma and the human and financial toll of the disease. These programs should include the following components:



- (1) Education and training
- (2) Asthma surveillance
- (3) Coalitions for prevention

REDUCE CHILDREN'S EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE AND OTHER INDOOR TRIGGERS IN THEIR HOMES.

Secondhand tobacco smoke and indoor allergens are major contributors to the incidence of wheezing in young children and play a significant role in the number and severity of asthma attacks. Reducing smoking in homes with young children will improve the health status of the estimated 2 million children with asthma who are exposed to secondhand smoke. In addition, exposure to allergens such as cockroach, house dust mite, mold, and animal dander causes many attacks of asthma that are preventable.



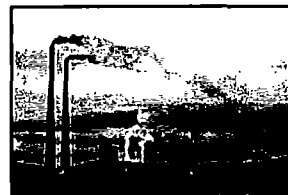
ESTABLISH SCHOOL BASED ASTHMA PROGRAMS IN EVERY COMMUNITY.

The educational system is a critical component of effective efforts to reduce illness due to asthma in children. Programs will be implemented in schools to assure a healthy physical environment at the school and to promote improved self-management of asthma through education.

CONTINUE TO REDUCE OUTDOOR AIR POLLUTION

The U.S. EPA set national ambient air quality standards (NAAQS) for six air pollutants in 1971, in part based on evidence of associations between air pollutants such as ozone, particulate matter, and sulfur dioxide and asthma. Since that time substantial new epidemiological evidence has been published supporting the association between levels of ozone and particulate matter and increased hospitalization for respiratory causes, such as childhood asthma. In 1997, NAAQS for both ozone and particulate matter were strengthened to improve the protection afforded by these standards and to help reduce the risk of ambient exposures that aggravate asthma in children.

Federal, State, local, and private sector efforts to implement the original NAAQS resulted in substantial improvements in air quality, yet notable problems remain. Following the 1990 Clean Air Act Amendments, efforts were expanded to improve nationwide air quality and reduce related health effects. In conjunction with the strengthening of the ozone and particulate matter NAAQS, EPA has taken steps to integrate implementation measures for these pollutants and to improve the effectiveness of control programs. EPA has also taken steps to inform the public about air pollution that may affect children.



3. SURVEILLANCE

Establish a coordinated nationwide asthma surveillance system for collecting and analyzing health outcome and risk factor data at the state, regional and local levels.

Current national surveillance permits tracking of asthma prevalence, asthma physician office visits, asthma emergency room visits, asthma hospitalizations and asthma mortality at a national level and in four geographic regions (i.e., Northeast, Midwest, South, and West) through surveys conducted by the National Center for Health Statistics. Surveillance information on asthma, with the exception of mortality data, are not available at the state or local level. This information is needed to identify high risk populations and environmental risk factors of

relevance to particular communities and to design and implement interventions that will be most suitable for, and therefore most likely to succeed, in that community. State and local health agencies also need this information to evaluate the impact of local sources of air pollution on childhood asthma in specific communities. A significantly enhanced and expanded surveillance program will be essential to study issues related to race and gender differences in asthma morbidity and mortality among children, identify gaps in providing comprehensive care, and monitor trends in asthma morbidity and mortality at the community level.

4. DISPROPORTIONATE IMPACTS ON THE POOR AND MINORITIES

Identify the reasons for and eliminate the disproportionate burden of asthma among different racial and ethnic groups and those living in poverty.

Poor and minority children are disproportionately affected by asthma, which has reached epidemic proportions in many American inner cities. Prevalence rates vary only by a few percentage points among different race and ethnic groups, yet emergency room use, hospitalization, and mortality rates vary 3- to 4-fold. Understanding the factors that contribute to the disproportionate impact of asthma on minority and lower income populations is the critical first step to reducing and eventually eliminating the disparities between rich and poor, minority and non-minority children. Such factors may include differing intensities of environmental exposures, such as exposure to cockroach antigen and access to and quality of care, among others.

Poor and minority children are disproportionately affected by asthma, which has reached epidemic proportions in many American inner cities.

IMPROVE ASTHMA MANAGEMENT FOR CHILDREN WITHIN THE MEDICAID PROGRAM.

Disease management combines prevention, intensive attention to treatment and patient compliance, and guidance for self-care. This concept has considerable promise for reducing the frequency and severity of asthma attacks. Integrating an asthma disease management initiative within the fee-for-service component of Medicaid would demonstrate the efficacy of this approach in improving children's health.

55288



Richard Durbin

UNITED STATES SENATOR ■ ILLINOIS

FAX• fax paper
to her.**TO:**Chris Jennings | gene Lambrew**OFFICE:****FAX NO:**()**FROM:**Anne Marie Murray.**PHONE:**(2 0 2) 224-8464**DATE:**Jan 28, 99**PAGES (including this cover sheet):****NOTE:**This is a copy of the Durbin "Asthma Initiative"We would like to work with the Administration so that we
are all on the same page. This issue is of major interest
+ concern to Senator Durbin.

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S.L.C.

AMENDMENT NO. _____

Calendar No. _____

Purpose: To provide for the establishment and operation
of asthma treatment services for children.

IN THE SENATE OF THE UNITED STATES—105th Cong., 2d Sess.

(no.) _____

(title) _____

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mr. DURBIN

Viz:

1 On page _____, after line _____, add the following:

2 **SEC. ____ CHILDREN'S ASTHMA RELIEF.**

3 (a) IN GENERAL.—Title V of the Social Security Act
4 (42 U.S.C. 701 et seq.) is amended by adding at the end
5 the following:

6 **"SEC. 511. ASTHMA TREATMENT GRANTS PROGRAM.**

7 "(a) FINDINGS.—Congress finds that—

8 "(1) asthma affects an estimated 14,000,000 to
9 15,000,000 individuals in the United States;

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S.L.C.

2

1 “(2) asthma is the most common chronic illness
2 in childhood, afflicting nearly 5,000,000 children
3 under age 18, and costing an estimated
4 \$1,900,000,000 to treat those children;

5 “(3) it is estimated that more than 7 percent
6 of children now have asthma;

7 “(4) exposure to environmental tobacco smoke
8 in childhood is associated with an increased risk for
9 developing asthma among certain children at risk;

10 “(5) children aged 0 to 5 years who are exposed
11 to maternal smoking are 201 times more likely to
12 develop asthma compared with those free from expo-
13 sure;

14 “(6) the Environmental Protection Agency re-
15 cently reported that there is sufficient evidence to
16 conclude that passive smoking is associated with ad-
17 ditional episodes and increased severity of asthma in
18 children who already have the disease;

19 “(7) although asthma can occur at any age,
20 about 80 percent of the children who will develop
21 asthma do so before starting school;

22 “(8) from 1980 to 1994, the most substantial
23 prevalence rate increase for asthma occurred among
24 children aged 0-4 years (160 percent) and persons
25 aged 5-14 years (74 percent);

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S.L.C.

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1 “(9) in Illinois the mortality rate for blacks
2 from asthma is the highest in the nation with 60.8
3 deaths per every 1,000,000 population;

4 “(10) asthma is often a mild chronic illness
5 that is treatable with ambulatory care, but over 43
6 percent of its economic impact comes from use of
7 emergency rooms, hospitalization, and death;

8 “(11) in 1995, there were more than 1,800,000
9 emergency room visits made for asthma and the rate
10 for emergency room visits was 48.8 per 10,000 visits
11 among whites and 228.9 per 10,000 visits among
12 blacks;

13 “(12) hospitalization rates were highest for in-
14 dividuals from birth to 4 years old and were 10.9
15 versus 35.5 per 10,000 visits for whites versus
16 blacks; and

17 “(13) from 1979 to 1992, the hospitalization
18 rates among children for asthma increased 74 per-
19 cent.

20 “(b) PURPOSES.—The purposes of this section are as
21 follows:

22 “(1) To provide funds for the establishment
23 and operation of mobile asthma treatment services
24 in areas with a high incidence of, or mortality asso-
25 ciated with, asthma.

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1 “(2) To provide access to medical care for chil-
2 dren in areas that have a high prevalence of asthma
3 and lack access to medical care.

4 “(3) To provide on-site education to parents
5 and children to recognize the signs and symptoms of
6 asthma, and to train them in the use of medications
7 to prevent and treat asthma.

8 “(4) To decrease preventable trips to the emer-
9 gency room through making medication available to
10 individuals who have not previously had access or
11 education in the prevention and treatment of asth-
12 ma.

13 “(c) AUTHORITY TO MAKE GRANTS.—

14 “(1) IN GENERAL.—In addition to any other
15 payments made under this title to a State, the Sec-
16 retary shall award grants to States to carry out the
17 purposes of this section, including grants that are
18 designed to develop and expand projects to—

19 “(A) fully equip mobile health care clinics
20 that provide preventive asthma care including
21 diagnosis, physical examinations, pharma-
22 cological therapy, skin testing, peak flow meter
23 testing, and other asthma-related health care
24 services;

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1 “(B) provide educational materials, includ-
2 ing displays and videos, to reinforce concepts
3 presented to asthma patients by medical teams;
4 and

5 “(C) identify and enroll eligible children in
6 the medicaid program under title XIX, the
7 State Children’s Health Insurance Program
8 under title XXI, or other children’s health pro-
9 grams.

10 “(2) AWARD OF GRANTS.—

11 “(A) APPLICATION.—A State shall submit
12 an application to the Secretary for a grant
13 under this section in such form and manner
14 and containing such information as the Sec-
15 retary may require.

16 “(B) REQUIREMENT.—In awarding grants
17 under this section, the Secretary shall give pref-
18 erence to qualified States that demonstrate that
19 the activities to be carried out under this sec-
20 tion shall be in areas with a high prevalence of
21 asthma or high asthma-related mortality (rel-
22 ative to the average asthma prevalence rates
23 and associated mortality rates in the United
24 States).

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1 “(d) SOURCE OF FUNDS.—Amounts in the Asthma
2 Treatment Trust Fund shall be used to make grants
3 under this section.

4 “(e) COORDINATION WITH OTHER CHILD HEALTH
5 PROGRAMS.—A State shall develop and implement oper-
6 ations and activities under a grant made under this sec-
7 tion in consultation and coordination with other programs
8 operated by the State under this title, title XIX, and title
9 XXI, particularly with respect to activities under pro-
10 grams funded under such titles that include outreach and
11 enrollment, delivery of benefits and services (including pe-
12 diatric health services and emergency care services), public
13 health education, establishment of service delivery stand-
14 ards, support of public health and social service agency
15 relationships, and development and collection of quality
16 assurance and data reporting.

17 “(f) REPORTS.—A State that receives a grant under
18 this section shall submit an annual report to the Secretary
19 that includes—

20 “(1) the prevalence of children suffering from
21 asthma in the State and the State childhood mortal-
22 ity rate associated with asthma;

23 “(2) the proportion of children with asthma in
24 the State; and

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1 “(3) such other information as the Secretary
2 may require.

3 “(g) APPLICATION OF OTHER PROVISIONS OF
4 TITLE.—

5 “(1) IN GENERAL.—Except as provided in para-
6 graph (2), the other provisions of this title shall not
7 apply to a grant made under this section.

8 “(2) EXCEPTIONS.—The following provisions of
9 this title shall apply to a grant made under this sec-
10 tion to the same extent and in the same manner as
11 such provisions apply to allotments made under sec-
12 tion 502(c):

13 “(A) Section 504(b)(4) (relating to ex-
14 penditures of funds as a condition of receipt of
15 Federal funds).

16 “(B) Section 504(b)(6) (relating to prohi-
17 bition on payments to excluded individuals and
18 entities).

19 “(C) Section 508 (relating to non-
20 discrimination).

21 “(D) Section 506 (relating to reports and
22 audits, but only to the extent determined by the
23 Secretary to be appropriate for grants made
24 under this section).”.

25 (b) ESTABLISHMENT OF TRUST FUND.—

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1 (1) IN GENERAL.—Subchapter A of chapter 98
2 of the Internal Revenue Code of 1986 (relating to
3 establishment of trust funds) is amended by adding
4 at the end the following new section:

5 **“SEC. 9512. ASTHMA TREATMENT TRUST FUND.**

6 “(a) CREATION OF TRUST FUND.—There is estab-
7 lished in the Treasury of the United States a trust fund
8 to be known as the “Asthma Treatment Trust Fund”,
9 consisting of such amounts as may be appropriated or
10 credited to such Trust Fund as provided in this section
11 or section 9602(b).

12 “(b) TRANSFER OF AMOUNTS EQUIVALENT TO CER-
13 TAIN TAXES.—There are hereby appropriated to the Asth-
14 ma Treatment Trust Fund amounts equivalent to the ex-
15 cess of the increase in the taxes received in the Treasury
16 as a result of the amendments made by section ____ (c)
17 of the ____ Act (relating to tobacco taxes), over such in-
18 crease which would have resulted if section ____ (c)(11)
19 had not been enacted.

20 (3) EXPENDITURES FROM THE TRUST FUND.—
21 Amounts in the Asthma Treatment Trust Fund
22 shall be available, as provided by appropriation Acts,
23 for making grants under section 511 of the Social
24 Security Act (42 U.S.C. 711).”