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# BIOTERRORISM AND PROPOSALS TO COMBAT BIOTERRORISM

## HEARING

BEFORE THE

## COMMITTEE ON ENERGY AND COMMERCE
## HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

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# BIOTERRORISM AND PROPOSALS TO COMBAT BIOTERRORISM

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**THURSDAY, NOVEMBER 15, 2001**

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
*Washington, DC.*

The committee met, pursuant to notice, at 10 a.m., in room 2123, Rayburn House Office Building, Hon. W.J. "Billy" Tauzin (chairman) presiding.

Members present: Representatives Tauzin, Bilirakis, Upton, Stearns, Gillmor, Greenwood, Cox, Deal, Burr, Whitfield, Ganske, Norwood, Shimkus, Wilson, Shadegg, Fossella, Davis, Bryant, Bass, Pitts, Bono, Walden, Terry, Dingell, Waxman, Markey, Towns, Pallone, Brown, Deutsch, Rush, Eshoo, Stupak, Engel, Sawyer, Wynn, Green, McCarthy, Strickland, DeGette, Barrett, Luther, Capps, Doyle, and Harman.

Staff present: Alan Slobodin, majority counsel; Joe Greenman, majority professional staff; Amit Sachdev, majority counsel; Anne Esposito, policy coordinator; Vikki Riley, assistant press secretary; Will Carty, legislative clerk; Bruce M. Gwinn, minority counsel; Edith Holleman, minority counsel; and Courtney Johnson, minority professional staff.

Chairman TAUZIN. The committee will please come to order. Let me ask our guests to take seats and we particularly want to welcome the Secretary of Health and Human Services to the committee today. Mr. Secretary, our customary procedure is to allow the chairman and the chairman of the subcommittee and ranking members to make opening statements before such an important hearing and our usual procedure is to allow all members' opening statements. We would ask unanimous consent that in doing so that the rest of the members of the committee would agree to limit their opening statements to 1 minute. Will that be acceptable to all members? Without objection—Mr. Waxman?

Mr. WAXMAN. Mr. Chairman, many of us came here because we had something to say in an opening statement. Are we going to have the chairman and the ranking member take more than 1 minute?

Chairman TAUZIN. My understanding is that the 3 minutes would be allowed to the chairman, Mr. Dingell, Mr. Bilirakis, Mr. Brown and I'm asking unanimous consent that other members limit their opening statements to a minute.

Mr. WAXMAN. I'm going to object. I think members might want to do that, but I don't think we ought to be restricted to 1 minute.

Chairman TAUZIN. The objection has been heard. The Chair recognizes himself for the appropriate time. Today, the full committee examines the threat of bioterrorism and proposals to combat bioterrorism. With the recent anthrax attacks, the spectrum of bioterrorism becomes a troubling reality which we need to address vigorously and obviously quickly.

Prevention, preparedness and response to bioterrorism is a priority, I believe, that Congress must critically evaluate and this committee will take this task on this morning. Much of our attention will focus on the Centers for Disease Control and Prevention and the preeminent agency in the Federal Government's public health infrastructure which provides so much of our national leadership and illness detection, response and indeed prevention, including what occurs as a result of deliberate release of biological agents. We recently witnessed its capabilities at work in detecting and reacting to the anthrax outbreaks and I believe I speak for the vast majority of Americans when I say that I am proud and comforted that we created the CDC. Lives have been saved in New York and Trenton and Florida and here in our Nation's capital because we have invested in its capabilities.

Now our ability to improve the response to present and future health threats depends upon our ability to look at the recent events and determine which parts of our public health apparatus have worked and which parts need to be enforced. In recent weeks, members of the committee led by Vice Chairman Burr, the chairman of the Subcommittee on Oversight and Investigations, Mr. Greenwood, and the gentlelady from Colorado, Ms. DeGette, have visited the CDC. Some found its facilities woefully inadequate to do its work. And over the past 3 years, the committee has reviewed certain aspects of the CDC and found serious gaps in the law, in the resources and the programs and the strategy relating to the CDC. With this background, we're working to upgrade and to equip the Agency much more properly and to make sure that it can assist our country in the time of need.

We're seeking to address critical aspects for our public health infrastructure. In light of this, I'm pleased today to welcome two witnesses who have spent countless hours in recent months helping to safeguard the public from these acts of bioterrorism. The Honorable Tommy Thompson, Secretary of the Department of Health and Human Services will discuss the coordinated response to acts of bioterrorism. His insights into what is needed to ensure that our Nation has taken every practical step to protect its citizens from bioterror will be extraordinarily valuable today.

As an aside, Mr. Secretary, I want to salute you for your foresight and leadership on these matters. You hired a bioterrorism advisor early in your tenure. You created a bioterrorism committee and a commission before the anthrax attacks and you've been ramping up production of the smallpox vaccine very rapidly and for all those things, our Nation is grateful.

We're also honored to have before us Dr. Jeffrey Koplan, the Director of CDC. Dr. Koplan participated in one of the greatest achievements in public health history, the eradication of smallpox. Now you're leading one of the largest public health investigations

of all time and I'm eager to hear your thoughts on how the CDC should be strengthened to meet the 21st century health threats.

At present, the committee is working on draft legislation in close coordination with the administration and through a bipartisan process to improve our Nation's preparedness for bioterrorism and other public health emergencies which include disease outbreaks and health problems stemming from chemical and radiological emergencies.

The key to doing this effectively is to use existing programs and increase their coordination and communication so we can get more money out of the States, to those States and local governments as quickly as possible. We want to build on the President's leadership in the efforts we've already seen. We'll continue to urge our Senate colleagues to pass a bill that this committee and the House passed overwhelmingly several weeks ago which would tighten safety and security controls on those deadly potential biological agents and impose stiff penalties to those who would break those rules. I'm confident this committee will produce a smart, strong, comprehensive package, one that increases security of deadly agents at its research facilities, strengthens our surveillance of the Nation's abundant food supply, enhances drug safety and reinforces the protection of our drinking waters. These will be sensible measures to address threats we simply cannot ignore.

I want to thank the witnesses for taking time out of the busy schedule to be with us and I look forward hearing your testimony and discussing these very vital issues.

[The prepared statement of Hon. W.J. "Billy" Tauzin follows:]

PREPARED STATEMENT OF HON. W.J. "BILLY" TAUZIN, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Today, the Full Committee examines the threat of bioterrorism and proposals to combat bioterrorism.

With the recent anthrax attacks, the specter of bioterrorism became a troubling reality, which we need to address vigorously. Prevention, preparedness, and response to bioterrorism is a priority, I believe, that Congress must critically evaluate. This Committee will take on this task this morning.

Much of our attention will focus on The Centers for Disease Control and Prevention (CDC). This preeminent agency in the federal government's public health infrastructure provides national leadership in illness detection, response and prevention, including what occurs as a result of a deliberate release of biological agents. We recently witnessed its capabilities at work—detecting and reacting to the anthrax outbreaks. And I believe I speak for the vast majority of Americans when I say that I am proud and comforted that we created the CDC. Lives have been saved in New York, Trenton, Florida, and here in our nation's capital because we have invested in its capabilities.

Now, our ability to improve the response to present and future health threats depends upon our ability to look at recent events and determine which parts of our public health apparatus have worked and which parts need to be reinforced.

In recent weeks, Members of this Committee—led by the Vice Chairman, Mr. Burr, the Chairman of the Subcommittee on Oversight and Investigations, Mr. Greenwood, and the gentlelady from Colorado, Mrs. DeGette—have visited the CDC. Some found its facilities woefully inadequate to do its work. Over the past three years, this Committee has also reviewed certain aspects of CDC and found serious gaps in law, resources, programs, and strategy relating to the CDC.

With this background, we are working to upgrade and to equip the agency properly to make sure it can assist our country in this time of need. We are also seeking to address other critical aspects of our public health infrastructure.

In light of this, I am pleased today to welcome two witnesses who have spent countless hours in recent months helping to safeguard the public from acts of bioterrorism. The Honorable Tommy Thompson, Secretary of Department of the Health

and Human Services, will discuss the coordinated response to acts of bioterrorism. His insights into what is needed to ensure that our nation has taken every practical step to protect its citizens from bioterror will be extraordinarily valuable.

As an aside, Mr. Secretary, I must salute you for your foresight and leadership on these matters: you hired a bioterrorism advisor early in your tenure, you created a bioterrorism commission before the anthrax attack, and you've been ramping up production of the smallpox vaccine.

We are also honored to have before us Dr. Jeffrey Koplan, the Director of the CDC. Dr. Koplan participated in one of the greatest achievements in public health history—the eradication of smallpox. Now you are leading one of the largest public health investigations of all time. I am eager to hear your thoughts on how the CDC should be strengthened to meet 21st century health threats.

At present, the Committee is working on draft legislation—in close coordination with the Administration and through a bipartisan process—to improve our nation's preparedness for bioterrorism and other public health emergencies, which include disease outbreaks and health problems stemming from chemical and radiologic emergencies. The key to doing this effectively is to use existing programs and increase their coordination and communication, so that we can get more money out to the States and local governments as quickly as possible. We want to build on the President's leadership and the efforts we have already seen.

And we will continue to urge our Senate colleagues to pass a bill that this Committee and the House passed overwhelmingly several weeks ago, which would tighten safety and security controls on the most deadly potential biological agents and impose stiff criminal penalties for those who break these new rules.

I'm confident this Committee will produce a smart, strong, and comprehensive legislative package—one that increases the security of deadly agents at our research facilities, strengthens our surveillance of the nation's abundant food supply, enhances drug safety, and reinforces protection of our drinking water. These will be sensible measures to address threats we simply cannot ignore.

I thank our witnesses for taking time out of their very busy schedules to be here, and I look forward to hearing your testimony and discussing these vital issues.

Chairman TAUZIN. Mr. Dingell is not here. The Chair will recognize Mr. Brown for an opening statement.

Mr. BROWN. I thank the chairman for scheduling this hearing and especially thank my friends, Dr. Koplan and Secretary Thompson for joining us.

I want to raise, briefly raise in the 3 minutes, a handful of issues. First of all, I appreciate the efforts on the CDC on antibiotic resistance, the links between antibiotic resistance and bioterrorism are clear. We must isolate emerging antibiotic resistance pathogens, track antibiotic overuse and misuse and monitor the effectiveness of existing treatments over time. I hope that the Secretary and that the CDC will work with us to address the critical issue of antibiotic resistance before our antibiotic stockpile is irreversibly compromised partly because of the events of September 11 and the aftermath, partly because of other problems we were obviously facing on that.

Second, I'm pleased the administration has requested additional authority to safeguard our food supply as conversations we've had in the past, Secretary Thompson. To address the safety of food crossing our border, Congressman Dingell and I introduced the Imported Foods Safety Act last month to provide the FDA with a host of new authorities and resources to inspect and detail food entering the United States. As you know, budget constraints have reduced the inspection—reduced ourselves to the level of inspecting only 1 percent of food crossing the border and because FDA lacks the ability to conduct real time tests for microbial pathogens and pesticides, very few shipments are actually tested.

Enactment of the Dingell-Brown bill would increase overall resources, provide more inspectors and bring forward adoption of

technology to conduct ultra-rapid tests for contamination unseen by the human eye.

Moving to the issue of public health preparedness, I have serious concerns about the administration's funding proposal. I have enormous respect for the CDC and the work they do for our State and our local health departments. We're fortunate that Dr. Koplan is at the helm. CDC was strained before September 11 and as a result since then they've had to shift personnel, personnel they really are not able to shift in many ways in terms of the work they need to do, key functions to respond to anthrax. Before September 11, the administration proposed decreasing CDC's funding from the previous year. Having personally seen, as the chairman mentioned, and I know Mr. Bilirakis has seen also the crumbling CDC facilities, knowing the critical responsibility that that very, very important agency fulfills, several of us on this committee have expressed serious concerns about the administration's commitment to this agency. I hope the events of September 11 have taught us how important that agency is.

The most important step we can take in bioterrorism preparedness is to stop neglecting CDC as our Government has done too often, and stop neglecting State and local public health departments that are the agency's partners in protecting the Nation's health.

The last issue, Mr. Chairman, I'd like to raise is the Cipro patent. You acknowledged that you had the right to temporarily break Bayer's patent under imminent domain authority, but argued the Government would face hefty costs if, in fact, required to pay whatever price the patent holder wanted to charge for a drug. I wanted to bring to your attention legislation I've introduced that would address the compensation issue and most importantly would preclude endless court battles and not necessarily Government spending. My bill would give you as the Secretary, compulsory licensing authority in the event of a public health emergency which means you could issue compulsory licenses to secure generic versions of a brand name drug, as long as you followed the regulatory and the statutory procedures established to ensure fair compensation for the brand name drug company. There are already compulsory licensing laws in place for the cable industry, for the air pollution industry, for atomic energy and other products and services. Unencumbered access to drugs is an essential element in our response to bioterrorism. Establishing the statutory and regulatory framework now to secure generic drugs on an expedited and affordable basis, simply makes sense.

I'd like to work with you, Mr. Secretary, to ensure that the tool of compulsory licensing is available to you which will keep us away from the difficulties of another Cipro kind of situation.

Mr. Chairman, I appreciate your holding this hearing. I particularly appreciate Secretary Thompson and Dr. Koplan for joining us. Thank you.

[The prepared statement of Hon. Sherrod Brown follows:]

PREPARED STATEMENT OF HON. SHERROD BROWN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. Chairman, Thank you for scheduling this hearing on bioterrorism preparedness. Secretary Thompson, Dr. Koplan, welcome. It is always a pleasure to have each of you here to testify before the Committee.

Mr. Secretary, in response to the emergent threat of bioterrorism, your Department needs greater resources and authority to adequately protect the public health.

During your prior visits here, we have agreed on the need for improvements in several areas within your jurisdiction. I look forward to continuing discussions with you and the Majority on this committee to achieve consensus on these issues.

To fully prepare for potential bioterrorist attacks, we will have to deal with a wide variety of public health issues, including vaccinations, food safety, and government stockpiling of vaccines and antibiotics.

In doing so—we must not forget the issue of antibiotic resistance. The links between antibiotic resistance and bioterrorism are clear.

According to the Journal of the American Medical Association (JAMA)—during the Cold War—Russian scientists engineered an anthrax strain that was resistant to the tetracycline and penicillin.

We can only assume that anthrax, and other bacterial agents, could also be engineered to resist antibiotics—including drugs like Cipro.

During the last couple of months, thousands of Americans have been prescribed the antibiotic Cipro because of a legitimate risk of exposure to Anthrax. Physicians tell us this use of antibiotics is appropriate.

But thousands of other Americans have sought prescriptions for Cipro without any indication of need or even a risk of infection.

If the U.S. and the rest of the world begins using drugs like Cipro haphazardly, these drugs will eventually lose their effectiveness.

And when facing lethal diseases like Anthrax, it is important to find an effective therapy quickly. Any delay can result in the death of a patient—or in the case of a larger exposure—in the deaths of thousands of individuals.

To adequately prepare for a bioterrorist attack, state and local health departments must be equipped to rapidly identify and respond to antibiotic-resistant strains of anthrax and other lethal agents.

We must isolate emerging antibiotic resistance pathogens, track antibiotic overuse and misuse, and monitor the effectiveness of existing treatments over time.

I hope you will work with me to address the critical issue of antibiotic resistance before our antibiotic stockpile is irreversibly compromised.

I'm pleased the Administration has requested additional authority to safeguard our food supply.

The recent attacks on the United States have aroused concern that food could be used as a weapon of bioterrorism.

Yet, the authorities and tools used to prevent, identify, and intercept tainted shipments at our borders are not up to the job.

To address the safety of the food crossing our border, Congressman Dingell and I introduced the "Imported Food Safety Act" last month to provide the Food and Drug Administration with a host of new authorities and resources to inspect and detain food entering the United States.

Budget constraints allow FDA to inspect less than 1% of all imported food shipments.

And because FDA lacks the ability to conduct real time tests for microbial pathogens and pesticides—very few shipments are tested for these adulterants.

Enactment of the Dingell/Brown bill would increase overall resources, provide more inspectors, and require adoption of technology to conduct ultra rapid tests for contamination unseen by the human eye.

Moving to the issue of public health preparedness, I have serious concerns about the Administration's funding proposal.

I have enormous respect for CDC and the work they do for our state and local public health departments.

We are fortunate to have Dr. Koplan at the helm of CDC as we face this unprecedented situation. CDC was strained before Sept. 11—the agency doesn't have surplus staff waiting in the wings in the event of a bioterrorist attack—and as a result they've had to shift personnel from other key functions to respond to the anthrax attacks.

If I have any concerns, it is that CDC has not had *more* say in the nation's response to this and future bioterrorist threats. I've had credible sources tell me that CDC was not the first, or even the second agency called in when anthrax was first detected. That worries me.

Before September 11, the Administration proposed decreasing CDC's funding from the previous year. Having seen the crumbling CDC facilities and knowing the critical responsibilities CDC fulfills, several of us on this committee expressed serious concerns about the Administration's commitment to this agency and its public health mission.

Now, when the demands on CDC and its partners, the state and local public health departments, have never been greater, the Administration is not willing to provide enough resources to respond to a public health crisis in even one state, much less 50.

Frankly, I don't understand it.

People and infrastructure are paramount to bioterrorism preparedness. You can stockpile antibiotics and vaccines, but without people on the ground to quickly identify and respond to threats, you aren't prepared. That's what CDC, in conjunction with state and local health departments, does.

CDC is the only agency that has infrastructure in all 50 states. They have a relationship with state health departments and they train these public health workers so they are prepared to respond at a moments notice.

The most important step we can take in bioterrorism preparedness is to stop neglecting CDC and the state and local public health departments that are the agencies partners in protecting the nation's health.

Mr. Secretary, In the dispute over the Cipro patent, you acknowledged that you had the right to temporarily break Bayer's patent under "eminent domain" authority, but argued that the government could face hefty costs if required to pay whatever price the patent owner wanted to charge for a drug. I wanted to bring to your attention legislation I have since introduced that would address the compensation issue, precluding endless court battles and unnecessary government spending.

My bill would give you compulsory licensing authority in the event of a public health emergency, which means you could issue compulsory licenses to secure generic versions of a brand-name drug, as long as you follow statutory and regulatory procedures established to ensure fair compensation for the brand-name drug company.

There are already compulsory licensing laws in place for the cable industry, air pollution prevention devices, atomic energy, and other products and services.

The spread of anthrax has already taken a significant toll on the nation's sense of security. Unencumbered access to drugs is an essential element in our response to bioterrorism. Establishing the statutory and regulatory framework now to secure generic drugs on an expedited and affordable basis simply makes sense.

Taking that step now will help ensure that the priority of doing what's best for the public is not subsumed by cost concerns, red tape, or legal haggling.

I'd like to work with you to ensure you have this tool compulsory licensing tool available to you before another "Cipro situation" arises.

Again, I appreciate your willingness to join us this morning, and look forward to your testimony.

Chairman TAUZIN. I thank the gentleman and I thank the gentleman for his, and Mr. Dingell's, and the rest of the members' extraordinary work with us as we attempt to fashion a bipartisan package. The Chair is pleased to now welcome and recognize for an opening statement, the chairman of the committee's Health Subcommittee, the gentleman from Florida, Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I have a more lengthy statement that I would submit for the record and in the interest of time——

Chairman TAUZIN. Let me make the unanimous consent that all members have the ability to introduce their written statements as part of the official record and without objection, it is so ordered.

Mr. BILIRAKIS. I would also like to thank you, Mr. Chairman, for holding this very important hearing. Bioterrorism is an issue that our subcommittee has been examining for several years now, but never as know, has the issue been as timely as it is now. The world has changed dramatically and it's imperative that we respond and prepare appropriately and that's why we're all pleased that the Secretary and the Director are here, along with Dr. Henderson. Mr.

Chairman, you said it, this has been a bipartisan effort from the beginning. The staffs have been working in a bipartisan manner and I'm not really sure how we're going to come out in the final analysis, but the fact of the matter is we have not tried to steamroll a piece of legislation through this committee. Thank you very much, Mr. Chairman.

[The prepared statement of Hon. Michael Bilirakis follows:]

PREPARED STATEMENT OF HON. MICHAEL BILIRAKIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman, thank you, for holding this important hearing today on the threat of bioterrorism. Bioterrorism is an issue the Health Subcommittee has been examining for several years now, but never has the issue been as timely as it is now. The world has changed dramatically since September 11th and it is imperative that we respond and prepare appropriately. That is why I am so pleased that Secretary Thompson and CDC Director Koplan have taken the time to testify before the Committee on these important issues.

On September 11th, America was brought into a war against terrorism. I share the concerns of many Americans who are worried about bioterrorism, including anthrax exposure and outbreaks of smallpox. Bioterrorist threats have become real, and we must ensure that this nation is ready to respond quickly and successfully in the event of future bioterrorist attacks.

The Department of Health and Human Services, under Secretary Thompson, is our national coordinator of public health surveillance and protection while the Centers for Disease Control and Prevention (CDC) are directly responsible for the nation's public health. Fortunately, the CDC has been researching and planning responses to bioterrorism.

The CDC has established a Bioterrorism Program to ensure the rapid development of federal, state and local capacity to address potential bioterrorism threats. Security, communication, and infrastructure are all important components of the CDC that need to be evaluated. I believe it is important to ensure that the CDC is prepared for all possible future public health emergencies.

Response to a bioterrorist attack will require rapid deployment of public health resources. Public health threats come in many forms. We can not know when or how a public health threat could occur and we must be prepared to combat biological agents in every form. A vital part of protecting the American population is guaranteeing a safe food and water supply and water supply.

Today we will hear from the Secretary Thompson and Dr. Koplan regarding the roles of CDC and other government agencies in combating bioterrorism. These agencies, working closely with Congress, must make certain that our public health infrastructure can detect disease outbreaks and other possible threats. We must realize that this is a long-term investment in our nation's public health that will require a long term commitment by Congress and the federal government. The Health Subcommittee will continue to look into bioterrorism and our national response in the next year and the coming sessions as we make this firm commitment to our public's health.

This is a time for the nation to unite. I personally thank and honor those who are on the front lines fighting this war, domestic and abroad. Again, thank you Mr. Chairman for holding this important hearing and thanks again to Secretary Thompson and Director Koplan for sharing their insights with us today.

Chairman TAUZIN. I thank the gentleman. Further requests for opening statements? When Mr. Dingell arrives, he's entitled, obviously, to preference. The Chair will recognize the gentleman, Mr. Waxman. Under our rules, members may give a 3-minute opening statement at this point.

Mr. Waxman.

Mr. WAXMAN. Thank you very much, Mr. Chairman. While we're all very concerned of bioterrorism, this is not the first time that our public health has seen a crisis. We saw the Legionnaire's Disease, Toxic Shock Syndrome and most obviously, we face the AIDS epidemic. It is not the first time as well that experts have come to us and said that our public health system is in disrepair. We've had

warnings and reports from the National Academy of Sciences, the Institute of Medicine for a decade now. We should have been able to learn the lesson from the previous disasters that we cannot short change our health care system. The most obvious lesson was in the 1980's, we were suddenly faced with the AIDS epidemic, so we require the Centers for Disease Control to take people away from the work they were doing to work on AIDS and now that we have to respond to an anthrax threat, we're taking people away from working on AIDS and other public health measures, to work on anthrax.

Now when we look at energy issues in this committee, we plan for surge capacity so that power systems can deal with unexpectedly high demands. We should learn some lessons to apply for the CDC and the public health. We can't budget for some sort of theoretical normalcy, that's not how the public health works. It's not a predictable assembly line. We should build in surge capacity for bioterrorism, epidemics and new problems.

I would emphasize that we need to focus our spending on systems and people, not just things. It's important to stockpile vaccines and drugs, but that's not enough. We need on-going epidemiology and disease surveillance. We need communication systems that work. We need better labs and more lab workers. We need people who can train and work with health professionals during a crisis.

I'm concerned that the budget that we got from this administration is insufficient to meet these needs. It relies on moving CDC and public health professionals from job to job, the same musical chairs that we saw with CDC when they had to cope with AIDS 20 years ago. It also provides a drop in the bucket for spending on public health systems and people and spends largely on things. It is as if the administration were building lots of fire stations and buying some fire trucks, but not hiring fire fighters or installing alarm systems.

Now let me add, this is not an issue of being unable to afford all the things we need to do to protect the public health. What we have is a conscious decision that we ought to use our money for tax cuts, especially for the wealthy, especially for corporations, rather than have money available to do the kinds of things that will protect all of the American people when we have a public health emergency. It's the clearest example of penny wise and pound foolish that I can imagine. We can do better. We should learn from our previous health problems and we shouldn't short change these efforts.

[The prepared statement of Hon. Henry A. Waxman follows:]

PREPARED STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

While the threat of bioterrorism cannot be overstated, this is not our first public health crisis. We have had Legionnaire's Disease and Toxic Shock Syndrome and earthquakes and hurricanes. Most obviously, we have had—and still have—the AIDS epidemic.

It is also not the first time that experts have told us that our public health system is in disrepair. We have had warnings and reports from the National Academy of Sciences and the Institute of Medicine for a decade now.

We should be able to learn lessons from these disasters to help us respond now.

The most obvious lesson is that we cannot shortchange the Centers for Disease Control and public health agencies. During the Eighties, CDC was so short of staff that it had to pull its professionals off of their ongoing work to devote themselves to the emerging AIDS epidemic. Just last month, CDC again had to pull its staff off of their other work (this time including AIDS) so that they could respond to anthrax and other threats.

When it works on energy issues, this Committee has learned that we have to plan for "surge capacity" so that power systems can deal with unexpectedly high demands. We should learn the same lesson for CDC and public health. We cannot budget these programs for some sort of theoretical "normalcy." That's not how public health works; it's not a predictable assembly line. We should build in "surge capacity" for bioterrorism, epidemics, and new problems. Only with new FTE's and contingency funds can we be prepared.

I would emphasize that we need to focus our spending on systems and people, not just things. It's important to stockpile vaccines and drugs, but it's not enough. We need ongoing epidemiology and disease surveillance. We need communications systems that work. We need better labs and more lab workers. We need people who can train and work with health professionals during a crisis.

I'm concerned that the budget from the Administration is insufficient to meet these needs. It relies on moving CDC and public health professionals from job to job—the same musical chairs that CDC had to cope with twenty years ago. It provides a drop in the bucket for spending on public health systems and people and spends largely on things. It is as if the Administration were building lots of fire stations and buying some fire trucks, but not hiring fire fighters or installing alarm systems.

And it is not a question of what we can afford to do for public health. The Administration has consciously decided to spend its money on tax cuts—tax cuts that benefit the wealthiest and corporations—and not to spend the funding on public health preparedness.

This is the clearest example of penny-wise and pound-foolish that I can imagine. We can do better. We should learn from our previous public health problems. Now we know what to do, and we should not shortchange the efforts.

Chairman TAUZIN. The gentleman's time has expired. The Chair asks are there requests for additional opening statements? The gentleman from Michigan, Mr. Upton, is recognized for an opening statement.

Mr. UPTON. Thank you Mr. Chairman. The anthrax attacks have brought home to each of us how important it is that we do all that we can to be prepared to respond quickly and effectively to bioterrorism. What was perhaps an abstract concern has now become very, very real. I wanted to share some good news from Michigan that I received this morning. We were granted a weapons of mass destruction civil support team by the Department of Defense. We're battling two fronts as we all know, one a world away in Afghanistan and the other one at home. It's a huge task to adequately protect our people, infrastructure, and we're grateful for that help.

The anthrax attacks have thrown the spotlight not only upon the vital role of the CDC, but also on the enormous challenges that the FDA must take on and meet in combatting bioterrorism. It has to be prepared to expedite the development, approval and production of bioterrorism vaccines, drug therapies and diagnostic tests to give us the weapons that we need to fight new strains of anthrax, smallpox, ebola and anything else.

We must also step up to the plate with regard to inspections of imports, whether of drugs and devices or imported foods. By rights, the Commissioner of the FDA ought to be at that table as well, but sadly, the FDA has gone into battle without a general at its head and I'm deeply concerned and I would urge the administration to quickly make that a top priority to help us.

I yield back.

[The prepared statement of Hon. Fred Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Chairman, thank you for convening today's hearing to continue our committee's examination of bioterrorism and proposals to combat it. I am pleased that Secretary Thompson and Dr. Koplan, the Director of the CDC are here to give us an overview of their activities. The anthrax attacks have brought home to each of us how important it is that we do all that we can to be prepared to respond quickly and effectively to bioterrorism. What was perhaps an abstract concern has become very, very real.

First, I just want to share some very good news for Michigan that I received this morning. We are being granted a Weapons of Mass Destruction Civil Support Team by the U.S. Department of Defense. We're battling on two fronts right now—one a world away in Afghanistan, the other right here at home. It's a huge task to adequately protect our people and infrastructure, and we are grateful for this help.

The anthrax attacks have thrown the spotlight not only upon the vital role of the CDC, but also on the enormous challenges that the FDA must take on and meet in combating bioterrorism. It must be prepared to expedite the development, approval and production of bioterrorism vaccines, drug therapies, and diagnostic tests to give us the weapons we may need to fight new strains of anthrax, smallpox, Ebola, and other agents of infection. The FDA must review and give approval to every drug, therapeutic, vaccine and anti-toxin that is to be administered to our population. It must work proactively with the NIH, the CDC, and the pharmaceutical and medical device community from the outset. It must significantly step up its inspections of imports, whether of drugs and devices or of imported foods, plugging the gaps and holes in our dangerously porous borders that could so easily be exploited by terrorists.

By rights, the Commissioner of the FDA should be flanking Secretary Thompson today, too. But we don't have a Commissioner. The FDA is going into battle without a general at its head, and I am deeply concerned about that. I want to stress in the strongest possible terms to Secretary Thompson and the Administration the need to act swiftly to nominate a new Commissioner who is well-prepared to lead the FDA into battle.

In the short time I have this morning, I would also like to highlight the vital role that telehealth networks can play. As chairman of the Telecommunications and the Internet, I have seen firsthand the potential of telehealth systems. We need to coordinate existing networks and link them with the CDC, the NIH, the FDA and other agencies joined in our war against bioterrorism. Such coordinated networks could be used for timely disease surveillance and reporting, for the rapid diagnosis of symptoms that could signal a bioterrorist attack, for training health care professionals and first responders even in the very rural areas of our country in the diagnosis and treatment of anthrax, smallpox, and other deadly diseases, and for linking the victims of attacks and those caring for them with the sophisticated information and treatment available at major medical centers.

That is why I was very disturbed to learn, Secretary Thompson, that the Department of Health and Human Services has plans to eliminate the Office for the Advancement of Telehealth and transfer its functions to the HIV/AIDS Bureau. The Office is currently the focal point for telehealth activities across federal agencies. It was instrumental in the formation of the Joint Working Group on Telemedicine, for which it provides both leadership and staffing. Rather than eliminating the Office, which should consider charging it with taking the lead in coordinating the telehealth networks currently in place and helping them become effective partners on the frontlines across America in our war on bioterrorism. Secretary Thompson, I hope you will give me a commitment today to strengthen the role of this Office and deep six the proposal to eliminate it.

Secretary Thompson, I look forward today to exploring these issues further with you.

Chairman TAUZIN. I thank the gentleman. Are there further requests for opening statements? The gentleman from Massachusetts, Mr. Markey, is recognized.

Mr. MARKEY. Thank you, Mr. Chairman, very much and we thank our guests for coming here today. My concern in my very brief opening statement is on the question of what happens if the terrorists make a successful attack at a nuclear power facility in

the United States. Obviously, there would be a very large release of radioactive iodine into the atmosphere. There would be a population which would be at greatest risk that live within the first 5 to 10 miles, but of course, it could go out further, but especially within those near in closer areas. And depending upon which way the wind was blowing, the radioactive plume would carry that radioactivity toward tens of thousands of Americans.

Now thus far the Nuclear Regulatory Commission has refused to order the stockpiling of potassium iodide within the communities that would be most likely affected across the United States. It seems to me that this is a decision that should not be made by Nuclear Regulatory Commission. It should be made instead by the health officials which are going to have responsibility for dealing with the consequences of a potential health disaster. And it seems to me that since it only costs between 3 to 5 cents to have a potassium iodide pill available, at least in the schools that are within the vicinity of a nuclear power plant, which is how they do it in other countries, that it's a relatively inexpensive way of stockpiling the needed antidote to the very great danger that would be created and thus far the Nuclear Regulatory Commission has refused to do it.

Now I believe that the Nuclear Regulatory Commission has been negligent in refusing to mandate that precaution. It can be stockpiled again, in schools. Children are the most vulnerable population. Adults are not as much and in the course of my questioning, Mr. Chairman, I am going to ask that our experts, our health care experts here enlist in the effort to put that kind of precaution in place. I thank you for holding the hearing.

[The prepared statement of Hon. Edward J. Markey follows:]

PREPARED STATEMENT OF HON. EDWARD J. MARKEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

Mr. Chairman, good morning and thank you for holding this important and timely hearing on bioterrorism. I join you and my colleagues in welcoming Secretary Thompson and Director Koplan and I thank them for being here today.

In 1998 Ashton Carter, John Deutch and Philip Zelikow spoke of the impending threat of terrorists using weapons of mass destruction in a Foreign Affairs magazine article called "Catastrophic Terrorism". The article opens with the following prescient and chilling description:

> "If the device that exploded in 1993 under the World Trade Center had been nuclear, or had effectively dispersed a deadly pathogen, the resulting horror and chaos would have exceeded our ability to describe it. Such an act of catastrophic terrorism would be a watershed event in American history. It could involve loss of life and property unprecedented in peacetime and undermine America's fundamental sense of security, as did the Soviet atomic bomb test in 1949. Like Pearl Harbor, this event would divide our past and future into a before and after. The United States might respond with draconian measures, scaling back civil liberties, allowing wider surveillance of citizens, detention of suspects, and use of deadly force. More violence could follow, either further terrorist attacks or U.S. counterattacks. Belatedly, Americans would judge their leaders negligent for not addressing terrorism more urgently."

September 11th and the subsequent Anthrax crisis have served as the sonic boom of wake up calls that no one can ignore. Much as our nation is using its military superiority to wage a war against Osama Bin Laden in Afghanistan, we must rely upon our healthcare superiority to wage a public health war against bioterrorism.

This war must include protecting dangerous bioagents from falling into enemy hands. In 1996 I introduced the "Biological Weapons Control Act of 1996" with former Representative John Kasich, and Senator Hatch. The bill imposed requirements for the transfer of select agents and was later signed into law as part of the Anti-terrorism and Effective Death Penalty Act of 1996. If we had not passed this

law, we would be largely in the dark with respect to who possesses which bioagents in this country. Last month the House took one more step in the battle against bioterrorism by voting to expand the 1996 law to require that all select agents be registered.

While there is no doubt that the United States has the resources and capability to wage this war, in its current form, the public health system is ill-prepared.

It is my hope that the Administration will agree to significantly increase emergency funding to the CDC so that a strong force can be deployed to combat bioterrorism . We will need the well prepared health care *ground troops* pre-positioned by improving hospital "surge" capacity in the event of a bioterrorist attack or epidemic. We must create the best *command control center.* This means providing the resources necessary to upgrade States' preparedness, improve public health laboratories and heighten disease surveillance and response and communication between state, local and federal officials. And finally, we need to provide the most *sophisticated defensive weapons* by expanding our current stockpiles and encouraging the development of new treatments.

And while the focus on stockpiling lately has been largely on Cipro, and smallpox vaccines we cannot be negligent in addressing other obvious and necessary protective measures.

For example, we are guilty of gross negligence for failure to stockpile potassium iodide—the Cipro of Nuclear Exposure in localities surrounding nuclear power plants. Potassium iodide is a cheap and effective protection against the cancer-causing effects of radioactive iodine on the thyroid gland. In the event of a terrorist attack on a nuclear power plant, cancer-causing radioactive iodine could be released into the surrounding area. In an urban setting it may take hours to escape the area. During Hurricane Floyd, it took some drivers 8 hours to go 35 miles. Yet the radioactive plume can travel much faster if the weather conditions permit.

In light of over 20 years of government inaction, I have introduced a bill to require the stockpiling of Potassium Iodide within the vicinity of all nuclear plants, HR 3279. Additionally, I thank you, Mr. Chairman for agreeing to work with me to address my concerns in the Commerce Bioterrorism Bill.

In closing, we've heard the clarion call to arms—we can't waste time we must address our ailing public health system. We must act responsibly lest we be judged negligent.

Chairman TAUZIN. I thank my friend. The Chair again reminds all members that their written statements are part of the record and would now ask if there are further requests for time. The gentleman from Florida, Mr. Stearns, is recognized for 3 minutes.

Mr. STEARNS. Mr. Chairman, thank you again for holding this hearing. I thank as a member on the Oversight Subcommittee, Chairman Greenwood, who ably conducted hearings on October 10 and November 1, in this area and I'm pleased we'll hear from one of the architects, chief architect of the Federal effort of striking back at bioterrorism, of course, which is Honorable Secretary Thompson.

One of the questions I think all of us are concerned about is should the public health system and the public safety and intelligence community share a uniform approach to planning against bioterrorism? Is that being done? If not, why? As we know, all us Members of Congress, how bureaucracies work. Sometimes there's no communication between them. I think that's perhaps a key that Honorable Thompson will address, and should CDC place greater emphasis on developing the front end of the public health system to ensure the creation of a robust ability to both detect and assess suspected bioterrorism incidents. And last, how can the CDC best coordinate with State and local health departments in an effort to assure that they have completed adequate bioterrorism preparedness plants.

So Mr. Chairman, I commend you for opening these hearings. This is a sobering high alert time and I think it's very important

to get the Secretary's insights and the witnesses', and I yield back the balance of my time.

Chairman TAUZIN. I thank my friend. I would like to announce also for the benefit of our audience that Chairman Greenwood had scheduled a bioterrorism hearing on September 11, ironically, and we had to postpone it and held that hearing just last week instead, but again, I do commend the chairman for his comments and his good work.

Are there further requests for opening statements? The gentleman from New York, Mr. Towns, is recognized for 3 minutes.

Mr. TOWNS. Thank you very much, Mr. Chairman. The events of September 11 and the recent anthrax attacks have brought home just how real the threat of bioterrorism can be. While we all feel the need to take action, I would caution my colleagues to remember that old adage, act in haste, repeat at your leisure. For example, we're all concerned about the availability of vaccines for smallpox, but should we risk the public health by taking shortcuts in vaccine production which could create serious side effects for hundreds of thousands of Americans and ultimately not protect against the disease?

We have a public health system in this country which varies greatly in terms of its sophistication and its ability to access the most up to date information about bioterrorist threat. Currently, only 13 States are connected to all of their local health jurisdictions. How do we ensure that the other 37 States have the same communication links? How do we ensure that our rural communities are as prepared as our urban areas to deal with the bioterrorism threat? On that note, Mr. Chairman, I yield back.

[The prepared statement of Hon. Edolphus Towns follows:]

PREPARED STATEMENT OF HON. ED TOWNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Chairman, I am pleased that this committee will indeed have an opportunity to review the important issue of bioterrorism before we adjourn this session.

The events of September 11th and the recent anthrax attacks against the media and members of this body have brought home just how real the threat of bioterrorism can be. While we all feel the need to take action, Mr. Chairman, I would caution my colleagues to remember that old adage: "Act in haste repent at your leisure".

For example, we are all concerned about the availability of vaccines for smallpox. But should we risk the public health by taking shortcuts in vaccine production which could create serious side effects for hundreds of thousands for Americans and ultimately not protect against the disease?

Within the approaching holiday season, we have concerns about the security of our food supply. But are country-of-origin labeling requirements practical and, more importantly, will they make our food any safer?

And finally, Mr. Chairman, we have a public health system in this country which varies greatly in terms of its sophistication and its ability to access the most up-to-date information about a bioterrorist threat. Currently, only 13 states are connected to all of their local health jurisdictions. How do we ensure that the other 37 have the same communication links? How do we ensure that our rural communities are as prepared as our urban areas to deal with a bioterrorism threat?

These are concerns which must be addressed responsibly and not in a hasty fashion just so that we can claim "we did something" before Congress adjourns. This is one area, Mr. Chairman, where we may not have the ability to leisurely repent our earlier decisions. I look forward to hearing the testimony from our witnesses.

Chairman TAUZIN. I thank my friend for his statement. Are there further requests for opening statements on this side? The vice chairman of the committee, Mr. Burr.

Mr. BURR. Thank you, Mr. Chairman.

Chairman TAUZIN. I'm sorry, the gentleman from California, Mr. Cox, is signalling and is recognized for 3 minutes for an opening statement.

Mr. COX. I thank you. In fact, I thought Mr. Greenwood was going to ask for time which is the only reason I yielded. I want to thank you, Mr. Chairman for——

Chairman TAUZIN. Would the gentleman yield a second—Mr. Greenwood is here. I think the committee ought to take great pride in the subcommittee's work, Mr. Greenwood performed this week, this last week, on the issue of charitable aid to the victims of the catastrophe in New York and Washington and Pennsylvania. As you know, the Red Cross just yesterday announced it was reversing its course and directing the money. Mr. Greenwood, a great job, sir.

There are lots of folks who will claim some credit for that, including Mr. Bill O'Reilly on his show who did a great deal to expose the problem early, but Mr. Greenwood and his subcommittee did a great job, I think, in helping to educate the Red Cross on the voices that we were hearing from America. And I think the Red Cross is to be commended for correcting that course and for dedicating itself to putting that money now to the victims of the families of New York and Washington and Pennsylvania.

Again, thank you, Mr. Greenwood. Mr. Cox is recognized for 3 minutes.

Mr. COX. Thank you, Mr. Chairman, again, thank you for holding this hearing on bioterrorism and I want to welcome Secretary Thompson, add my welcome to those of my colleagues. I know all of us on the committee appreciate the time that you're taking away from your other responsibilities to testify before us this morning. I would personally like to thank you as well as Deputy Assistant Secretary Claude Allan and Dr. Donald Henderson for meeting with the House Policy Committee to discuss this exact topic over the last month.

This committee has dedicated itself for several years to improving the resources and programs of the National Institutes of Health, the Centers for Disease Control and the Food and Drug Administration. Now we are taking additional steps to improve the Nation's ability to respond and more importantly prevent public health emergencies instigated by terrorists' attacks. In the process of drafting the legislation that this committee is currently considering, it's become clear that our Nation's biomedical researchers and scientists are being hindered by laws already on the books that constrain them from developing products that could treat, detect and prevent bioterrorist attacks. Some of these impediments are as simple as our failure to make the R&D tax credit permanent, as a result of which America's biomedical research has been conducted in an atmosphere of uncertainty, financial uncertainty.

The Food and Drug Administration still takes too long to approve lifesaving products, although efforts have been and are being made to improve and streamline the approval process and our increasingly dysfunctional lawsuit system which imposes exorbitant and easily avoidable costs on our health care consumers and providers alike, has particularly deleterious effects on the development and marketing of vaccines.

I know, Mr. Secretary, that you have been a leading advocate of reform in all of these areas and I would particularly like to commend you, the President and the rest of the Bush Administration for your leadership at this time. Mr. Chairman, I yield back.

Chairman TAUZIN. I thank the gentleman for his statement. Are there further requests on this side? Mr. Pallone from New Jersey is recognized.

Mr. PALLONE. Thank you, Mr. Chairman. On September 28, the General Accounting Office published a report requested by Senators Kennedy and Frist which stated that, in fact, our health departments are ill-equipped, we are vulnerable to bioterrorism and that our response to bioterrorism is poorly coordinated and under funded on the Federal, State and local level.

Mr. Chairman, I have to say I was disappointed in the Federal Government's response to the chain of anthrax events. The information that was presented about medications and doses were inconsistent and in general, fear and confusion about the power and limitations of anthrax were instilled in an already panicked nation. For the future, our efforts need to focus on preparing for similar threats, as well as more severe threats of diseases that are highly contagious and deadly such as smallpox.

Mr. Chairman, bioterrorism is not a partisan issue, but I did want to mention that our Democratic caucus has spent a lot of time since September 11 focusing on this issue. Last week, the Democratic Health Care Task Force invited Janet Heinrich and her team from the GAO, the comment on their report which, as I said, cited bioterrorism and vulnerability. And this presentation was very helpful in understanding the current gaps in our public health infrastructure. Several proposals were brought up during this meeting, namely H.R. 3255, Representative Bob Menendez' bioterrorism bill which has been introduced on behalf of the House Democratic Caucus and H.R. 3219, Representative Jane Harman's bill to fund the CDC renovations. And the team from the GAO agreed that these proposals would certainly be a good starting point for improving our bioterrorism response and Mr. Secretary, I'm not trying to be partisan in saying this, but I really believe that and I know that you have looked at these proposals and I really would commend them to you because I think that having taken them out on the road and talked at Town Forums about them, they really seem to be a good basis for dealing with the issue.

The first bill, the Menendez bill, H.R. 3255, proposes a $3.5 billion package for public health preparedness, the majority of which would be directed toward State and local governments. Ms. Harman's bill, H.R. 3219, would provide $1.5 billion over the next 5 years for CDC renovation and this would help speed up completion of the CDC's master building plan.

With regard to the CDC, I just wanted to mention, of the $3.8 billion, fiscal year 2001 CDC budget, only $181 million was devoted to bioterrorism, of which only $67 million went to State and local governments. This year, $1.6 billion has been proposed in the emergency supplemental. However, only a small portion of that amount, $175 million would go to State and local governments and we all know the importance of public health on the State and local level and much more needs to be done in terms of funding.

I'm just asking you, Mr. Secretary, if you would take these two bills that I've just mentioned into serious consideration. I'm getting a lot of feedback back from locals about what needs to be done and I think the House Democrats, without being partisan, really spent a lot of time getting feedback from State and local governments and that these are the types of things that are trying to be addressed in these two bills and I hope that we can work together on a bipartisan basis to improve our public health system as timely as possible, because this is—the issue we're discussing today is the key issue that I hear about in the District and at home. This is the thing that most people care about as their priority right now.

Thank you, Mr. Chairman.

[The prepared statement of Hon. Frank Pallone, Jr. follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Chairman Tauzin, Chairman Bilirakis, thank you for holding this important hearing on proposals to combat bioterrorism.

As we saw just a month ago from the unfortunate anthrax incidents on Capitol Hill and throughout the nation, the need for better communication in response to bioterrorism threats is extremely compelling. Immediate collaboration among federal, state and local government and their medical communities; public health officials; emergency management; and law enforcement is crucial.

When the terrorist attacks against the World Trade Center and Pentagon took place on September 11th, shortly thereafter concerns about biological or chemical warfare were voiced. The nation was given the impression by Secretary Thompson that the United States was fully prepared to combat terrorism and that there was no need for panic. On September 28th, the General Accounting Office (GAO) published a report requested by Senators Kennedy and Frist, which stated that in fact, our health departments are ill-equipped, we are vulnerable to bioterrorism and that our response to bioterrorism is poorly coordinated and under-funded on the federal, state and local level.

As a result of this ill-preparedness, the response to anthrax found in Senator Daschles office, and the chain of anthrax events that followed, was decentralized, uncoordinated, and quite frankly, confusing. The CDC unfortunately lacked leadership in presenting information to the public and to key health departments. The information that was presented about medications and doses were inconsistent, and in general, fear and confusion about both the power and limitations of anthrax were instilled in an already panicked nation. It is unfortunate that 4 deaths were the result, but it is important to keep in mind that this was anthrax, a substance that is not contagious. Obviously our efforts need to focus on preparing for future similar threats, as well as more severe threats of diseases that are highly contagious and deadly, such as small pox.

We as a Committee and we as a Congress, want to help to improve this current situation of bioterrorism unpreparedness. Far greater challenges are headed our way, and it is our responsibility and aspiration to provide what you need to ensure the publics safety.

Last week, the Health Care Task Force invited Janet Heinrich and her team from the GAO to present to us on the report, which cited bioterrorism vulnerability. This presentation was very helpful in understanding the current gaps in our public health infrastructure. Several proposals were brought up during this meeting, namely HR 3255: Rep. Bob Menendezs bioterrorism bill introduced on behalf of the House Homeland Security Task Force, and HR 3219: Rep. Jane Harmans bill to fund CDC renovation. Our team from the GAO agreed that these proposals would certainly be good starting points for improving our bioterrorism response.

HR 3255, the Bioterrorism Preparedness Act of 2001, proposes a $3.5 billion package for public health preparedness, the majority of which will be directed toward state and local governments. The main highlights of the bill that address public health infrastructure and response to bioterrorism are: 1) improving community emergency response capacity and preparedness, 2) ensuring an adequate supply of vaccines and treatments for all Americans, 3) enhancing community planning and intergovernmental coordination and 4) enhancing surveillance, improving communications and strengthening technology infrastructure. I feel that this bill provides

an excellent starting point for ensuring a strong and organized response to bioterrorism.

In addition, several of my colleagues recently visited the CDC campus and came back to report to Members that a substantial investment in our public health system and CDC bioterrorism-related programs is badly needed. The CDC is responsible for our national pharmaceutical stockpile, our health alert network, our public health training network, and many infectious disease labs. Of the $3.8 billion FY 2001 CDC budget, only $181 million was devoted to bioterrorism, of which, only $67 million went to state and local governments. This year, $1.6 billion has been proposed in the Emergency Supplemental, however, only a small portion of that amount, $175 million would go to state and local governments. We all know the importance of public health on the state and local level and much more needs to be done in terms of funding.

One of the most striking comments made by my colleagues regarding their visit to the CDC, was that the buildings and facilities were badly in need of renovation. My colleague, Rep. Jane Harman, has introduced a bill, HR 3219, that would provide $1.5 billion over the next five years for CDC renovation. This will help speed up completion of the CDCs master building plan, which is crucial at this time when the CDC must have the ability to carry out vast communications and maintain a high level of security.

Thank you, Secretary Thompson and Director Koplan, for coming before our Committee to address this important issue of response to bioterrorism. I hope that you will take these two bills that I have just mentioned into consideration and I hope that we can work together to improve our public health system as timely a fashion as possible.

Thank you.

Chairman TAUZIN. I thank the gentleman. Further requests for opening statements? The gentleman from North Carolina, the vice chairman of the committee, Mr. Burr.

Mr. BURR. Thank you, Mr. Chairman. Let me take this opportunity to welcome Secretary Thompson and Dr. Koplan. We've tried to put this slate together several times and if it hadn't been us that's messed it up, it's been the President, but we excuse him for last week.

Mr. Chairman, let me reiterate something that you said and that's that, in a bipartisan way, the committee staff has worked aggressively for the last week or longer to address the bioterrorism bill that I think members on both sides of the aisle agree that we need to do. It will focus on two specific areas, but not limited to those two, a rebuilding of our public health infrastructure in America that I think all of us agree needs to be done to respond successfully to any threat that we might see in any community. And second, to accelerate the facility upgrade of our CDC facilities which will be really the nucleus of our ability to understand what's happening and what we should do. Mr. Linder from Georgia, has worked aggressively with the CDC. He, along with Ms. Harman, has introduced that bill and it is the plans of this committee to incorporate that acceleration in our bioterrorism bill where we would accelerate a 10 year plan, Jeff, to a 5 year plan, and hopefully find appropriators to go along with us. It is my hope that it won't be too long before we have an opportunity to produce out of this committee a bipartisan piece of legislation on bioterrorism and I look forward to that.

Mr. Chairman, I yield back.

Chairman TAUZIN. I thank the gentleman. Further requests for time? The gentleman from Michigan, Mr. Dingell, is recognized for 5 minutes.

Mr. DINGELL. Mr. Chairman, I thank you. Mr. Secretary Thompson and Director Koplan, thank you, for being here and welcome.

I particularly want to discuss proposals to address possible acts of bioterrorism directed against our citizens. I believe there are serious deficiencies in our public health systems, inadequacy of budget and equipment at CDC, major shortfalls in the capability of Food and Drug to address its problems, antiquated facilities at CDC, and indeed, an overall shortage in the ability of our hospitals and local units of Government to respond to the serious challenges that can come from these kinds of events.

We know how to fix our public health system. We know increased funding is required, as well as improved Federal direction and coordination. I believe it is now a simple and direct question of political will, given greater urgency because of recent and unfortunate terrorist events. We need money for training, more nurses, more laboratory staff, for developing new vaccines and antibiotics, for developing stockpiles of pharmaceuticals and other medical supplies. We need more money for public hospitals and community health centers and we do need leadership from the Federal Government.

Second, the administration should be able to address and fix the problems in the initial response to anthrax attacks. I have attached to my statements for inclusion in the record, a copy of the November 10 National Journal article entitled "Contagious Confusion" which discusses many of the lessons learned. Legislation can help in some respects, but ultimately the Secretary and the administration will have to be the ones who ensure that Federal response improves and that State and local authorities have the tools and the support that they desperately need to do better; and I would note that in discussions with my local officials, they find a massive problem in term of inadequate Federal support for local undertakings which are, after all, the front line of defense in matters of this sort.

Third, there is a greater recognition that our general level of preparedness is not adequate. For example, our food safety system is not prepared to prevent international and intentional adulteration from occurring, particularly with imported food. We have neither the manpower at the borders, nor the technology, to detect adulteration, intentional and otherwise, or to direct it to proper hands so that it may be scrutinized and the dangers detected.

When food arrives at U.S. ports of entry, there are an inadequate number of people and inadequate inspection awaiting it. It can come wherever the sender wishes it to go and there's no way of channelling it into proper and necessary inquiries into the safety of foods and other imported commodities of that character. Even when imported food is sampled and tests are conducted, it takes overlong. It takes days or weeks for labs to process the tests. By that time, the food is long gone and people have been significantly at risk for significant period of time.

We in Congress must give Secretary Thompson the tools and resources he needs to properly address the threat and he must face up to the fact that he has great needs and speak honestly of those needs to this Congress. And the administration must not shy away from seeking what is needed to take the necessary steps.

Mr. Secretary and Director Koplan, thank you for being here and I look forward to your testimony and I thank you, Mr. Chairman.

I yield back the balance of my time.

[The prepared statement of Hon. John D. Dingell follows:]

PREPARED STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

I welcome Secretary Thompson and CDC Director Koplan to this Committee, particularly to discuss proposals to address possible acts of bioterrorism directed against our citizens. We all know there are serious deficiencies—in our public health system, in our initial responses to the anthrax mail attacks, and in our general level of preparedness. Our task now is to discuss them objectively and constructively, and to craft solutions. This Committee has been engaged in such an effort over the last two weeks, and although no agreement has been reached, I commend the Chairman for undertaking this task. Many other efforts in the Congress and the Administration are underway, and the collective efforts should ultimately bear fruit.

First, we know how to fix our public health system. We know that increased funding is required, as well as improved federal direction and coordination. Now it is a simple and direct question of political will, given greater urgency because of recent terrorist events. We need money for training, for more nurses and laboratory staff, for developing new vaccines and antibiotics, and for developing stockpiles of pharmaceu-ticals and other medical supplies. We need money for public hospitals and community health centers. And we need leadership from the Federal Government.

Second, the Administration should be able to address and fix the problems in the initial response to the anthrax attacks. I have attached to my statement, for inclusion into the record, a November 10 *National Journal* article "Contagious Confusion," which discusses many of the lessons learned. Legislation can help in some respects, but ultimately the Secretary and the Administration must work to ensure that the Federal response improves, and that the state and local authorities have the tools and support they need to do better. We must have a clear, timely, and medically credible response at the Federal level.

Third, there is greater recognition that our general level of preparedness is not adequate. For example, our food safety system is not prepared to prevent intentional adulteration from occurring, particularly with imported food. We have neither the manpower at the borders nor the technology to detect adulteration, intentional or otherwise, of food when it arrives at U.S. ports of entry. Even when imported food is sampled and tests are conducted, it takes days or weeks for labs to process the tests—and the food is long gone. We in Congress must give Secretary Thompson the tools and resources he needs to properly address this threat, and the Administration must not shy away from seeking what is needed.

I thank Secretary Thompson and Director Koplan for being here, and I look forward to their testimony.

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[Friday, Nov. 9, 2001—National Journal]

CONTAGIOUS CONFUSION

By Sydney J. Freedberg Jr. and Marilyn Werber Serafini

In a way that the far bloodier September 11 attacks did not, the anthrax assault has required unprecedented collaboration: among law enforcement, emergency management, and public health officials; among federal, state, and local government; and between government at all levels and the medical community. If the attacks-by-mail did America any kind of favor, it was to highlight how many weak links there are in the chains that bind these agencies to each other in a crisis—links that must be strengthened before a far heavier blow breaks them apart completely.

Consider Clifford Ong, Indiana's new statewide counter-terrorism coordinator, appointed two weeks into the crisis as the Hoosier version of national Homeland Security chief Tom Ridge. Ong's office, intended to be the state's central clearinghouse for anthrax information, first learned about Indiana's most serious anthrax scare, not through official channels, but from the media. Although about 600 miles from any confirmed case of anthrax, Indianapolis happens to have one of the only two facilities nationwide that repair and recycle post office sorting machines—including a tainted printer from Trenton, N.J. State authorities did not even know the repair plant was there until a subcontractor called asking for advice about how to handle machinery possibly exposed to anthrax. The state then tested for anthrax at the repair plant, and the report came back negative. Ong relaxed. But he didn't know that the main contractor at the plant had asked the U.S. Postal Service to come and do its own test. This second test, performed by an out-of-state lab, came back positive. Suddenly, there was anthrax in Indiana, and yet state authorities weren't told. Reporters in Washington were. Ong had to field the frantic calls.

"Our problem isn't locally," said Ong, who has long worked with the local U.S. district attorney and the FBI field office. "Washington seems to respond within the Beltway to national media without any concern that we have local media . . . It puts us in somewhat of a defensive position."

This snafu—just one of many—shows how vital information can fall into the cracks between organizations, into blind spots where fear can flourish like mold inside a wall. Considering that just four people died of anthrax in one month, the average American was far more likely to be struck by lightning, which kills 80 to 100 people every year, than to contract the disease. The point is that anthrax is not contagious—but fear is. "The medical problem was actually pretty small," said Jack Harrald, the director of the Institute for Crisis, Disaster, and Risk Management at George Washington University in Washington. "The terror problem, in terms of managing people's fear, was pretty huge—and not very well managed."

The failure of government, medicine, and media to respond to fears and ignorance about anthrax with real understanding led to millions of dollars in losses—to businesses that had to find substitute mail carriers or evacuate their workplaces for testing, as well as to local governments that had to respond to every emergency anthrax scare. In Los Angeles, where hazardous-materials responses increased 300 percent in mid-October, "we received a call from an employee at a doughnut shop that there's a white, powdery substance on the floor," said Deputy Chief Darrell Higuchi, of the Los Angeles County Fire Department. The shop, of course, sold doughnuts with powdered sugar. "Yet," said Higuchi, "you feel for the callers, because they are scared."

Fear thrives on ignorance. But there is no effective, authoritative, nationwide system to communicate information about bioterror. Nor is there a single national spokesperson for the public's health. Indeed, some have criticized the Bush Administration for failing to designate someone as the voice of the anthrax crisis, even acknowledging White House reluctance to call on Surgeon General David Satcher, a leftover Clinton Administration appointee. Instead, information has moved through dozens of parallel and poorly coordinated channels of communication: The Centers for Disease Control and Prevention talks to state health officers, the FBI to local sheriffs, the Federal Emergency Management Agency to disaster officials, medical associations to their members. But when people in different fields, such as police and physicians, must work together, or when there simply is no state or local counterpart to a federal agency, the channels are less clear—as Ong found out in dealing with the Postal Service. The system simply isn't set up to share information.

In fact, civil liberties laws often forbid necessary communication. Said Lawrence Gostin, the director of the Center for Law and the Public's Health, a joint project of Georgetown University and Johns Hopkins University: "The law thwarts vital information-sharing vertically from federal to state, and horizontally between law enforcement, emergency management, and public health."

The biggest gap is between government and the medical community. A CDC alert on bioterrorism, sent to state health officials just after September 11, had still not reached many local emergency rooms a week later. And the crucial linchpins between doctors and officials—local public health offices—are notoriously overworked and short of funds. As many as one in five public health offices do not even have e-mail, said Sen. Bill Frist, R-Tenn., a physician. Many localities still collect epidemiological data on disease outbreaks only by asking doctors to send postcards through the mail—hardly an ideal approach in any fast-moving outbreak, let alone one that strikes at the postal system.

Anthrax has finally kick-started efforts to revive public health systems, after decades of neglect. In North Carolina, for example, the Legislature is about to allocate millions of dollars to replace reporting by postcard with high-speed, highly secure electronic links. Ultimately, the network will connect not only local officials, but also every hospital, pharmacy, and doctor's office in the state.

New funding and new networks are essential first steps. But in a country where almost all health care is provided by the private sector—indeed, where most critical terrorist targets, from Internet servers to nuclear plants to sports arenas, are privately owned—defense against terrorism probably cannot be achieved by a new agency, a new program, or a new technology. True "homeland security," most experts say, will require an overarching system that links not just every level and agency of government, but also the private sector, nonprofit groups, and the general public. Computers and the Internet will be vital in helping to set up this new national network, but it will be the intangible connections between people working together in a common cause that will really make the new system work.

*The Broken Linchpin*

If it sometimes seems as if the world has turned upside down since September 11, that's because it has. Terrorism has upset the traditional pyramid of who protects Whom. No longer do the Pentagon's armed troops bear the brunt of foreign blows. Whether the danger comes from airliners-as-bombs or from anthrax envelopes, local firefighters, medics, and police respond long before Washington can act. But even the local emergency teams come second to the scene. In a terrorist attack, the first responder is the ordinary citizen—the airline passenger who decides to rush the hijackers, the mailroom clerk who notices a suspicious package, or anyone who wonders whether these flu-like symptoms they're feeling might be anthrax. It is their decisions, prudent or paranoid, that trigger the government response. Said Peter Probst, a former Pentagon and CIA official, "The first line of defense is an educated, engaged public."

That word, "educated," signals where things start breaking down. Even those officials who should be best equipped to inform have stumbled over their own statements, and each other's—and that includes Surgeon General Satcher and Health and Human Services Secretary Tommy G. Thompson.

"You've got Satcher saying one thing, Tommy Thompson saying another, and the CDC saying a third," fumed one local official who spoke with *National Journal.* One day the word is to put everyone on Cipro, the next day not, the third day it's another antibiotic altogether. "There isn't a consistent message."

With that confusion at the top, many officials, never mind ordinary citizens, admit turning to the news media as their first source of knowledge. But as reporters themselves grope in the dark for information, and constantly face the pressure for round-the-clock, up-to-the-minute coverage, they may magnify inconclusive clues, or even outright rumors, into major scare stories. There was so much misinformation about anthrax early on, said one congressional staffer well versed in bioterror, "the first few days, I was kicking the television a lot."

Many confused citizens dialed 911, just to be sure. Far more fell back on the second line of defense: their doctors. Physicians are still trusted more than most other professionals. And even though only a handful of American doctors have ever seen a case of inhalation anthrax (the last U.S. case was in 1978), most rushed to learn what they could. Until recently, medical education on bioweapons has been minimal. But after September 11, well before the first anthrax case in Florida, sensitivity to terror of all kinds was so high that the major medical associations quickly rallied to upload data to their Web sites and downlink teleconferences to their members.

That information probably saved lives. Had Florida photo editor Bob Stevens died in August, said Randall Larsen, director of the Anser Institute for Homeland Security, a consulting group in Northern Virginia, "it's highly unlikely he would have been diagnosed as dying with anthrax, because they weren't looking for it." Before September 11, when authorities sent anthrax samples to four medical laboratories as a test of their bioterrorism alertness, three of the labs just threw the samples out, mistaking the anthrax bacteria for contamination on the slides.

In another test, out of a roomful of doctors at Johns Hopkins medical center, just one recognized an X-ray of a strange chest inflammation as characteristic of anthrax. Even after the September 11 attacks, HHS Secretary Thompson initially suggested that Stevens's death was due to a freak natural cause. But doctors were on high enough alert by then to spot the symptoms.

Although the professional medical associations could deluge their members with basic references on anthrax, they lacked the quick communications systems to collect and broadcast up-to-date data on the ever-changing outbreak. In fact, since most associations serve only a single medical specialty—and even the mighty American Medical Association serves fewer than half of all doctors—they could not even help share information among different types of doctors in a given community.

The painstaking, county-by-county collation of data gathered from individual physicians has always fallen to local public health offices—the traditional American defensive line against disease. But emergency officials, medical associations, and independent experts alike all agree that the public health infrastructure has long been, to quote one congressional staffer, "the forgotten stepchild." These local offices are perpetually short on funds, technology, and—above all—personnel. They are burdened with laws written to guard against 19th-century scourges such as syphilis and tuberculosis, and few of these laws even require doctors to report outbreaks of likely bioweapons such as anthrax, much less the subtler indications of spreading disease.

"Suppose there's a run on anti-diarrhea medication. How would we know that? If there are a lot of absences from school or work, how would we know that?" said Georgetown University's Gostin. "We need a public health agency to be able to get information from the private sector."

New York City, considered a national model, does keep hourly tabs on such things as sales of the anti-diarrheal Kaopectate. Los Angeles hospitals are linked by computer to share diagnosis data. But most areas lack such sophisticated "disease surveillance" systems, even in states that have really tried. Virginia, for example, connects its local health offices across the state by computer, said George Foresman, a Virginia emergency management official, but the state's effort to bring private practices into the network stalled because "we just had not been able to secure the funding."

The problems are not only fiscal. Even with a $1.4 million federal grant, Michigan found the private sector deeply reluctant to share information. "We've asked pharmacies if we could monitor what antibiotics are going out," said Dr. Sandro Cinti, of the University of Michigan medical center, "but they didn't want to give away that information."

In the absence of even such imperfect electronic systems, most public health officials collect data the old-fashioned way: slowly. In some places, doctors' offices fill out and mail in forms to health agencies; in other places, they call in, and local officials must laboriously enter the information by hand, and then in turn mail another piece of paper to the state health office. Conversely, when Illinois authorities, who have invested heavily in linking public health offices to local hospitals, wanted to send every physician in the state advice on anthrax, they had to take the licensing board's master list of addresses and mail every one of them a letter. There was no comprehensive e-mail or electronic system.

"The information-gathering and decision-making loop isn't fast enough," said Clark Staten, the executive director of the Emergency Response & Research Institute in Chicago. "The bad guys can move faster than the good guys—at the present time." And during that lag, fear can spread, and people can die.

*More Than Medical*

Even in a better-than-average flu season, doctors may run out of vaccine and hospitals out of beds. In some cities last year, said Sen. Edward Kennedy, D-Mass., "they had sick patients that couldn't even be treated in the emergency rooms—they were out in cars."

Any major natural disease outbreak overtaxes American medicine. But biological terrorism takes the complexity an octave higher. Each scattering of spores is obviously a public health problem. But it is also evidence of a crime—and of a hazardous material in the environment. Anthrax not only requires close "vertical" cooperation among federal, state, local, and private medical organizations, it also cuts horizontally across functional lines. Ordinary disease can be dropped neatly into an organizational box marked "medical." Bioterrorism requires out-of-the-box cooperation among public health professionals, private doctors, law enforcement agencies, firefighters, emergency management systems, and even foreign intelligence agencies.

This kind of jurisdiction-crossing is so alien to American government that it is often outright illegal. If the Central Intelligence Agency had somehow found out beforehand about the anthrax-laced letter addressed to Senate Majority Leader Thomas A. Daschle, for example, it may not have been allowed to warn health officials until after it was sent, according to James Hodge, the project director of the Center for Law and Public's Health. To protect civil liberties, said Hodge, "there's a firewall between intelligence agencies and public health."

Even when there's no legal obstacle to collaboration, many of the various agencies lack the experience, the contacts, or the procedures to work together. Both the U.S. Postal Inspection Service and the Centers for Disease Control are trying to track the anthrax letters to their source. The two agencies share information, but they don't share people: Instead of combining forces, detectives and doctors are on two separate teams following different methods to reach the same goal.

Sometimes, the lack of coordination could have even worse consequences. "When I was the health commissioner of New York, I had no clue who was the head of the FBI office, and he had no clue who I was," said Margaret Hamburg, who went on to become HHS's top bioterror official under President Clinton. "The last thing they want to be doing is exchanging business cards in the middle of a crisis." Yet, that is just what often happened with the anthrax scare.

In the District of Columbia, for instance, where traditional federal-local complications compounded all the other problems, the initial confusion and inconsistencies in testing and treatment for Capitol Hill staff versus postal workers boiled over into racially tinged fury. One community forum turned, unfairly, into a pillorying of D.C. public health chief Ivan Walks. Soon Dr. Walks and Mayor Anthony Williams were holding joint press conferences with Postal Service officials and the CDC. But those relationships had to be set up on the spot—and the public health office still does

not have a full-time representative in the District's interagency Emergency Operations Center.

D.C.'s problem is not uncommon. "We somehow managed to leave the public health system . . . outside the emergency system," said Harrald, at D.C.'s George Washington University. Emergency managers, firefighters, and police have largely overcome past problems of coordination by planning and training together before disasters, and by jointly staffing command posts during times of crisis. Such a combined system cranked into action in New York City on September 11. "The federal government had thousands of people moving in the right direction 20 minutes after the second tower was hit," Harrald said. "We know how to do this. That's the good news."

The bad news is that, in most places, no one told public health officials the good news. In D.C., "it took a long time before the emergency room at [George Washington University] hospital and the emergency room at Children's Hospital and the attending physician of the Capitol and the CDC had the same picture of what they were dealing with," Harrald said. "I'm not throwing stones at individuals. The problem is that we didn't set the systems up before the event."

*The American Answer*

In the first month of anthrax attacks, the country's system of defenses against bioterror often seemed to be no system at all, only chaos. Fortunately, reality is more nuanced, and more heartening, than that. True, there is no one coherent national system. But there are systems—all partial, all imperfect, but needing mainly to be strengthened and brought into an overarching structure. Senate Health, Education, Labor, and Pensions Committee Chairman Kennedy and panel member Frist last year co-sponsored the *Public Health Threats and Emergencies Act of 2000,* which authorized $540 million a year to strengthen the public health infrastructure and to better recognize and respond to bioterrorism attacks. Congress has not yet funded the new law, but already the two Senators have upped their request to $1.4 billion a year.

The final sum needed for homeland security will surely be much higher. But "we're not going to create a whole new Department of Defense," with a $350 billion budget and staff of 3 million, said David McIntyre of the Anser Institute. "We're going to play with the chips that are on the table."

"The pieces are there," said Frist. The task is taking the pieces that exist—federal, state, local, and private—"and coordinating them in a seamless way. It can be done." In Frist's own field, transplant surgery, moving precious organs quickly across the country and then ensuring that patients' bodies do not reject the new tissue require far-flung hospitals and diverse disciplines to work closely together—and they do it, every day.

High on Capitol Hill's agenda is a massive reinvestment in the nation's long-neglected public health system. Top priority is a secure, high-speed electronic data-link for doctors and public health officials who are now scrawling disease reports on postcards. The CDC already has an electronic Epidemic Information Exchange system to share outbreak alerts among federal, state, and local public health officials, as well as the military. And long before September 11, the CDC had given all 50 states seed money to start work on a National Electronic Disease Surveillance System to link all 2,000-plus local health offices around the country. This network could automatically and swiftly share, for example, the results of a crucial diagnostic test. Ultimately, it could also tap into hospitals and even private practices. But for now, the surveillance network does not actually exist. A bare-bones "base system" is scheduled to begin in 20 states in 2002. That seemed plenty fast—before September 11. Now, lawmakers are likely to hit the gas.

But strengthening public health is only half the battle, because public health officials will still get their information from the private sector. The real challenge is to track—from every hospital, every doctor's office, and every pharmacy around the country—the telltale upticks in certain symptoms, or prescriptions, that although seemingly innocuous in isolation, could signal an impending crisis. It is a daunting task.

Yet it is also mostly done already. Insurance companies routinely require doctors to code each diagnosis and report it electronically for reimbursement, keeping electronic tabs on everything from pharmaceutical sales to major surgeries. *The Health Insurance Portability and Accountability Act of 1996* (HIPAA) made such reporting systems mandatory nationwide, though a significant 43 percent of doctors are not yet hooked up. In its patient-privacy rules, the act also has a little-known exception that requires doctors to share data on threats to public health.

Medical information companies are already on the Hill touting software solutions. A properly designed system could tap into the existing streams of data, strip off

names and other individual identifiers, and crunch the numbers into trends. To be sure, such an early-warning system might well find false patterns. An upsurge in sales of certain drugs might indicate an outbreak of disease, or it could simply reflect effective advertising. Conversely, the system might miss a real outbreak if doctors consistently misdiagnosed as flu the ambiguous early symptoms of, say, anthrax—the reason why D.C.'s Walks is currently working on a system that codes not just final diagnoses but actual symptoms as well.

Still, the most sophisticated computer is only a tool. The most important linkages are among people. And in small ways, that linking process has already begun, too. Tom Ridge has held teleconferences with all 50 state governors. Local officials and medical associations are reaching out to one another, often through e-mail. And a FEMA program called "*Project Impact*" gives local governments grants and training to bring together different agencies, businesses, and community groups for disaster planning. Mayor Susan Savage of tornado-prone Tulsa, Okla., says that Project Impact simply but systematically asks, "What does the private sector bring to the table that can complement public resources?" On September 11, for example, when 800 airline passengers were stranded at the Tulsa airport, the city mobilized everything from public buses for transportation to local preachers for counseling, pulling resources freely from the public, private, and nonprofit sectors.

Officials, legislators, and experts increasingly agree that such bottom-up approaches are the model for homeland security. Imposing a single national system from the top down is not only impractical, it is probably unwise. What makes more sense is a "network of networks," an overarching system that lets each local government or private group tailor its approach to its own unique needs—within the overall framework.

A prototype nationwide network of networks has actually already been built. Unfortunately, it was promptly taken apart soon after. Late in 1999, when the public and private sectors alike were fretting that their computers might crash once the year hit "00," then-Secretary of State Madeleine K. Albright visited the national Y2K crisis center and exclaimed, "You could really run the world from here."

Like a terrorist, the Y2K bug threatened to strike unpredictably at any target: federal, state, local, or, in the vast majority of cases, private. Imposing a topdown structure to address the potential threat was impossible, recalled John Koskinen, Clinton's Y2K coordinator: "You need to build off existing structures, and not create new ones." So Koskinen pulled together existing networks—government agencies, corporations, trade associations, and industry groups—in a loose but comprehensive confederation that reached into every threatened sector, with himself as the lead spokesman.

"The year-2000 preparations were a pretty good dress rehearsal" for the kind of coordination required since September 11, said David Vaughan, a Texas public health official. JoAnne Moreau, the emergency preparedness director of Baton Rouge, La., agreed: "We developed relationships with agencies and companies and factions that we never knew would have some kind of role."

The lesson that Y2K holds for homeland defense is that the federal government cannot, need not, and probably should not, do everything. Of course, without strong guidance from Washington, the thousands of private and local government responses could create an irrational tangle, like an ill-tended garden. The federal role is to fertilize the growth and, when necessary, prune it back. "There are 1,800 separate legal jurisdictions in the United States, and the American people and the Constitution like it that way," said David Siegrist of the Potomac Institute for Policy Studies think tank. "The federal government needs to offer incentives . . . and set standards."

In a shadow war with an amorphous foe, America can prevail only by empowering individuals and small groups to innovate—because it is they, and not any federal official, who will be on the front lines. Thirty years ago, noted McIntyre, if a child showed up at school beaten black and blue, teachers might think, "Tough parents," and move on. Today, they would report the possible abuse—and thereby set various responses in motion. A public similarly well-educated to watch for something genuinely wrong in their world would go a long way, not just toward calming panic, but toward stopping terrorists before they strike.

"We don't want to be people who watch each other. We want to be people who watch out for each other," said McIntyre. "It's the distinction between a controlled society and a civil society. A civil society requires citizens. And in good times, maybe we forgot that."

We have certainly been reminded now.

Chairman TAUZIN. The gentleman yields back the balance of his time. Mr. Whitfield? Dr. Ganske, 5 minutes for an opening statement.

Mr. GANSKE. I thank you. I thank the chairman for calling this hearing and I thank the Secretary for coming. I'm sure that the Secretary, after all the additional study he's done on microbiology should probably be awarded a master's or a Ph.D. at the end of his tenure as Secretary.

I hope that this committee is able to come together on a bipartisan agreement on a bioterrorism bill, Mr. Tauzin and Mr. Dingell. I hope they're able to do that. To date, we haven't seen an agreement. For the past month, I have been, you might say in consultation with Senator Bill Frist, a physician in the Senate, on the bill that he and Senator Kennedy have been working on and have come to an agreement on in a bipartisan way. In fact, I talked to Senator Grassley just a day or so ago and he informed me that he thought that would be noncontroversial and most likely we will see a nearly unanimous vote in the Senate on that bill.

I've also had extensive discussions with Senator Chuck Hagel on the food provisions in that bill which I think are excellent. It is my intent to introduce that bill in a bipartisan manner, either today or tomorrow. I do not feel that the level of funding in the Senate bill is excessive, considering the things that we need to do for the CDC, for animal disease labs, for vaccines, and for supplies of drugs.

As a physician, I've been interested in this issue for a long time. I'm happy to have worked with Congressman Brown on issues related to antibiotic resistance. I've had some personal experience with some serious infectious diseases, such as the so-called flesh-eating infection, necrotizing faceitis. I've also had personal experience with a very serious food infection that became a case of encephalitis a few years ago when I was on a surgical mission.

We recently got a phone call from a constituent because we had sent her a letter in response to an inquiry. She phoned back irate that we were potentially contaminating her household with anthrax in sending her a letter from Washington. This is really on a lot of people's minds. The bill that I will introduce deals with a lot of things, but one of the things that I think is a good item in the Frist-Kennedy bill is the issue of block grants to States because it is clear that whereas we need to do many things on the Federal level, the States are in a lot of trouble financially. Secretary Thompson knows that and they are frequently bound by balancing budget amendments to their State constitutions. They need some additional financial help to deal with the public health aspects of this bioterrorist threat. I think that is one of the advantages of the Kennedy-Frist, Frist-Kennedy bill which I will be introducing. There are other aspects of that bill particularly on food safety, and the threat to agriculture that we need to address further than what we have done in Congress. The economical blow to our agricultural sector from the introduction of bioterrorist agent such as hoof and mouth disease would be absolutely devastating.

So I am hopeful that this committee can come to a bipartisan agreement, but if not, we will have an alternative in the form of a companion bill to the Senate bill and I yield back.

Chairman TAUZIN. The gentleman's time has expired. Mr. Deutsch.

Mr. DEUTSCH. Thank you, Mr. Chairman, and thank you, Mr. Secretary for being here this morning.

Mr. Secretary, I know you have spent a great deal of time and effort in terms of trying to have the smallpox vaccine available in our stockpile in a number sufficient for all Americans, and I'm very pleased that Mr. Henderson is here today and actually, obviously, very pleased that you brought him on board as part of your team.

This is really the first opportunity since September 11 that I have and this committee, even though we have jurisdiction over CDC, to really talk to you specifically about smallpox. And I would tell you that from my own perspective, there is no more important issue that you can do as Secretary than to get the vaccines available for Americans on the shelf. And the reason why I'm taking the time in terms of the opening statement is in this setting, which I have mentioned, is the first hearing that we have had in over 2 months, specifically on—or the opportunity to ask questions on smallpox. I only have 5 minutes in that setting and hopefully, either in your statement or in dialog we've had in other settings, to talk about it, but i guess, I know that you're absolutely doing the most you can possibly do. You're working the hardest. Your intentions are the same intentions, but still we're more than 2 months down the road and we don't have a contract. We don't have a specific plan to put smallpox vaccines on the shelf, in our stockpile and I think Mr. Henderson, probably as much as anyone in the world can talk about the disaster that would occur if there was literally one case of smallpox that was found int he United States of America. And unfortunately, it's sort of the more you know, the more you don't want to know situation and I think by this point you know far more than you want to know, but what we all are aware is how even though there are only two official stockpiles of smallpox in the world, it is very clear that there is probably much more smallpox that had been developed and was available for terrorists in the world.

Three years ago, as you are well aware, less than 3 years ago, was the last time we had inspectors in Iraq and by the public domain information it appears very convincing that Iraq had smallpox at that time. The same thing which we are well aware that in the 1990's when the Soviet Union basically disintegrated, it was not just one location where they were developing smallpox, they were developing it in many locations and just so that people are aware, to take smallpox and I'm not an expert and Mr. Henderson really is the—Dr. Henderson is really the world expert on this, but we're really talking about a vial which could have kept a smallpox in a freeze-dried state, could have been sent, just one vial. We're not talking about a nuclear power plant. We're not talking about a reactor. We're not talking about a plutonium facility. We're talking about a vial and a vial potentially with one person could have the destructive capability of ten hydrogen bombs. And I guess I have a concern that as significant as all of our acknowledge that that is the potential. The intensity and I know you're doing as much as you possibly can do, but what I really have had sought and asked for and really in the setting today is really what more

can we do, because the downside exposure of smallpox is so severe that it's almost as if anything we can do to get vaccine on the shelf is critical and I—at the opening in terms of questions, I look forward to that and again I appreciate your being here.

Chairman TAUZIN. I thank the gentleman for his statement. Further requests for opening statements? The gentleman from Georgia, Mr. Norwood is recognized.

Mr. NORWOOD. Thank you, Mr. Chairman, I'll accept your unanimous consent request for 1 minute out of respect for the Secretary's time. Welcome, Mr. Secretary, we're glad you're here.

Last week, I had the privilege of joining the President and Secretary Thompson on the trip down to CDC. You don't have to spend time there to realize the importance of their work to national security. My Georgia colleagues, John Lender and Saxby Chambliss recognize, as well. I'm happily a co-sponsor of their bill, as is Ms. Harman and I sincerely hope this committee accepts their work to make certain CDC has the appropriate authorizations to accomplish their very important mission and I hope we will work that into this committee's bioterrorism bill.

I also briefly want to commend your attention to Mr. Thornberry's bill. It's very simple. In an emergency, frankly, the difference between a for profit and a nonprofit hospital is basically irrelevant and access to Federal funds in an emergency should not be limited in my view, just to nonprofit hospitals. I hope the committee will accept that simple fix as well.

I appreciate you being here today, Mr. Secretary and Dr. Koplan and we all look forward to your testimony.

I yield back, Mr. Chairman.

[The prepared statement of Hon. Charlie Norwood follows:]

PREPARED STATEMENT OF HON. CHARLIE NORWOOD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Thank you Mr. Chairman for holding this hearing this morning. Last week I had the privilege of joining the President on his trip to the CDC. You don't have to spend too much time there to realize the importance of their work to our nation's security.

My Georgia colleagues, John Linder and Saxby Chambliss, recognize this as well. I sincerely hope the Committee accepts their work to make certain CDC has the appropriate authorizations to accomplish their very important mission into the Committee bioterrorism bill.

I would also like to bring attention to Mr. Thornberry's bill as well. In an emergency, the difference between a for-profit and a non-profit hospital is irrelevant. Access to federal funds in an emergency should not be limited to non-profit hospitals. I hope the Committee accepts this very simple fix.

I appreciate your attendance today Secretary Thompson, Dr. Koplan and look forward to your testimony. I yield back the balance of my time.

Chairman TAUZIN. I thank my friend. Further requests for time on this side? The gentlelady from California, Ms. Eshoo, is recognized.

Ms. ESHOO. Thank you, Mr. Chairman, for holding this all-important hearing, and Secretary Thompson, it's wonderful to see you again. Drs. Koplan and Henderson, welcome.

I have questions, obviously, that I would ask this morning, but I want to welcome you, No. 1, and I can't help but think of the time, the years in growing up and what my father would tell me about World War II. He talked about the attack and then he said our country went into high gear. And so I think as we're shifting

into high gear, we have to be mindful of what we can do in our time, in our day.

We know that our public health service across the country is absolutely key and central in this. We have outstanding professionals in all of our communities, but we know that they need more. We know that the CDC is superb, but we have a ways to go in terms of upgrading that place being Ground Zero in this preparation for us to respond, God forbid, to what we need to respond to.

What are the medications that we need to have on the shelf? These are all the thing that we need to be prepared for. That's what this hearing is about. I don't think this is a Democrat and Republican—this is not a partisan issue. This is where we have to join ranks and not debate about the sums, but the substance. The sums should be attached to the substance of what we come up with and I also am very, very mindful that out of this effort, out of this bioterrorism discussion that new discoveries are going to come in terms of the drugs and the research and the development of that research and that will hold our Nation in good stead for years to come. So I look forward, very sincerely, Mr. Secretary, with the chairman, with all of my colleagues on this committee that is front and central in this issue to coming up with those things that generations to come, they will look over their shoulders and say we did something noble and good in our time and in our day.

Thank you.

Chairman TAUZIN. I thank the gentlelady. Further requests for time? The gentleman from Illinois, Mr. Shimkus, is recognized for 3 minutes.

Mr. SHIMKUS. Thank you, Mr. Chairman and thank you, Mr. Secretary, for coming and I would just want to say this is a national security issue. I think we all agree. We did have a historical aspect of the influenza outbreak in 1918. It shows us the risk we have. Had we had 5,000 casualties—had we had 5,000 injured people instead of approximately 5,000 dead, we would have found out that we wouldn't have been able to contain and treat those folks in New York City.

World War II and the cold war really had a good model. Our civil defense plan was a pretty good model to nationalize civil defense issues and I think it's time we kind of turned that back, especially as we address bioterrorism and my big concern is our front line responders, the fire departments, the police officers. No matter what we do at the Federal level, they're going to be the first ones there and we have to help them prepare and then follow up with the surge capacity needed to meet the needs early. We know that early intervention will be the key and somehow we've got to find that great balance to bring in our locals and prepare them to respond and they can do the job if we're there to assist them and that will be my focus and Mr. Chairman, thank you. I yield back.

[The prepared statement of Hon. John Shimkus follows:]

PREPARED STATEMENT OF HON. JOHN SHIMKUS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Thank you Mr. Chairman for holding this hearing on the important issue of bioterrorism. Now, more than ever, our country needs to be prepared to deal with terrorist attacks of all kinds, including bioterrorism.

I am especially concerned over the growing shortage of medical laboratory personnel. These professionals are needed for the immediate response to a bioterrorist situation.

Laboratory professionals must provide prompt and accurate laboratory results so that a potential biological threat can be detected. Considering the times, it is difficult to imagine how our health delivery system would function without this needed laboratory workforce. I am hopeful that any bioterrorism package that moves forward would recognize this need.

In addition, I would like to mention the importance of community health centers as a first line of detection for a bioterrorism attack.

Health centers are often located in isolated rural areas where they are the only health care provider for miles. They are also often expected to fulfill vital local public health functions because there is no local health department or its resources are limited. I urge the members of this committee and HHS to remember this important part of our nation's health care delivery system as we craft this proposal.

Again, I would like to thank you Mr. Chairman, for holding this important hearing today.

Chairman TAUZIN. The Chair thanks the gentleman. Further requests for time on this side? The gentleman from Ohio is recognized. Mr. Rush, do you seek recognition? The gentleman from Ohio is recognized.

Mr. SAWYER. Thank you, Mr. Chairman, for holding this hearing and I thank our witnesses for your participation today.

I'd just like to make a couple of brief observations. First of all, the CDC has made a good beginning. The strategic plan is a good start and during the anthrax episode, health officials in my District tell me that health alert network functioned well in sharing timely information. That's important.

The work entered into cooperative agreements with State and major local health departments I think is an important element in preparedness, because clearly and I think we would all agree that in a crisis, all responses is local. It falls to our cities and our counties first to be able to react and we've got to make sure that they have the tools they need to react appropriately.

That leads me to my second observation and that is that that does not seem to be the case yet, that of the $8.7 billion that OMB suggests we're spending in fighting terrorism, only about 3.5 percent of that is reaching the local level in the form of training, planning and equipment grants. I believe we need to do better than that. I think we can do better than that in the kind of environment that we've heard talked about by the chairman and others. I'm confident that we will do that.

I yield back the balance of my time, Mr. Chairman.

[The prepared statement of Hon. Tom Sawyer follows:]

PREPARED STATEMENT OF HON. TOM SAWYER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Thank you Mr. Chairman and thank you for holding this hearing. I would also like to thank the Secretary for testifying in front of the committee today about ways the government can better protect the public from bioterrorism.

In early October, when the first anthrax case was confirmed, the threat of bioterrorism ceased being theoretical or distant. It became real and immediate, regardless of its ultimate source. Subsequently, 22 cases have been confirmed by CDC and tragically, four people have died as a result of anthrax inhalation. Clearly, the treatment of postal workers who were exposed to anthrax was a disaster. The federal and local governments must do a better job in responding because in the future, the biological agents that terrorist use may be more contagious and more deadly.

The CDC has made a good beginning in leading the nation's efforts to prepare for a bioterrorism attack. As part of HHS's 1999 Bioterrorism initiative, the CDC took on this burden and has performed admirably working with limited resources.

Over a year ago, CDC issued a well thought-out strategic plan to deal with bioterrorism and has worked with State public health departments to strengthen planning, lab capacity and communication. In conversations with heath officials in my district, they have all told me that during the current anthrax episode, the Health Alert Network has performed exceptionally well in informing them about the latest developments and medical information.

In response to the bioterrorism initiative, CDC also began entering into cooperative agreements with State and major local public health departments to help them upgrade their preparedness and response capabilities. These agreements focus on five areas: Preparedness Planning and Readiness Assessment, Surveillance and Epidemiology, the Health Alert Network, and Biologic and Chemical Agents Laboratory Capacity. However, last year, the CDC was able to award only slightly more than $50 million to all public health departments across all five of these areas. Due to a lack of funding, all state public health departments could not even access money in each of the grant categories. In light of September 11 and the anthrax mailings, we need to increase the funding substantially for these vitally important programs.

During a crisis, all response is local. Police, firefighters, health workers, EMTS and mayors are immediately responsible to react. The federal government cannot meet these events as they occur. Consequently, we must make sure that our local health care and safety forces are prepared, and that bioterrorism funding is targeted appropriately.

Unfortunately, this does not seem to be the case yet. An analysis of OMB's figures shows that the federal government is spending about $8.7 Billion to fight terrorism but only 3.5% of that is making it to the local level in the form of training, planning and equipment grants. We need to do better. We must ensure that bioterrorism proposals direct resources to those who will be responding. I look forward to hearing from the witnesses on how they believe that this can best be accomplished.

Chairman TAUZIN. Thank you, my friend. Further requests for time on this side? The gentlelady from New Mexico, Ms. Wilson.

Ms. WILSON. Thank you, Mr. Chairman, Mr. Secretary, I appreciate your being here today. All of us know that we have to strengthen our capacity to respond to and detect biological threats, but I think we also have to recognize that what we're talking about here is only one part of a renewed focus on health security. Many of the threats that we know we're going to have to face include nuclear and chemical contaminants and those are largely unaddressed thus far in the legislation that's emerging certainly from the Senate and possibly also here in the House.

We do know with respect to biological agents that there are some things we have to do. We have to expand our laboratory capacity which was overwhelmed by a relatively small incident involving anthrax in three different communities. That regard last year, the Congress established a national center for infectious disease which a year ago the CDC did not recommend for continuance and I hope that that's been reconsidered.

We need to research, develop and deploy low cost technologies for real time detection of contaminants, whether they are biological, nuclear or chemical. The idea that—the visions that we've seen on our televisions of q-tips and petri dishes and men in bunny suits are not where we should be. We are within 3 to 5 years of the deployment of real time detection of chemical and biological and nuclear contaminants in water systems across the country and we should accelerate that deployment and develop those technologies for the air, the water and the food that we eat. We need to strengthen our controls on hazardous biological agents and this committee has already acted, the House has already acted in that regard. We also need to develop really an encyclopedia of cultures of those materials that we know exist and the genetic sequences of those cultures so that if there is an outbreak, we're able to find out

who the parents were of that outbreak. And finally, we need to protect our water systems and our food supply.

One of the things that we haven't addressed and really is not within the realm of this committee is the role of the National Guard, the Department of Defense and to some extent our national laboratories in this effort. We need to move beyond some of the stovepipe approaches and I know that you've made efforts int hat regard to make sure there's a coordinated Federal and national response to the challenges that we face. There are capabilities developed for one purpose that now can be applied to a completely different problem. I yield the balance of my time.

Chairman TAUZIN. I thank the gentlelady. Further requests for time. The gentleman from Maryland, Mr. Wynn, is recognized.

Mr. WYNN. Thank you very much, Mr. Chairman. First of all, I'd like to welcome the Secretary for being with us as well as Dr. Koplan. Mr. Secretary, I just wanted to add my voice to the chorus you've heard today calling for assistance to State and local governments, the well renowned first responders, if you will. I say this because I was distressed yesterday at Appropriations Committee, at the urging of the administration, amendments were defeated which would have provided additional funding for homeland security. Included in that amendment was money to help local governments at the county level, at the municipal level, as well as at the State level.

Now it may be that the administration feels there's a more appropriate vehicle and that's certainly the administration's prerogative, but I certainly would hope that after hearing so many voices say we need to help local governments, that the administration will step up to the plate on the question of providing additional funding to help those first responders, to help our public health infrastructure.

Dr. Koplan, this week I attended the memorial service for two postal workers who died of anthrax, and at that memorial service, attended by over a thousand individuals, there was a great deal of resentment. There was the sentiment that there is a double standard between the treatment of postal workers and the treatment of congressional staff. I know that's not true and my point is not to point fingers because obviously, I'm speaking with the clarity of hindsight. I guess we all are. I would only say that in dealing with the welfare of service industry personnel, whatever the situation, that we exercise maximum caution on their behalf because after the fact, it's obviously too late. I know you're in a very difficult situation. Everyone looks to you for answers that may not be available, but I would just, as I say, sound a cautionary note with respect to the decisions you make that ultimately affect the lives of thousands and thousands and thousands of people at the blue collar level, that don't occupy these halls.

Thank you. I relinquish the balance of my time.

Chairman TAUZIN. I thank the gentleman for yielding. Further requests for time on this side? I see none for further requests from this side. The gentleman from Texas, Mr. Green is recognized.

Mr. GREEN. Thank you, Mr. Chairman, and I'll submit a complete statement and I'll try to stay within a minute. I want to wel-

come our Secretary again and also the medical experts who are there with him.

September 11 in the resulting 2 months plus since then have brought new territory for our country with bioterrorism. In watching it over the last 2 months and particularly in the last month because of the anthrax scare in mid-October, it seemed like we had different information coming out from different agencies. I know there's an effort in administration to streamline that and I would hope that the CDC would be able to do that, following my colleague from Maryland next to me, the assistance to the local public health department. I'm from Houston and we haven't had an anthrax infestation in a thousand miles, but our emergency rooms are showing up, our first responders are hearing from people and so we need to make sure that even though it may not be Maryland or New York or Florida, we're still having to respond locally. And the information that CDC provides and HHS provides needs to be as succinct and speak with one voice as we can.

With that, I would, like my colleagues, like to talk about a bill that Congressman Quinn and I from New York has introduced on staffing for fire and emergency response personnel in first responders to deal with the problem, not only from experience in New York, but all across the country for the need for increase to first responders and thank you, Mr. Chairman, I yield back my time.

[The prepared statement of Hon. Gene Green follows:]

PREPARED STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. Chairman, thank you for holding this full committee hearing on what is one of the most important issues our committee will discuss this year.

Americans have been living in fear since September 11, not only of major attacks like those at the World Trade Center and the Pentagon, but also of a bioterrorist attacks like the anthrax outbreaks in Florida, New York, New Jersey, and here in Washington.

These attacks are new territory for this country. We have never had to deal with a bioterrorist attack like this. So in many ways, it is understandable that we have had some missteps along the way.

But we must take stock of what we've learned so far.

We have learned that a bioterrorist attack is not always going to be obvious. It might take several weeks before a pattern is noticed or the public becomes aware of the threat.

In the case of Bob Stevens, the photo editor from Florida who was the first anthrax victim after the September 11th attacks, Secretary Thompson suggested that he probably died from a freak natural cause.

The CDC had many different spokesmen who often contradicted each other, and other administration officials.

Now I'm not pointing fingers or casting blame. As I mentioned earlier, we are all relatively new at this.

But we must identify ways that we can protect the public—not only from a bioterrorist threat—but also from the kinds of confusion and chaos we have witnessed so far.

We have also learned that our nation's public health system, which has been neglected for decades now, is ill-prepared for any kind of mass biological threat.

Many public health departments lack modern technological equipment, such as computers, e-mail, Internet access, or even such outdated devices as fax machines.

This inhibits their ability to communicate with the people on the front lines—the doctors and nurses—about possible bioterrorist attacks.

Since most of the health care in this country is provided through private entities, we must develop a system where the public health departments can have real time communications with physicians, hospitals, clinics, pharmacies, schools, and other facilities, so that we can immediately identify and track potential public health problems.

There is also dire shortage of health care professionals, such as nurses, pharmacists, and laboratory personnel.

And many of the dedicated individuals who are currently working in our hospitals and clinics lack the proper training to identify and treat bioterrorist threats like anthrax and small pox.

I know that my colleague and friend Mrs. Capps has been working on this issue for quite some time now, and is trying to secure funding so that we can train a new generation of nurses and other health care professionals.

I hope that the Administration and our friends in the majority will work with her on this issue.

I would also like to point our that many of our communities suffer a significant shortage of first responders, such as firefighters and emergency medical personnel.

Firefighters play a central role in our terrorism preparedness plan, and we must ensure that each community has an adequate number of well-trained fire fighters who can respond to fires, emergencies, and terrorist attacks, including chemical and biological attacks.

That is why I have introduced H.R. 3185, the Staffing for Adequate Fire and Emergency Response (SAFER) Act of 2001, which is modeled after the successful COPS program, and would to a long way to ensure that our local fire departments are prepared for a bioterrorist attack.

The bottom line, Mr. Chairman, is that our states and localities need resources in order to be prepared for a bioterrorist attack.

As this committee considers legislation to prevent and mitigate a bioterrorist attack, I encourage the leadership to consider these issues, and provide the resources necessary.

Thank you, Mr. Chairman, and I yield back the balance of my time.

Chairman TAUZIN. I thank the gentleman. The gentleman from Tennessee, Mr. Bryant, is recognized.

Mr. BRYANT. Thank you, Mr. Chairman. I will be brief. Let me thank you for holding this hearing and addressing a point, my colleague from Texas, Mr. Green, just made. I've been going back and forth between judiciary and here. We just passed out of the full Judiciary Committee a bill which will clearly criminalize the making of hoax, prank-type calls or letters and at the Federal level and hopefully it will have some impact as that word gets out that there should be quite a deterrent out there for folks who would do this.

Second, I would echo the opening statement of my friend from California, Mr. Cox. I agree with him and I think there are certain areas that we have to look at as we prepare to turn over to our pharmaceuticals the task of producing sufficient vaccinations for the various possibilities of bioterrorism and as a part of that, and some of this is outside the jurisdiction of this committee, but clearly some relief in antitrust law will be needed there to allow these companies to come together and unite in the production for so many different reasons to avoid duplication and so on.

Second, some relief in terms of liability that in today's litigious world, at least the litigious United States, companies have to have some protection there as we're going to be going into areas that we've never been before with some of these diseases.

And with that, Mr. Chairman, with respect to our Secretary, I'd like to yield back the balance of my time and perhaps move this along.

Chairman TAUZIN. I thank the gentleman for yielding. The gentlelady from Missouri, Ms. McCarthy, is recognized.

Ms. MCCARTHY. Thank you, Mr. Chairman. I too will excerpt and submit my statement for the record. I welcome the Secretary and his team here today, Dr. Koplan. Thank you for all you're doing to help work, build our public health infrastructure and Mr. Secretary, like most members, I've been having conversations in my

community with my first responders and those in the line of fire, so to speak, about what we at the Federal Government could be doing to help them do their job. Obviously, all their budgets have been cut because of needs at the local level and that's why I think like the Bioterrorism Protection Act that's been referred to you earlier this morning is worth your review and support.

First of all, two key sections in it address public health infrastructure and response to bioterrorism and dedicate Federal monies already allocated in the monies that we've approved, to improve the community emergency response capacity and preparedness and address some of the concerns about hospital capacity and training of medical personnel and increased nursing and clinical lab personnel and training to the first responders.

In my community conversations, these are the real needs out there in the heart of America. And the bill also enhances community planning and intergovernmental coordination and dedicates funds to those. And that's another concern. When you have a metropolitan area like Greater Kansas City with a regional council that crosses State lines, coordination is absolutely essential. Getting results back from labs in a timely way is important. Requiring States to submit medical response plans to the Federal Government would aid you, I think, in your work as well. So these kinds of issues are addressed in this bill, as well as a whole section on protecting our food and water and many of these issues have been raised by others this morning, but I think you would find these helpful and I know that the local governments would, as well, keeping our water supply safe is certainly a concern we all share.

So I look forward to working with you on legislation and very much look forward to hearing your remarks today and I yield back my time, Mr. Leader.

[The prepared statement of Hon. Karen McCarthy follows:]

PREPARED STATEMENT OF HON. KAREN MCCARTHY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Mr. Chairman, thank you for scheduling this full committee hearing on bioterrorism and proposals to combat it. I join my other colleagues in welcoming Secretary Thompson. CDC Director, Dr. Koplan, and Dr. D.A. Henderson, Director of the new Office of Public Health Preparedness, and I thank you for your testimony.

The bioterrorism related programs of the Centers for Disease Control and Prevention, such as the National Pharmaceutical Stockpile, the Health Alert Network, the Epidemiology and Laboratory Capacity in Infectious Diseases Program, and the Public Health Training network, have been underfunded since the inception of bioterrorism funding in fiscal year 1999. In the fiscal year 2001 CDC budget, less than half of the available funds for bioterrorism preparedness reached the state or local governments. Our local public health infrastructure is in need of more resources in order to build the healthcare capacity to effectively handle new bioterrorist threats.

Building our public health capacity at the state and local levels should be the first step in a reinvestment in our healthcare infrastructure. HR 3255, the Bioterrorism Preparedness Act of 2001, also known as BioPAct, of which I am a cosponsor, is a comprehensive $7 billion package that strengthens our public health infrastructure, including military and intelligence coordination with public health agencies and first responders. The majority of these resources will be earmarked for state and local governments and deal with anticipating new bioterrorist threats and our capacity to prevent and manage any that may occur. Half of the funds, $3.5 billion, are dedicated to public health infrastructure preparation and response to bioterrorism threats due to staffing shortages, proper training for hospital workers and first responders, sufficient supplies of vaccines and antibiotics, and the need to fully integrate a response to these threats into local planning, emergency communication and disaster response systems. Another $800 million is provided to help address viral

and bacterial threats to our food and water supply, including protecting our crops and livestock.

Dr. Koplan, in a recent public health training network broadcast sponsored by the Association of State and Territorial Health Officials and the Department of Health and Human Services, CDC and the Food and Drug Administration, you laid out seven priority areas for building the public health infrastructure, and I wanted to highlight two here today that are directly related to bioterrorism. During the broadcast, you delineated the CDC's first priority as the public health workforce, as this is the basis for our country's public health system. Without an adequate supply of well trained and well staffed health care facilities, our country cannot be prepared for a bioterrorist attack, and our citizens cannot be protected.

Last month, Congressman Dennis Moore and I hosted a meeting at the University of Kansas Medical Center focused on local preparedness for bioterrorism. More than 250 doctors, hospital and health department administrators, and representatives of area governing bodies, police, fire, and ambulance services assembled to voice their concerns about the level of preparedness in the wake of a chemical or biological weapons attack. The consensus of these local leaders who would be on the front line of any bioterrorist attack was that cost cutting has left Greater Kansas City health care providers with few resources to prepare for these emergencies. Health department officials spoke of the need for additional staff to identify and investigate biological attacks in their earliest and most treatable stages. Hospitals and rescue workers need more training and resources to handle large numbers of casualties.

While local public safety agencies have been preparing responses to terrorist attacks for several years, their plans assume 500 to 1,000 victims, a number far less than what we witnessed on September 11. Dr. Rex Archer, the Director of the Kansas City Health Department, indicates that Kansas City needs an additional dozen public health workers dedicated to solely investigating disease outbreaks. The Bioterrorism Preparedness Act of 2001 will have a direct positive effect on Greater Kansas City and other local communities as they rebuild their local public health infrastructure.

Dr. Koplan, in that same public health training network broadcast, you mentioned as a priority of the CDC the building of our country's laboratory capacity to produce timely and accurate results for diagnosis and investigation. Similar to other areas of the health care industry, laboratories are trying to cope with a shortage of qualified personnel. A strong and capable laboratory workforce is essential to our public health infrastructure and to our nation's preparedness.

I am also pleased to be a cosponsor of Congressman Shimkus' legislation, HR 1948, the Medical Laboratory Personnel Shortage Act of 2001. This bill would allow the Secretary of Health and Human Services to assure an adequate supply of medical technologists and medical laboratory technicians to provide primary health services in health professional shortage areas by granting scholarships and loans for health professional training under the National Health Service Corps' scholarship and loan repayment program. An integral and timely section of this legislation directs the Secretary to support programs that train medical laboratory personnel in disciplines that recognize or identify the resistance of pathogens and that recognize or identify a potential biological agent.

At the bioterrorism roundtable I convened in Kansas City, several of the participants, including Matt Shatto, a city public health employee, stressed the need for increased staffing and resources for our local laboratories. These front line workers realize that without the laboratory resources needed to quickly detect bioterrorist agents and recognize epidemiologic aberrations, our nation will not be adequately protected. HR 1948 is important legislation in our fight against bioterrorism and will contribute to our national and local level of preparedness in the wake of a chemical or biological attack. I urge the Chairman to take swift action on this bill.

Finally, no plan to protect our nation can be truly comprehensive without the inclusion of the possible risks arising from our food supply. Our esteemed Ranking Member, Mr. Dingell, has introduced HR 3075, the Imported Food Safety Act of 2001, a bill with the primary aim of safeguarding our food supply. With the lack of security at our ports of entry and a shortage of qualified food inspectors, our food supply is a potential means of launching a bioterrorist attack, as it is an open target for the spread of biological agents.

In order to protect the United States against future bioterrorist attacks, the lack of security at ports of entry and the dearth of food inspections needs to be addressed now. I hope that the CDC can play a role in educating the public health workforce about the symptoms and treatments for food borne illness. Secretary Thompson, I know that food safety is one of your top priorities as you mentioned in a Women's Caucus meeting, and I hope that you will be able to speak on this issue.

I would like to reiterate my support for three bills that will have a significant impact on bioterrorism preparedness: BioPAct, the Medical Laboratory Personnel Shortage Act of 2001, and the Imported Food Safety Act of 2001. I hope the Administration will support these measures as well. Thank you Mr. Chairman for scheduling this hearing, and thank you to Secretary Thompson and Dr. Koplan for taking the time to testify at this hearing.

Chairman TAUZIN. I thank the gentlelady. Further requests for time? The gentleman, Mr. Pitts, is recognized for 3 minutes.

Mr. PITTS. Thank you, Mr. Chairman, for holding this important hearing and thank you, Mr. Secretary for the great job you've done responding to the anthrax threat. We're proud of the work that the CDC is doing in trying to address our Nation's bioterrorism crisis and threat and we need to make sure that the CDC has adequate resources to defend our Nation against this new threat.

I am concerned that some of the valuable CDC resources have been wasted to promote questionable activities with little or no proven effectiveness in the prevention of disease and I will submit for the record documentation regarding some of these questionable programs. I'd appreciate your looking into these abuses and helping provide greater accountability in the CDC. Thank you for your leadership.

I yield back the balance of my time.

[The prepared statement of Hon. Joseph R. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. Chairman, the Centers for Disease Control is the nation's foremost agency of public health.

The need for this important agency has been clearly demonstrated in wake of September 11.

Before September 11 the threat of bioterrorism seemed remote to most Americans.

Now we know all too well how serious and deadly bioterrorism can be.

I understand that the CDC has worked hard to address our nation's current bioterrorism crisis.

We need to make sure that the CDC has adequate resources to defend our nation against this new threat.

But I am concerned that valuable CDC resources have been wasted.

CDC funds have been used to promote questionable activities that encourage risky behavior and have little or no proven effectiveness in the prevention of disease. T

hese expenditures represent a flagrant disregard for the moral values of many Americans.

Taxpayer dollars should not be used to advertise for the Playboy Foundation.

Taxpayer dollars should not be used to promote teen abortion.

Taxpayer dollars should not be used to fund sexually explicit billboards, gay flirting classes or sex workshops.

Mr. Chairman, the examples that I have just cited are the tip of the iceberg.

The rules of common decency do not permit me to describe many of the other programs and activities currently supported by the CDC.

Even the titles of some of these programs are pornographic.

However, I will submit for the record documentation that describes in detail the hedonistic excesses currently being supported by the CDC.

I was originally going to ask the Secretary to support a review by the Inspector General on this misuse of funds, but I have just learned that the Secretary has already requested an IG review. I want to thank the Secretary for his quick action on this matter, and I look forward to working with him to restore the credibility of the CDC by putting an end to this outrage.

Mr. Chairman, please note that I do realize that these abuses were allowed to flourish under the previous administration, and do I not place blame on Secretary Thompson for the CDC's involvement in these questionable programs. In fact, the President's nominee to head the CDC has yet to be confirmed.

I am happy to work with you, Mr. Chairman, and Secretary Thompson, to ensure that greater accountability is established at the CDC, and I look forward to seeing

him fill leadership posts at the CDC with individuals who reflect the values and priorities of the new Administration.

ATTACHMENT 1

[Sunday, September 9, 2001—Associated Press]

FED FUNDS USED FOR EXPLICIT WORKSHOPS

By Larry Margasak, Associated Press Writer

WASHINGTON (AP)—The advertisements addressed to gay men were provocative: Learn to write racy stories about your sexual encounters, choose toys "for solo and partner sex" or share tales of erotic experiences.

All of it was done at government expense, in the name of preventing AIDS.

These expenditures—along with other recent allegations of fraud and abuse of federal money to fight AIDS—have upset some AIDS activists and lawmakers.

"The tragic consequences are that people die when they don't get their vital medical services," said Wayne Turner, spokesman for the AIDS activist group Act Up in Washington. "The days of the AIDS gravy train are numbered."

Added Iowa Sen. Charles Grassley, the senior Republican on the Senate Finance Committee: "We don't have money to bum when people are suffering and dying."

After learning of mismanagement of AIDS money, Grassley won a commitment from the Health and Human Services inspector general for increased audits of federal treatment funds.

The sexually provocative prevention programs run by San Francisco AIDS groups are funded in part from the $387.7 million the federal government is spending this year on AIDS prevention.

The government also spends $1.8 billion for medical treatment of low-income victims of AIDS and $257 million for housing for low income and homeless sufferers of the sexually transmitted disease that attacks the body's immune system.

Allegations of mismanagement or poor administration of the AIDS treatment funds have arisen in the Kansas City area, Indiana and the District of Columbia. The housing assistance program was criticized in Los Angeles. An AIDS clinic operator in Dallas was sentenced to prison for using federal AIDS funds to pay a psychic.

Federal officials who administer the AIDS funds say they rely primarily on state and local governments and—in the case of prevention program content—citizen review boards to ensure the money is spent properly.

Lisa Swenarski, spokeswoman for the Centers for Disease Control and Prevention, said the sexually provocative materials "have been brought to our attention and we are looking into it." Under CDC guidelines, prevention programs cannot promote or encourage sexual activity.

"We defend the process of having the local review panels make those decisions," she said.

Douglas Morgan, a director in the AIDS bureau of the Health Resources and Services Administration, said state and local governments that receive AIDS prevention grants "have been very good in identifying these issues. We expect them to notify us" of fraud and abuse.

But those who run the federally funded workshops on writing sex stories and using sex toys say that was the only way to draw gay men into discussions about AIDS prevention.

"Many who are at risk experience AIDS-prevention burnout," said Brian Byrnes, director of prevention services for the San Francisco AIDS Foundation—the group that conducts the "Hot Writing" workshop.

"Like the marketing of any product, you need to find language that will attract the target population: Men at high risk for HIV infection or transmission," he said.

San Francisco officials, who distribute more than $40 million annually in federal treatment and prevention funds to community AIDS groups, agreed. "If you put out a flier saying, 'Please come learn how to prevent AIDS,' nobody shows up," said Steven Tierney, director of HIV prevention for the city.

Community organizations say prevention experts participate in events with sexually provocative themes, but promotions on the groups' Internet sites give no hint of a disease-prevention program.

"It was a dark and steamy night," began the advertising for the "Hot Writing" seminar in San Francisco. "This pens-on-paper workshop is for guys who like to write or want to finally get that sexy story down."

Another advertisement welcomed interested gay men "to our world of toys. Learn how to choose, use and care for toys for solo and partner sex."

Gay men were invited in another program to "share tales of intercourse," part of a " Sex in the City" series. Other programs focused on pleasing sex partners, meeting friends without paying cover charges and making sex more erotic.

On the treatment side of the federal AIDS effort, recent allegations of mismanagement of taxpayer funds have prompted investigations across the country.

An AIDS task force appointed by Kansas City, Mo., Mayor Kay Barnes is holding public meetings to determine whether funds were distributed fairly, especially to minority groups.

In Dallas, AIDS clinic operator Mythe Kirven pleaded guilty to paying $27,800 in federal funds to a self-proclaimed psychic. Kirven was sentenced to 18 months in prison and ordered to pay $262,828 in restitution.

California's state auditor found in 1999 that the Los Angeles Housing Department had not spent $21.8 million of prior-year federal housing funds for homeless and low-income AIDS victims.

Indiana officials terminated contracts last year with the company that processes claims for AIDS treatment services after learning that doctors, dentists and other providers were not paid. A new contractor has been hired.

In the nation's capital, an audit found no documentation for almost half the sampled disbursements of the HIV Community Coalition of Metropolitan Washington. Sundiata Alaye, the group's new executive director, said changes were made and "we've got an excellent control structure in place now."

ATTACHMENT 2

[Thursday, September 20, 2001—St. Louis Post-Dispatch]

AIDS AWARENESS BILLBOARDS START COMING DOWN, ON SLAY'S ORDERS; MAYOR SAYS PHOTOS WERE OFFENSIVE

Mark Schlinkmann, Regional Political Correspondent

Workers began removing nine AIDS awareness billboards Wednesday at Mayor Francis Slay's orders because he believed they included photos that were offensive to some city residents.

Eight signs showed two bare-chested men embracing, one with his head buried in the neck of his partner and the other with his hand on the partner's shoulder. A condom was pictured on the ninth. Slay said he didn't object to the goal of the ads, urging African-Americans to get tested for AIDS. But he said the photos used "would offend families, people with children, a whole host of people."

"You wouldn't see those in Creve Coeur. in Chesterfield, in other areas of our community," Slay said in an interview.

The decision Tuesday by Slay and his acting health director, Michael Thomas, angered members of a regional AIDS-HIV planning committee that devised the ad campaign and is the grant recipient. The group got a $64,000 federal grant, overseen by the city

Nine other signs with other photos passed muster with the mayor and Thomas, who said be knew nothing of what photos were being used until Tuesday. The signs went up Monday and Tuesday at sites across the city.

ATTACHMENT 3

[Bay Area Reporter, September 21, 2000]

KGO BANS HIV PREVENTION COMMERCIALS FROM DAYTIME TV

by Terry Beswick

Oprah would probably cope with it, and Rosie wouldn't bat an eyelash, but programming officials at the local ABC/Disney television affiliate are apparently squeamish about men with bare chests and about a transgender with breasts.

KGO Channel 7 has rejected a new federally-sponsored "HIV Stops With Me" commercial featuring seven HIV-positive "spokesmodels" arguing for taking responsibility for their personal health and for the health of their community.

Based on a telephone survey of the viewing habits of gay and bisexual men in San Francisco, the local social marketing firm that produced the commercial wanted to air the ad during the Oprah and Rosie O'Donnell talk shows, found to be the most popular shows on the ABC network. The station countered with an offer to air the commercials after 10 p.m.

"What KGO said is that children six or seven years old will see it and ask their parents about it and they won't know what to say," said Les Pappas, president of

Better World Advertising [BWA], which produced the ads and had offered the station $12,000 to air them during daytime TV. "It's outrageous."

Targeted to HIV-positive gay men and transgenders in the Bay Area, the ads are part of a $350,000 social marketing campaign subcontracted to BWA, one component of a Department of Public Health $1,826,877 contract with the federal Centers for Disease Control and Prevention. The CDC also awarded funds to five other cities for demonstration projects designed to confine HIV within the HIV-positive community.

ATTACHMENT 4

--- Original Message ---
From: preventionews@cdcnpin.org [mailto:preventionews@cdcnpin.org]
Sent: Friday, October 26, 2001 6:08 PM
To: prevention-news@hattrick.qrc.com
Subject: [CDC News] HIV/STD/TB Funding Information 10/29/01

The following funding information has been recently added to the CDC National Prevention Information Network's (NPIN) Funding Database (http://www.cdcnpin.org/db/public/fundmain.htm). For more information about HIV, STD, and TB funding opportunities, please contact the CDC NPIN at 1-800-458-5231.

Fund Title: Reproductive Health and Rights: General Service Foundation

Funder Name: General Service Foundation

Fund Description: Among other things, the General Service Foundation makes grants in areas of Reproductive Health and Rights. This program is dedicated to improving access to comprehensive reproductive health care, including abortion, for women and adolescents; and to supporting education efforts which increase awareness and action around issues of reproductive health, sexuality, and reproductive choices. Grants are made domestically for research development, policy analysis, litigation, technical assistance, advocacy, and outreach. The Foundation also funds organizations working in Mexico whose work parallels the goals of the domestic agenda. Generally, grants are not made for service delivery, or university-based research, and the Foundation does not support local or state-based organizations in the United States working within a limited geographic range.

Inclusive Target Audience(s): 306—Adolescents. 390—Women

Fund Subject(s): Adolescents, Advocacy, Health care, Outreach, Sexually transmitted diseases, Women

Application Deadline: February 1, 2002—Spring; September 1, 2002—Fall

Fund Location (Eligibility): Location unrestricted. (United States)

Fund Location (Ineligibility): n/a

Fundee, Geographic Location (Eligibility): Location unrestricted. (United States)

Fundee, Geographic Location (Ineligibility): n/a

Fundee, Other Eligibility: Priority is given to organizations working with underserved communities and populations whose reproductive health and rights are most impacted by poverty.

Fundee, Type of Support: Technical assistance

Fundee, Inclusive Target Organizations: CBO—Community Based Organization

IRS—IRS 501 (c)(3) Organization

Application Technical info Person: Lani Shaw

www.generalservice.org

557 N Mill St, Ste 201

Aspen, CO 81611

970-920-6834

970-920-4578—FAX

lani@generalservice.org

Executive Director

Application, Type of Information Required: Review the Foundation's Guidelines, and past years' grants lists to be sure the projects fits within the Foundation's specific areas of interest by accessing the Internet: www.generalservice.org; or contact Lani Shaw, Executive Director and Program Officer for instructions.

If you have information about your organization's conference or funding opportunities that you would like included in the NPIN databases and/or in the weekly e-mail announcements, please send it via e-mail to info@cdcnpin.org

The PreventioNews Mailing List is maintained by the National Prevention Information Network (NPIN), part of the Centers for Disease Control and Prevention's National Center for HIV, STD, and TB Prevention. Regular postings include the Prevention News Update, conference announcements, funding opportunities, select articles from the Morbidity and Mortality Weekly Report series, and announcements about new NPIN products and services.

ATTACHMENT 5

THE CDC NATIONAL PREVENTION INFORMATION NETWORK—OCT 30, 2001

*Playboy Foundation: General Fund Announcement.*

**Fund Description:**

The Playboy Foundation seeks to foster social change by confining its grants and other support to projects of national impact and scope involved in fostering open communication about, and research into, human sexuality; reproductive health and rights; protecting and fostering civil rights and civil liberties in the United States for all people, including women, people affected and impacted by HIV/AIDS, gays and lesbians, racial minorities, the poor, and the disadvantaged; and eliminating censorship and protecting freedom of expression. Recent grantees include: the Gay Men's Health Crisis, for its public policy work on behalf of people with HIV/AIDS; the AIDS Action Council, for its efforts to advocate and lobby on behalf of community-based HIV/AIDS organizations; and the AIDS Legal Referral Panel, to support its policy work on issues affecting women with HIV/AIDS.

**Inclusive Target Audience(s):**

- Homosexuals
- Minorities
- Low Income Persons
- Lesbians
- Women
- Persons With AIDS
- HIV Positive Persons

**Fund Subject(s):**

- Advocacy
- Homosexuals
- Information exchange
- Policy development
- Public awareness
- Research
- Sexual behavior

**Fundee, Inclusive Target Organizations:**

- Community Based Organization
- IRS 501 (c)(3) Organization
- Non Profit

**Fund Location (Eligibility):**

General grants: Location unrestricted—U.S.

*Fundee, Other Eligibility:*

The Foundation is especially interested in projects where a small grant can make a difference.

**Fundee, Type of Support:**

Program development

**Playboy Foundation**

**Procedure Contact Person:**

Unspecified
Executive Director
680 N. Lake Shore Dr.
(phone extension: x2667)
Chicago, IL 60611
(312) 751-8000
**Fund Duration:** Open ended.
**Letter of Intent Date:** n/a
**Application Deadline:** n/a
**Intended Award Date(s):** n/a
**Project Start Date(s):** na
**Maximum Amount:** $10,000.00
**Minimum Amount:** $5,000.00
**Fund Identification Number:** 988

ATTACHMENT 6

--- Original Message ---
From: preventionews@cdcnpin.org [mailto:preventionews@cdcnpin.org]
Sent: Friday, August 31, 2001 3: 1 0 PM
To: 'prevention-news@hattrick.qrc.com'
Subject: [CDC News] HIV/STD/TB Funding Information 08/3 1/01

The following funding information has been recently added to the CDC National Prevention Information Network's (NPIN) Funding Database (http://www.cdcnpin.org/db/public/fundmain.htm). For more information about HIV, STD, and TB funding opportunities, please contact the CDC NPIN at 1-800-458-5231.

Fund Title: The David Bohnett Foundation: Fund Announcement Funder Name: David Bohnett Foundation

Fund Description: The David Bohnett Foundation is a grant-making organization formed in 1999 for the purpose of improving society through social activism. Planned giving areas include: (1) the promotion of the positive portrayal of lesbians and gay men in the media, (2) the reduction and elimination of the manufacture and sale of handguns in the US, (3) voter registration activities, (4) Community based social services that benefit gays and lesbians, (5) animal language research, animal companions, and eliminating rare animal trade, and (6) the development of mass transit and nonfossil fuel transportation.

Inclusive Target Audience(s): 338—Homosexuals, 386—Lesbians Exclusive Target Audience(s): n/a

Fund Subject(s): Homosexuals, Lesbians, Social services

Application Deadline: October 31, 2001

Fund Location (Eligibility): California; Washington, DC; and other major cities, such as Chicago.

Fund Location (Ineligibility): n/a

Fundee, Geographic Location (Eligibility): California; Washington, DC; and other major cities, such as Chicago.

Fundee, Geographic Location (Ineligibility): n/a

Fundee, Other Eligibility: The Foundation encourages grants proposals from non-profit organizations with 501 C3 designations whose mission and programs are closely aligned with the Foundation's giving areas.

Fundee, Other Restrictions: n/a

Fund Products: n/a

Fundee, Type of Support: Capital Campaign, General/operating support, Matching grants, Seed money

Fundee, Inclusive Target Organizations: IRS—IRS 501 (c)(3)
Organization
NPF—Non Profit

Fundee, Exclusive Target Organizations: n/a

Application Procedure Contact Person: Michael Fleming
www.bohnettfoundation.org
The David Bohnett Foundation
2049 Century Park East, Ste 2151
Los Angeles, CA 90067
310-277-4611
310-203-8111-FAX
mfpfleming@yahoo.com
Program Officer

Application, Type of Information Required: Contact funder for application information.

Fund Identification Number: 1915

Chairman TAUZIN. Further requests for time? The gentleman from New York, Mr. Engel, is recognized for 3 minutes.

Mr. ENGEL. Thank you very much, Mr. Chairman. I appreciate your efforts in calling this hearing today on this issue of critical importance. Since I work in Washington, I live in New York, I represent the District in New York City and the suburbs that I think that I, as well as my other New York colleagues have been uniquely affected by the incidents starting with September 11 and continuing.

In the wake of the anthrax attacks, we must examine the response by the Department of Health and Human Services and the

Centers for Disease Control during this crucial time. It's imperative we learn from the things we did right, as well as those we did wrong, and use that information to better prepare for the future.

Many questions arise as we look back on CDC's response. Was the information made available to the public accurately? Was it delivered in a timely fashion? And did our Government officials speak in a unified voice. We have to be diligent in examining these issues. Our very lives, obviously may depend on what we learn from the last few weeks and how we apply that information to prevent and respond to future attacks.

While I appreciate the efforts of those in the difficult position of responding to the anthrax attacks, I know we can do better and we will. We must be sure that we prepare for any scenario. The CDC and Congress needs to work together to prevent and fight bioterrorism and we need to do it proactively.

Our public health officials and health care providers must be better educated about how to recognize and treat those infected with biological agents. In addition, our hospitals must be well equipped to treat the American public if we are attacked again. Bioterrorism has the potential to inflict enormous casualties on the public. As such, it's imperative that we put forth the necessary resources to protect the American public from this form of attack. On September 11, and I was in New York City when the terrorists struck, the unthinkable became reality and in the days following we faced further biological attacks. The truth is we were unprepared for such horrendous acts of hate and violence and we as a country, of course, must never be unprepared again.

These are all issues that require our serious attention and Mr. Chairman, I commend you for holding this hearing and I look forward to working with you and Mr. Secretary to strengthen our efforts to fight bioterrorism. I might also add that I can think of no better witnesses than Secretary Thompson and Dr. Koplan to come here this morning and I'm eagerly awaiting to hear their testimony. I thank you both for attending and I thank you, Mr. Chairman. I yield back.

Chairman TAUZIN. I thank the gentleman. Further requests for time on this side? Seeing none, are there further requests for time? Mr. Rush is now requesting time and under our rules, Mr. Rush is recognized for 3 minutes.

Mr. RUSH. Thank you, Mr. Chairman. Mr. Chairman, I also want to commend you for this hearing and I want to commend the Secretary and thank him for this visit to this committee.

I want to say that I am engaging in this discussion and looking forward to this hearing with a sense of caution and concern and growing feeling of trepidation in that I see out in my District and in my city and throughout urban areas, I see the fact that we are confronted with a two-tiered public health system and I want to join the course of concerns and comments from my colleagues because they seem to all agree with the ideal that our public health system does need to be supported, does need to be enhanced and our public health system does need to be built back up.

Mr. Secretary, as you know, you're from a neighboring State and I'm sure you can recall the summer of 1995 when we had a heat wave in the city of Chicago which resulted in approximately 700

deaths of people, most of these individuals were poor people, people who had no connection with the public health system. As I look across my city and my State and as I look across urban America, I see hospitals closing down throughout America, retreating from inner city communities and those kinds of locations. And what it tells me, frankly, is that if, in fact, we were to have a significant bioterrorism threat in a large urban area, then we will be hard pressed to engage most of our public in terms of—even getting the basic information out to them.

I look at our program, the S-chip program and I see across America, literally millions of people who are eligible for the S-chip program, but not being encouraged to sign up for the S-chip program, not being involved in S-chip program at all and therefore it seems to indicate that there's some kind of void, there's some kind of a problem, there's some kind of a brokenness that existed within our public health delivery system and information system that prevents people in certain poor and marginal communities from engaging fully in our public health system.

So the question that I'm left with is if, in fact, there is a significant bioterrorism threat, then what will happen to these individuals? And I think that the response by the CDC and by you, Mr. Secretary, is certainly warranted because to me I think this is going to be a catastrophe, if, in fact, we are confronted with either bioterrorism or any other kind of natural disorder that might occur and at some point in time would like for you to respond.

Mr. Chairman, I yield back.

Chairman TAUZIN. The gentleman's time has expired. Further requests on this side? Seeing none, the gentleman from Ohio, Mr. Strickland is finally recognized.

Mr. STRICKLAND. Thank you, Mr. Chairman. I have been waiting patiently to say thank you to the Secretary. I gave you a letter earlier today, sir. When you first appeared before our committee, some months ago, I recall you saying that your goal was to make your Agency more sensitive to the concerns and needs of members and to our constituents and I have thanked you in that letter for three issues in which you and your staff have been very helpful. And I want to thank you for that.

I also want to associate myself with remarks of my colleague, Mr. Deutsch, regarding the dangers that we face from smallpox. I think the challenges faced by the companies that produce vaccines and the importance of these vaccines to both the public health and the national defense call for a national vaccine authority. The National Academy of Sciences recommends such an authority which could investigate the need for Government production of vaccines, the overseeing of such production, incentivizing of private vaccine development, and the strategic funding of research into the vaccines that we most need. And I hope we can move in this direction.

Mr. Secretary, I do thank you for what you've already done and for what you're trying to do, but most of all, I thank you for what you're going to do in the future to protect this great Nation and the people who live within it.

Thank you very much and I yield back my time.

[The prepared statement of Hon. Ted Strickland follows:]

PREPARED STATEMENT OF HON. TED STRICKLAND, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. Chairman, thank you for convening this important hearing about the challenges of bioterrorism. I look forward to hearing from both Secretary Thompson and Dr. Koplan about the role and needs of the Department of Health and Human Services and the Centers of Disease Control and Prevention to best equip this country to respond to a bioterror crisis.

I am hopeful that this Committee will craft bipartisan legislation that doesn't shortchange any of the needs our public health system requires to get up to speed in defending our country against bioterrorist threats. There are many threats, including the need to build an agile surveillance and communication system between the federal government, local public health offices, and the doctors and nurses who are on the front lines of treating any disease outbreak. We need a better interface between the many federal agencies that have a role in defending against a bioterror attack. We need to educate and train health providers who will be the first to see the symptoms of bioterror in emergency rooms and doctor's offices. We need to protect our food and water supplies from contamination and we need to address the already problematic nursing workforce shortage, which would be much worse than it already is during a bioterror attack when many people are in need of treatment from a limited number of health care professionals.

One specific need that I have heard about from constituents in my district is the need to ensure that we have enough vaccines and other medications to treat those who are exposed to bioterror agents and to prevent the spread of disease. The vaccine industry is not profitable, and private manufacturers have trouble keeping effective and adequate supplies of basic vaccinations, such as that for tentanus. In fact, there are just four major vaccine makers in business, and only two of those four are based in the United States. We already know what happens when a vaccine manufacturer goes out of the vaccine business: last year, a company stopped manufacturing the flu vaccine, leaving us with a shortage and the need to ration the available vaccine. Obviously, a shortage and rationing during a large scale bioterror attack could be devastating.

The challenges faced by the companies that produce vaccines and the importance of these vaccines to both the public health and national defense call for a national vaccine authority. The National Academy of Sciences recommends such an authority, which could investigate the need for government production of vaccines, oversee such production, incentivize private vaccine development, or strategically fund research into the vaccines we most need.

The need for vaccines and the other needs of a strong bioterror defense requires a commitment by this Committee to look closely at our resources and how we must allocate those resources in the best interest of public health. I look forward to hearing from Secretary Thompson and Dr. Koplan about these issues.

Chairman TAUZIN. The gentleman has completed his statement and yields back. Further requests for statements on this side? Then the gentlelady, Ms. DeGette, is recognized for 3 minutes.

Ms. DEGETTE. Thank you, Mr. Chairman. We all agree here today that we have ignored an underfunded public health in this country for over 25 years. While the CDC's efforts at early identification at bioterrorism and most notably the recent anthrax attacks is commendable. We can't simply sit here today and put a bandaid over the issue of our outdated public health system in this country.

In my visit to CDC 2 weeks ago with Congressman Greenwood, for example, I saw freezers with biological agents in them sitting in the hallways of the CDC. Now you'll be glad to know that those freezers did not hold the most serious agents like smallpox, anthrax, plague and the like. Still, this is an indication of the symptom of decades of neglect of public health issues. And it's not enough for us to just simply sit here and talk about it. I know that many of my other colleagues are talking about going to the CDC and I think it's important that we see this for ourself, to see the

tremendous constraints that the Agency is trying to undertake their important role in the coming years.

One final note that I would make also is that we can work to identify biological or chemical warfare in its early stages in our local health responders, but if we do not have beds for the sick or isolation wards to keep the diseases at bay, we will ultimately lose out as a society.

Let me give you an example. Denver Health is probably, as Dr. Koplan and I discussed when I was at CDC, is probably one of the most well-equipped local health agencies, probably one of the three most well-equipped in the country to respond to an attack. But if, for example, somebody released a communicable disease agent like smallpox over Mile High Stadium during a Bronco game, even though we could identify, we don't have beds to put the sick in. We don't have isolation wards to put the sick in to stop the disease from spreading and until we address this very important issue at our local level, we will never be completely safe as a country from biological warfare. I yield back the balance of my time.

Chairman TAUZIN. I thank the gentlelady. Further requests for time? The gentleman, Mr. Luther, is recognized for 3 minutes.

Mr. LUTHER. Thank you, Mr. Chairman. I'll be brief as well. Like others, I believe we need to examine our country's shortcomings and develop a comprehensive plan to ensure that if we are again confronted with bioterrorism, that we respond quickly and effectively.

I'm pleased that in some ways my home State of Minnesota may be ahead of the curve in preparedness because we do have a strong public health system, as I know the Secretary is aware. But I believe we need the strongest possible leadership at the Federal level to protect Americans against this very serious threat. I very much appreciate Secretary Thompson, from my neighboring State and Drs. Henderson and Koplan, for being here today. And I join others in asking each of you to do what is necessary within the administration and outside the administration, even if unpopular at times, to get the highest priority placed on this matter, to ensure the safety and security of all Americans. I think Americans expect that and I yield back the balance of my time.

Chairman TAUZIN. Further requests for time? The gentlelady, Ms. Capps, is recognized.

Ms. CAPPS. Thank you, Mr. Chairman. The topic before us today is critical to our Nation's public health and emergency preparedness. Thank you, Secretary Thompson, Drs. Koplan and Henderson for being with us. The cases of anthrax have caused us to reevaluate the current practices and capabilities of our public health infrastructure. Our health system may be able to deal with the day by day health needs, but clearly lacks surge capability. It would struggle to cope with the potentially large number of patients that may require treatment after a severe bioterrorist attack. Many public hospitals do not have up to date medical equipment, adequate communications or proper integration with other institutions across the country, including our national health agencies. We must improve our Nation's detection and surveillance capabilities. Public hospitals must be able to identify and report cases that could be significant and medical staff across the country, need to know what

to look for and who to report to. And of course, CDC is an essential piece of this puzzle.

Unfortunately, we started this year off on the wrong foot when the administration looked to cut $168 million from CDC's budget. This kind of cut is unwise, even when we're not particularly worried about major threats to our public health, but it seems particularly short sighted given what we know today. Clearly, some of the resources Congress has already given to the administration need to be devoted to CDC. But I am concerned that the administration's proposal to address bioterrorism does not allocate enough resources to many of these priorities, particularly as compared with the Senate's bipartisan proposal and H.R. 3255, the Bioterrorism Protection Act, for example, in development rapid detection of biological weapons and research into vaccines and treatments.

I don't believe the public wants us to skimp in these areas. These are important priorities that need to be addressed in full. We also need to make sure that we have enough personnel to deal with bioterrorist threats to our public.

As many on this committee know, we are facing a critical shortage of properly trained nurses. The American Hospital Association estimates that we need 126,000 more nurses right now. The problem is only going to get worse and a significant number of nurses are going to be retiring over the next decade. We know that. And fewer nurses are entering the field. As this situation occurs, we will face a massive shortfall of nurses in all fields, just as the Baby Boom generation begins to retire and to need more care. This directly relates to the short term and long term threats of bioterrorism and terrorism in general in the United States. We need to act now to address this problem.

I have spoken with you, Mr. Secretary. I appreciate that. And I appreciate your willingness to work on this topic and I want to thank our Chairman and particularly, Mr. Bilirakis for efforts to work with me on this issue. I appreciate your willingness to make this a priority for this committee and hope that we all would agree that the appropriateness of passing a bioterrorism package must include efforts to address the nursing work force situation.

Thank you.

[The prepared statement of Hon. Lois Capps follows:]

PREPARED STATEMENT OF HON. LOIS CAPPS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Thank you Mr. Chairman, it is so important for the Congress, and this committee in particular, to address our nation's public health preparedness.

I want to thank Secretary Thompson and Dr. Koplan for taking the time to join us today and share their efforts and perspectives.

There is clearly a need for us to make sure that the federal and state agencies tasked with protecting our health have the resources they need.

The cases of Anthrax have caused us to reevaluate the current practices and capabilities of our public health infrastructure.

What we seem to find when we look at it is a public health system that may be able to deal with day to day health needs but lacks surge capacity. It would struggle to cope with the potentially large number of patients that may require treatment after a severe bioterrorist attack.

Many public hospitals do not have up to date medical equipment, adequate communications, or proper integration with other institutions across the country, including the national health agencies that will have important information in the case of bioterrorism.

We have to improve our nation's detection and surveillance capabilities. Public Hospitals must be able to identify and report cases that could be significant. And medical staff across the country need to know what to look for and who to report to.

CDC is an essential piece of this puzzle. It has done a good job in past years to address outbreaks of serious diseases and work with state and local agencies.

Unfortunately we started this year off on the wrong foot when the Administration looked to cut $168 million from the CDC's budget.

This kind of cut is unwise even when we were not particularly worried about major threats to public health, but it seems particularly short sighted given what we know today.

Clearly some of the resources Congress has already given the Administration need to be devoted to CDC.1But I am concerned that the Administration's proposal to address bioterrorism does not allocate enough resources to many of these priorities.

As compared to the Senate's bipartisan proposal and HR 3255, the Bioterrorism Protection Act, the administration's request does not go far enough in helping state and local public health capacities and hospital preparedness.

And both bills go further in developing rapid detection of biological weapons and research into vaccines and treatments.

It is of course necessary for the government to continue on a fiscally responsible path, but this is not the place to skimp. These are important priorities that need to be addressed in full.

We also need to make sure that we have enough personnel to deal with bioterrorist threats to our public health.

As many on this committee know, we are facing a critical shortage of properly trained nurses.

The American Hospital Association estimates that we need 126,000 more nurses right now. And the problem is only going to get worse.

A significant number of nurses will be retiring over the next decade, and fewer new nurses are entering the field.

As this contraction occurs, we will face a massive shortfall of nurses in all fields just as the baby-boom generation begins to retire and need more care.

This directly relates to the short term and long term threats of terrorism and bioterrorism in the United States. We need to act now to address this problem.

I have spoken before with Sec. Thompson about this issue and I appreciate your willingness to work on it. And I want to thank you Mr. Chairman, and Chairman Bilirakis, for your efforts to work with me on this issue. I appreciate your willingness to make this a priority for the committee.

I hope we all would agree that it would be best to include efforts to address the nursing workforce situation a bioterrorism package.

I am eager to hear the comments of my colleagues and our distinguished guests and I look forward to working with you on these issues.

Chairman TAUZIN. I thank the gentlelady. She's absolutely on point in her statement. I recognize the gentlelady from California, Ms. Harman, for an opening statement.

Ms. HARMAN. We're almost ready for your opening statements. I thank you, Mr. Chairman. I would like tell you and our witnesses that I come from a family of medical doctors. My late father served three generations of patients in Los Angeles and my brother was a resident at a public health service hospital and is now an oncologist and hematologist and I have, I think, a long standing appreciation for the importance of our public health system.

Like Mr. Burr, I also serve on the House Intelligence Committee and went to CDC a few weeks ago, learning what others have learned about the talented people there working in shabby conditions. I would just hold up a few of your pictures here showing $500,000 equipment, pieces of equipment with plastic covers to protect it from the rain, and important biological culture and tissue samples in hallways in firetraps that were built in the 1940's and that are still standing on your Chamblee Campus.

I think that the Federal response to bioterrorist threats, which are real and continuing has been good, at least there have been

good aspects to it, the best of them the great people, the enormous talent that they possess and the selfless dedication that they show. There have also been flaws revealed in two areas. One, the lack of resources which everyone has been talking about, and two, a lack of organization.

On the resources point, I want to commend you, Mr. Chairman, and our vice chairman, Mr. Burr, for deciding to move an important bipartisan piece of legislation that I cosponsor, to accelerate infrastructure improvements at the CDC and cut in half the time needed to improve these buildings where talented people work in the shabbiest conditions. I think that that is a critical thing we can do and I gather we will do it, so thank you very much. That's one piece.

On organization, we've heard again from many who've spoken before me about the vague lines of authority and some of the muddled procedures that led to some of the gaps in our response to the anthrax attacks. I realize that every witness here has moved to correct those gaps. I think you will have a lot of success in doing that. However, I continue to believe that the new Office of Homeland Security in the White House needs to have more authority, more statutory and budget authority, to help you coordinate better. Without one voice, one threat assessment, one national strategy, I believe we will continue to have problems. And so I would urge us all to line up behind bipartisan legislation to give statutory authority to Governor Ridge, and I would tell the witnesses here that you are part of the solution and I commend you for all the work that you've been doing. Thank you, Mr. Chairman.

[The prepared statement of Hon. Jane Harman follows:]

PREPARED STATEMENT OF HON. JANE HARMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Thank you, Mr. Chairman, and I would also like to thank Secretary Thompson and Dr. Koplan for appearing before the Committee today.

Our nation's response to the anthrax attacks over the past month has shown some of our government's great strengths, but also some of our weaknesses. I am well aware of the Administration's existing programs to combat bioterrorism and support the work you have done so far with limited resources.

Unfortunately, we still have a long way to go before our nation will truly be prepared for a bioterrorist attack. Vague lines of authority and muddled procedures led to miscommunications and glaring oversights, such as the delayed testing of postal workers. I do not want to play the blame game—we are, after all, only beginning understanding the science of an anthrax attack—but am glad for the opportunity to begin to look at how we can improve our federal response.

One lesson we learned is that there is no one quick fix that will improve our bioterrorism response. Our domestic public health response should be as strong and coordinated as the military campaign we are waging in Afghanistan—if not stronger. We should have substantial and diverse funds directed to local public health departments and hospitals so that they can do everything from updating emergency response plans for bioterrorism to establishing advanced surveillance systems that can detect the outbreak of new diseases.

All of those who have spoken before me have mentioned useful—and essential—ways to invest in our public health system. I would like to mention one point that has not yet been raised—an investment in the basic infrastructure at CDC.

I visited the Centers for Disease Control on October 22nd and saw that the fight against bioterrorism is being waged by talented people working in shabby conditions. Many of the CDC's laboratories are housed in "temporary" structures, built in the 1940's, where the ceilings leak and plastic sheeting covers sensitive equipment. Power outages, cramped quarters and inadequate working facilities impair our abilities to find breakthrough cures and treatments. I think you both agree that we must provide our best scientists the resources to conduct research and evaluate

lab samples in a safe, secure environment. My colleagues John Linder, Saxby Chambliss, and I introduced legislation to invest $1.5 billion in CDC buildings and facilities over the next five years, so that you, Dr. Koplan, will be able to upgrade laboratories and essential for bioterrorism response and improve security at CDC.

I understand that the legislation the Commerce Committee is drafting will include an authorization of funds for CDC buildings and facilities. I would like to stress that a $300 million investment in each of the next five years is essential to provide the steady stream of funds CDC needs to build and renovate the facilities needed to meet today's bioterrorist threat. 1Securing these facilities—as important as that is—is one of a great many homeland security needs. Most of the problems with our bioterrorism response activities cannot be solved by throwing around money—to be sure, we do we have unlimited resources to do this. What we do need is a unified threat assessment and a national strategy to meet it.

At the federal level, the US government needs to eliminate the communication gaps that led to confusion over the type of anthrax that was sent to Senator Daschle's office. We must integrate the bioterrorism research agenda of the Departments of Health and Human Services and Defense. We must clarify who is responsible for managing the investigation of a suspicious disease outbreak. Governor Ridge can accomplish all of these tasks—and integrate these federal efforts with our state and local response—but only if he has the statutory authority to do his job. He should not be communicating our message on anthrax—he should be the apex of a well-coordinated, multi-layered system of bioterrorism response.

In a House Commerce Oversight and Investigations Subcommittee on federal bioterrorism preparedness on October 10, seven assembled witnesses agreed that Gov. Ridge must have budgetary authority. I would hope that everyone gathered here would agree.

Chairman TAUZIN. The gentlelady's time has expired. I'm pleased to let the gentlelady know, I know she knows this. In the draft bill, we're providing $300 million a year for 2 years to upgrade those facilities.

[Additional statement submitted for the record follows:]

PREPARED STATEMENT OF HON. JAMES GREENWOOD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. Chairman, I congratulate you for holding this hearing on bioterrorism and for your work in moving a responsible and comprehensive bioterrorism proposals for discussion. I am heartened that this committee is galvanized by the dangers we face and is committed to leading the effort to fight this new kind of war in a new kind of way. And I also want to thank you for your personal commitment of time and valuable full committee resources to support the work the Subcommittee on Oversight and Investigation, which I chair, has done in this area.

Both the hearing and recent passage of the Bioterrorism Enforcement Act constitute full committee actions which, in large measure, are an outgrowth of the discoveries we have made about the threat of bio-terrorism as a result of a series of hearings held before the Subcommittee on Oversight and Investigations.

And there is much work to do. Our traditional public health surveillance system is the equivalent of relying on the pony express in the age of the world wide web.

Many parts of the country still rely on doctors mailing in postcards to their local public health departments. The traditional system is too limited in what is reported, too slow in its reporting, too late in the patient evaluation process, and too incomplete to meet our country's emerging needs in this area.

In the last six weeks, the subcommittee has held hearings on such critical issues as the effectiveness of Federal programs designed to bolster the preparedness of States and local communities to deal with bioterrorist attacks; building an early warning public health surveillance system; and the physical security at the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health. In addition, on October 23, this committee managed the House passage of H.R. 3160, the "Bioterrorism Enforcement Act of 2001," which imposes Federal controls on possession and use of certain biological agents. This legislation addressed issues raised in previous Oversight and Investigations Subcommittee hearings the provisions of H.R. 3160 should be included in any proposed bioterrorism package.

From the subcommittee's bioterrorism oversight work my sense is the committee should focus on several areas today.

First, there is a need for a better early warning system and rapid response to biological attacks, especially the need to fund front line first responders, establish uni-

versal protocols and enhance the State-Federal partnership in this area through the existing grant structure.

Another area worthy of our immediate attention is one of Federal preparedness and security. From my visit to the CDC facilities on November 2 and the Oversight Subcommittee hearing on November 7, I note that while the Secretary has correctly identified physical security as a priority and the CDC is beginning to address some security concerns, the agency is still faced with making a full transition to a post-September 11 mindset. This includes not only the actions needed to protect biological materials and certain deadly pathogens used in research against theft, but also the very real need to carefully guard any stockpiles of medicines and vaccines which may prove essential in responding to an act of biological terrorism and which are in the governments care. Third, there is a critical need for information sharing and coordination at every level of government between public health and traditional law enforcement and intelligence gathering agencies. Meeting this need is particularly crucial to first responders.

The antrhax investigation clearly demonstrated the need for this kind of communication to occur, but this committee needs to identify ways in which we can help nurture this flow of information.

I am delighted that the committee is working on legislation to address these problems.

I welcome Secretary Thompson and Dr. Koplan. I look forward to the Secretary's testimony and a constructive dialogue with the witnesses.

Chairman TAUZIN. It's finally time for us to welcome our witnesses and I certainly want to do so, but before I introduce the Secretary, I have the very special honor of introducing to all the members and our guests today and to the Americans who may be viewing this hearing via television a real American hero in the person of Dr. Donald Henderson. Dr. Henderson was actually the head of the World Health Organization team which eradicated smallpox which was such a scourge on this earth for so long. I think he deserves our applause and our appreciation.

Mr. BROWN. Mr. Chairman, I would add that Dr. Henderson was a graduate of Oberlin College which actually won its first football game 2 weeks ago, since Dr. Henderson graduated.

Chairman TAUZIN. Pretty exciting. Mr. Secretary, we're delighted to have you here and Dr. Koplan, on behalf of the CDC, we deeply appreciate your presence. You've heard, obviously, from a great number of our members today about how seriously we take our responsibility here and I know you do too and we welcome your testimony, sir.

## STATEMENT OF HON. TOMMY THOMPSON, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES; ACCOMPANIED BY JEFFREY P. KOPLAN, DIRECTOR, CENTERS FOR DISEASE CONTROL AND PREVENTION

Mr. THOMPSON. Thank you so very much, Chairman Tauzin, and good morning and to ranking minority member——

Chairman TAUZIN. Would the Secretary pull that mike a little closer so that we——

Mr. THOMPSON. Thank you so very much. Let me just start off by thanking all of you. It was music to my ears, as an advocate of the public health system in America that on a bipartisan basis individuals were talking about the importance, the need, to invest in our public health system and let me just say thank you to all of you.

I also learned a great deal this morning, especially the fact that anytime I appear in front of your committee, I will bring Dr. Hen-

derson back in front and it was unprecedented and it was a very precedent to start.

I want to start off by thanking you, Mr. Chairman, this committee, for their leadership on this issue. Like me, all of us have been working extremely hard on this issue, long before the attacks on September 11. The Nation should be comforted by your leadership on this committee for all that you've done so far and what you continue to do in this very important area.

Thank you for inviting me to speak to you on the role of the Department's Centers for Disease Control and Prevention which played such a very important public health protection led. I am joined by Dr. Jeffrey Koplan, who has just done an outstanding job and I think he is one of those unsung heroes and I thank him so very much for being here. He's the Director of the Centers for Disease Control and Prevention and Dr. Henderson who is our new head of our newly created Office of Public Health Preparedness. I can't stop but just make a quick observation in regards to the facilities at CDC Headquarters. I came in front of this committee in June and talked to you about the need for improving those facilities and I'm so appreciative that all of you are talking about it. We have three campuses down there and we still rent 25 other buildings around the city. It doesn't make much sense and we need to improve it and I thank you so much for your leadership.

The strength of our public health system is of the utmost importance to the President and the Department of Health and Human Services and also the Centers for Disease Control, as our Nation's doctors, nurses, the EMTs and the other health professionals who are on the front lines, as a lot of you have indicated. And we must provide them the support and the expertise they need to respond to public health causes. Let me assure you that the response from the Federal, the State and the local officials, to each and every unprecedented attack over the last 2 months has been very strong, like our counterparts at the State and the local levels.

We at the Department of Health and Human Services and the CDC have faced and we have met new challenges. Just a month ago, for example, our best information told us that inhalation anthrax was up to 80 percent fatal. We never want to see fatalities. And it truly is a tragedy that four people have died. But the fatality for inhalation anthrax in these attacks has been about 40 percent. And I am happy to report that the last of those hospitalized went home yesterday. It's a testament, I believe, to CDC's expertise that we have been able to save lives, prevent countless people from becoming ill and treat those who have fallen ill. And it's a testament to the CDC and to the public health professionals on the front line that people with inhalation anthrax are walking out of the hospital. While our response has been strong, we must and we will do more. WE must do more. The response to anthrax attacks is an evolving science. We've learned so much over the last 6 weeks and we're learning more each and every day.

Winston Churchill once said, "let our advance worrying become advance thinking and planning." I think that's very apropos for this discussion. We at the Department of Health and Human Services have taken those words to heart on the bioterrorism front. Since I arrived in Washington a short 8 months ago, we have as-

sembled the greatest collection of doctors and scientists in the world, I believe, from the CDC to the National Institutes of Health, to the HHS Headquarters downtown who are all advising the Government and strengthening our Nation's preparedness.

Last spring, I named Dr. Scott Lillibridge my special assistant for bioterrorism and his counsel has been invaluable. And now that the threat of a bioterrorist attack has been realized, I have strengthened our team even further by adding Dr. Henderson as the head of the Office of Public Health Preparedness, which will coordinate the Departmental to responses to the public health emergencies.

As many of you all know and I'm very happy that you saluted him, Dr. Henderson is the father of the eradication of smallpox, having directed the World Health Organization's Global Smallpox Eradication Campaign from 1966 to 1977. Dr. Henderson brings a lifetime of preparation for the demands of the job and I am personally grateful that he agreed to join me in Washington to assist me, the Department and the Nation during this time.

I am also very happy to report that we're in the process of hopefully having Major General (Retired) Philip Russell who comes on who is an expert in vaccines to come on and join with Dr. Henderson, along with Dr. Michael Aster from California to come, who's an expert on laboratories to also assist this team.

President Bush and I recognize, as you all do, the vital role the CDC plays in protecting the homeland from bioterrorist attacks. I spent several days last week, or 2 weeks ago working at CDC and to see first hand the work that they are doing to respond to the anthrax attacks and the number of great scientists we have down there working overtime in their laboratories, sometimes sleeping there, making sure they get the analysis done properly and correctly and expeditiously.

President Bush and Governor Ridge and I also visited CDC last week where he made major announcements. President Bush has been keenly focused on preventing bioterrorism and the coordination he has demanded and achieved of a far-reaching Federal Government has been admirable coordination and communication and I believe it's improving each day and it needs to improve each day.

In the aftermath of September 11, the President requested an additional $1.5 billion to strengthen our ability to prevent and respond to a bioterrorism attack as part of the $40 billion homeland defense package. The President has also asked for $600 million to strengthen FEMA's planning and response activities. Our request includes $643 million to expand the national pharmaceutical stockpile and $509 million to speed the purchase of 300 million doses of smallpox and with these resources HHS will expand its program capabilities to respond to an all hazardous event.

In response to Congressman Deutsch, I'd like to point out that we have accelerated—there was not going to be any delivery of smallpox vaccine until 2004, 2005 and we hopefully will now have all of the 300 million doses, in hand, on stock within the next 12 months. And Dr. Henderson, I believe, is going to come back this afternoon and also fill you in on some further details.

With the additional resources, we will also add four more push packs to the current aid already located across the country, making

more emergency supplies available and augmenting our existing supplies of 400 tons by another 200 tons. The President and the Department are also committed to the development and the approval of new vaccines and therapies. The CDC, the Food and Drug Administration and the National Institutes of Health, all agencies within HHS are collaborating with the Department of Defense and other agencies to support and encourage research to address scientific issues related to bioterrorism. We also set up a scientific committee to take a look at how we could accelerate new vaccines and new therapies in the area of bioterrorism.

The capability to detect and counter bioterrorism depends to a significant degree on the state of relevant medical science. Our continuing research agenda and collaboration with CDC, FDA, NIH and DOD is critical to our overall preparedness. The President is calling for additional resources to expand HHS's capacity to respond to terrorist incidents, Also included in the amount is $20 million to support additional expert epidemiology teams that can be sent to the States and cities to help them respond quickly to infectious disease outbreaks as well as other public health risks.

And let me reiterate something I said in front of this committee in June—my conviction that every State should have at least one federally funded epidemiologist who has graduated from the CDC's Epidemic Intelligence Service Training Program that would be very helpful to strengthen our local and State public health system.

The President is also asking for $50 million to strengthen the Metropolitan Medical Response System to increase the number of large cities from 97 to 122 that are able to fully develop their MMRS units and to spend more money getting our medical response and emergency systems up to speed.

It is imperative that we work together in a bipartisan basis with cities to ensure that their MMRS units have the proper equipment and the proper training. We are also providing $50 million to assist hospitals and emergency departments in preparing for, and responding to, incidents requiring immunization and treatment, and we are providing $10 million to augment State and local preparedness by providing training to the State health departments on bioterrorism, and, yes, on emergency response.

The President is also requesting $40 million to support early detection surveillance to identify potential bioterrorism agents, which includes web-based disease notification to the health community nationwide. This amount will provide for the expansion of the Health Alert Network, which helps early detection of disease, to 75 percent of the Nation's 3,000 counties. I believe it is important that we set as a goal to have most of the counties connected in the coming years.

We are providing $15 million to support the increased capacity in no less than 78 laboratories in 45 States. This funding will enhance our ability to identify and be able to detect all of the critical biological agents. And we are implementing a new hospital preparedness effort to ensure that our health facilities have the equipment and the training they need to respond to mass casualty incidents.

In total, more than $300 million in additional funding is being requested just for fiscal year 2002 for State and local preparedness.

This also means that we will have to come back in front of this committee and the Congress in the years to come for additional resources for our local and State public health departments.

As to food safety, something that Congressman Dingell is very much interested in and I salute him for it, I would like to commend this committee—along with you, Chairman Tauzin, you have been an absolute leader, and I thank you so very much—for your leadership on one of my top priorities. I truly appreciate the cooperation we have received from members of this committee.

The President is requesting $61 million to enhance the frequency and the quality of imported food inspections and to modernize the import data system to enable us to detect tainted food. This funding would also provide for 410 new FDA inspectors to help ensure that our food is better protected.

In the past, additional resources for food safety have not always been a priority, and the result is not enough of America's food supply is currently being inspected. That is unacceptable. We do need additional resources to enhance the frequency and the quality of imported food inspections and to be able to modernize the import data system.

But it is not simply a matter of money. We also need enhanced authority to prevent potentially deadly foods from entering into commercial channels. Let me mention several areas that I think are important and are included in legislation we have submitted to Congress.

Currently, the FDA cannot require the owner of food to hold further distribution until a product's safety can be determined. In a public health emergency, I believe that authority to detain food is not only reasonable but vital to protecting the American public. This administration has requested that new authority in cases of emergency.

We also need to enable the FDA to prevent importers, who have a history of repeated violations of our food safety laws, from continuing to import food into this country. And we have asked the food importers to be given and to give us advance notice that their shipments are approaching our borders, so that FDA will have time to gather information that it needs to make quick, informed decisions about whether to allow that entry into this country.

From the farm to the table, we owe it to all Americans to protect the safety of the food supply. Some of these ideas that I have presented are not new, and some of you on this committee have supported these and other initiatives in the past, and I commend you. We are committed to working with this committee to see that legislation is enacted this year. We don't have much longer to act, and this, to me, is a No. 1 priority.

It is my understanding that the committee may be including universal product numbering language in the bioterrorism bill. As you know, I am a strong supporter of technology that improves the way that we do business, for improving the safety and the quality of health care. I have said on several occasions that bar coding technology has mass potential for safeguarding against medical mistakes. And since September 11, we are all the more aware of how critical it is to shore up and expedite the health care supply chain

and delivery function, so we can have more lives saved. Products went in there that are needed—especially in times of crisis.

Improving the health care technology is a critical building block, Mr. Chairman, of the infrastructure we must erect to ensure the utmost preparedness for bioterrorism and other disasters.

Finally, I know members of this committee have expressed concern about the overall security of the Nation's laboratories, and I share their concerns. There has been, and needs to be, a great deal of focus on the critical need for additional resources in order to heighten security at CDC facilities.

As many of you know, in 1996, there was an internal review of the physical security at CDC facilities. The Office of Inspector General recommended enhancing security measures at CDC facilities. In response, the CDC has implemented several new security improvements. A followup review conducted by the OIG earlier this year indicated that CDC had taken several positive steps to ensure the safety and security of the CDC facilities, and that even more actions must be taken if appropriately funded.

Additionally, immediately after September 11, I ordered from the Department a rapid assessment of the Security Department, which resulted in an additional $30 million of the supplemental request to address core improvements of these facilities. Included in this amount is $8 million for needs that can be addressed immediately on our CDC campuses and $22 million for crucial upgrades that will tighten security at facilities where dangerous pathogens are stored.

Further improvements remain one of my highest priorities in our fight against bioterrorism, and I have assigned a member of the Inspector General's staff to my command center to focus on security at the labs across the country. And I have hired Jerry Hower as a consultant to work with us to ensure our labs across America are as secure as possible.

Jerry is one of our Nation's leading experts in bioterrorism and has worked as a consultant to the Department. His counsel has been, and will continue to be, invaluable. Jerry is the former director of New York City's Office of Emergency Management and was responsible for putting in place much of the plan that enabled the city of New York to respond so well to the terrorist attack on September 11. We should also look at improving security at the private facilities as well.

I want to thank you, Mr. Chairman, and the members of this committee for swiftly moving a proposal President Bush requested that will give the Department new authority to regulate the possession, the use, and the transfer of biological agents and toxins at the many private laboratories and institutions throughout our country.

Together we are building a stronger infrastructure that will allow us to even more effectively respond to any public health emergencies in the future.

Thank you, Mr. Chairman, for inviting me, Dr. Koplan, and Dr. Henderson to testify on this very important topic. And now I would be happy to take your questions.

[The prepared statement of Hon. Tommy Thompson follows:]

PREPARED STATEMENT OF HON. TOMMY G. THOMPSON, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning Mr. Chairman and Members of the Committee. Thank you for the invitation to discuss my Department's role in protecting our nation's public health and bioterrorism. I am accompanied today by Dr. Jeffrey P. Koplan, Director of the Centers for Disease Control and Prevention (CDC), and Dr. D.A. Henderson, the head of our newly created Office of Public Health Preparedness, which will coordinate the Department-wide respond to public health emergencies. Before I begin, I would like to compliment this Committee for its foresight in working to enact "The Public Health Threats and Emergencies" bill last year, which was a landmark piece of legislation supporting improvements to our nation's public health infrastructure. Through your hard work and dedication, much of the infrastructure and tools to increase the public health capacity to address bioterrorism and other public health emergencies is already in place. Thank you.

The terrorist events of September 11th and later events related to anthrax have been defining moments for all of us—and they have greatly sharpened the Nation's focus on public health. Prior to the September 11th attack on the United States, CDC had made substantial progress in defining and developing a nationwide framework to increase the capacities of public health agencies at all levels—federal, state, and local. Since September 11th, CDC has dramatically increased its level of preparedness and is developing and implementing plans to increase it even further. In recent weeks, I have spent considerable time at CDC—and President Bush, Homeland Security Director Ridge and myself also visited the CDC last week—witnessing first hand the efforts to address the health threats this Nation currently faces and to prepare for future needs to protect the Nation's health.

I know some critics are charging that our public health system is not prepared to respond to a major bioterrorist attack. I know that some state and local labs are feeling overwhelmed right now, but the response from state and local authorities—to each and every threat—is continuing and will continue. And we should be proud of how well we have all responded to events that have broken our hearts even as they have steeled our resolve.

Just a month ago, for example, our best information told us that inhalation anthrax was 80 percent fatal. We never want to see fatalities, and it truly is a tragedy that four people have died. But the fatality rate for inhalation anthrax in these attacks has been 40 percent—and I am happy to report today that the last patient hospitalized is now at home with his family. It's a testament to the CDC's expertise that we have been able to save lives, prevent countless people from becoming ill and treat those who have fallen ill. And it's a testament to the CDC and public health professionals that people with inhalation anthrax are walking out of the hospital. While our response has been strong, we must—and we will—do more. The response to anthrax attacks is an evolving science, one that is being rewritten with each passing day.

The Department of Health and Human Services plays a vital role in protecting our homeland from a bioterrorist attack, and an even more important role in responding to the health consequences of such an attack. In the aftermath of September 11th, President Bush has requested an additional $1.5 billion to strengthen our ability to prevent and respond to bioterrorism.

Let me outline several areas of this budget request that specifically relate to the work performed by CDC.

FUNDING INITIATIVES

*National Pharmaceutical Stockpile*

The President's request includes $643 million to expand the National Pharmaceutical Stockpile, which is managed by CDC. With these resources, HHS will expand its program capabilities to respond to an all-hazards event.

As you may know, there are currently 8 Push Packs available as part of the Stockpile. Each one includes no less than 84 separate types of supplies; things like antibiotics, needles and I-Vs, a tablet counting machine and nerve agent antidotes. Each Push Pack provides a full course of antibiotics and other medical supplies and is shipped to an area within 12 hours to help state and local response efforts. These Push Packs are complemented by large quantities of pharmaceuticals stored in manufacturers' warehouses. This is called Vendor Managed Inventory (VMI). The VMI and the 8 Push Packs combined have enough drugs to treat 2 million persons for inhalation anthrax following exposure.

I have directed that the Stockpile should be increased for anthrax so that 12 million persons can be treated. CDC will reach that level of response during Fiscal Year 2002. With the additional resources, we will also add four more Push Packs

to the current eight already located across the country, making more emergency supplies available and augmenting our existing supplies of 400 tons by another 200 tons.

*Research*

The Administration is also committed to the development and approval of new vaccines and therapies. The CDC, the Food and Drug Administration and the National Institutes of Health—all agencies within HHS—are collaborating with the Defense Department and other agencies to support and encourage research to address scientific issues related to bioterrorism.

The capability to detect and counter bioterrorism depends to a significant degree on the state of relevant medical science. This continuing collaborative research agenda of CDC, FDA, NIH, and DOD is critical to overall preparedness.

*Laboratory Capability*

The President is calling for an expansion of HHS's capacity to respond to bioterrorist incidents, including $20 million for the CDC's Rapid Response and Advance Technology and specialty labs, which provide quick identification of suspected agents and technical assistance to state labs. We're also providing $15 million to support increased capacity in no less than 78 laboratories in 45 states. This funding will enhance our ability to identify and detect critical biological agents.

*Surveillance, Communications, and Training*

Also included in this amount is $20 million to support additional expert epidemiology teams that can be sent to states and cities to help them respond quickly to infectious disease outbreaks and other public health risks. And let me reiterate my conviction that every state should have at least one federally funded epidemiologist who has been trained in the CDC's Epidemic Intelligence Service (EIS) training program. The President's budget will accomplish this goal. Currently, there are 42 EIS officers in 24 States.

The President is also requesting $40 million to support the nation's Public Health communications infrastructure to facilitate information sharing concerning potential bioterrorism agents, which includes Web-based disease notification systems to the health community nationwide. This amount will provide for the expansion of the Health Alert Network, which will assist CDC in disseminating critical, time-sensitive disease alerts to 75 percent of the nation's 3,000 counties, and Epi-X, a secure web-based communications system that provides information sharing capabilities to state and local health officials. These expansions will encourage state and local health departments to be vigilant in identifying public health threats. I intend to have all counties connected in the coming year. One of our goals is to assist state and local health departments achieve 24/7 capacity to receive and act upon health alerts. And we're providing $10 million to augment state and local preparedness by providing training and resources for state health departments to develop readiness plans on bioterrorism and emergency response.

*Food Safety*

The President is also requesting $61 million to enhance the frequency and quality of imported food inspections and modernize the import data system to enable us to detect tainted food. This funding will also provide for 410 new FDA inspectors to help ensure that our food is better protected.

*Security for CDC Facilities*

The Administration is also requesting an additional $30 million to enhance the security of CDC and other critical facilities operated by the Department. Members of this Committee have expressed concern about the overall security of the nation's laboratories, and I share their concerns. There has been—and needs to be—a great deal of focus on the critical need for additional resources to heighten security at CDC facilities. I have read a 1996 HHS Inspector General report that recommended security at facilities be increased, and a recent review of those findings. Progress has been made, but the Department must do better.

Included in the amount requested by the President is $8 million for needs that can be addressed immediately at our CDC campuses, and $22 million for crucial upgrades that will harden security at these facilities that house some of the country's most dangerous pathogens. These investments are important to our public health mission and our fight against bioterrorism, and I implore you to fund this request.

LEGISLATIVE INITIATIVES

In legislation the President sent to Congress to strengthen the Department's ability to respond to bioterrorism, much of the new authority requested lies in the area of food safety. I am particularly concerned about this issue.

As I have mentioned, too few resources have in the past been dedicated to food safety. But it is not just a matter of money. The Department—FDA—has for years needed enhanced authority to stop potentially deadly food supplies from entering into commercial channels.

Currently, the FDA cannot require that the owner of food hold further distribution of that product into the stream of commerce until a product's safety can be determined. In a public health emergency, FDA needs the authority to detain food for a reasonable time so that it can assess the hazard and not worry that goods are entering into commercial channels. In the case of certain public health emergencies, this limited new authority would be vital to protecting the American public.

Also included in the Administration's proposal is increased maintenance and inspection of source and distribution records for foods. Under current law, if the FDA suspected food was being used in a biological attack, the Agency could not access the records of food manufacturers, packers, distributors and others to identify the location of a product or the source of that product. Such records might not even be maintained. Requiring that records be kept, and that FDA have the authority to inspect and copy these records is not unreasonable in light of the serious health consequences that could occur if our food supply became a vehicle for bioterrorism.

The President has also requested that the FDA be able to prevent importers who have a history of repeated violations of our food safety laws from continuing to import food into this country. And, the Administration has asked that food importers give advanced notice that their shipments are approaching our borders, so that FDA will have time to gather information that it needs to make quick, informed decisions about whether to allow entry into this country.

Also requested by the Administration are additional tools to improve the security and safety of the many private laboratories throughout this country that handle potentially deadly pathogens. The possession, use and transfer of biological agents and toxins by these facilities is an issue that concerns many not only in the public health community, but also in the intelligence and defense communities. Under the proposal, the Department would have the authority to regulate entities handling these pathogens.

This Committee and the full House of Representatives, have already recognized the importance of this issue, by passing legislation that addresses this issue. Thank you, Mr. Chairman, and members of this Committee, for swiftly moving the President's proposal.

CONCLUSION

In conclusion, the Department's top priority is to protect the Nation's health. To do this, the Department, through the CDC, continues to focus on building a solid public health infrastructure—with our state and local partners—to protect the health of all citizens. As recent events have shown so dramatically, we must be constantly vigilant to protect our nation's health and security. The war on terrorism is being fought on many fronts, and we must ensure a strong, robust public health system to be on guard at all times to prevent and respond to multiple and simultaneous terrorist acts. The arsenal of terrorism may include biological, chemical, and radiological agents as well as conventional and non-conventional weapons, as the attack on the World Trade Center so vividly attests.

Regardless of the arsenal, the Department of Health and Human Services is helping to build core public health capacities in this country that will allow us to more effectively respond to any public health emergency in the future.

At this time, I would be happy to answer questions from you and Members of the Committee.

Chairman TAUZIN. Thank you, Mr. Secretary. Let me first recognize myself for 5 minutes, and members in order. Mr. Secretary, this morning we learned on the national news that the head of the Taliban, Mohammed Omar, announced that they are planning—not Al-Qaeda, the Taliban, that they are planning the destruction of the United States. And they are planning events that are unimaginable to mankind, and one can only guess that he is referring to

determined attempts to inflict biological, chemical, or even nuclear damage upon the United States.

This morning we also learned that the terrorist manuals that we have been knowing about for a long time, the jihad terrorist manuals operated by bin Ladin and his group, actually now include new volumes, one on chemical and biological warfare and one on nuclear bomb-making. They were discussed this morning on the morning news. This is serious business.

And the first question I have for you is one some of the members have related to already in their discussions with you. And before I ask it, let me put on the record that we have now an agreement that your office will share with us documents on the report on security of the labs and CDC, which we had requested, and also information on the agents. And I thank you for that agreement.

The question I have for you is that you just now appointed Dr. Henderson as your new Office of Public Health Preparedness Director. You also have an Office of Emergency Preparedness. You also have Scott Lillibridge as your Special Assistant for National Security and Bioterrorism. In addition, you have a Bioterrorism Preparedness and Response Program.

Now we know you are in charge. But with all of these offices, how do we know, really, who is in charge and responsible for what? How are you organizing this? How are you coordinating this internally? And if I can ask a second question quickly, how are you also coordinating this with the Defense Department and other intelligence agencies that are critical in this endeavor to protect our country?

Mr. THOMPSON. Mr. Chairman, what we have done is we have taken a huge room across from the Secretary's office as an intervention room. And in there we have set up a complete command structure in which we get all of the information coming in from CDC, the FBI, the CIA, the National Security Council, on an hourly basis.

And in charge is Dr. Henderson, who is the overall command general who collects the information and then advises me. And Scott Lillibridge is the individual that is actually inside the intervention room reporting to Dr. Henderson.

Chairman TAUZIN. So Dr. Henderson will have overall supervision of all of these other offices.

Mr. THOMPSON. That is correct.

Chairman TAUZIN. And report I suppose also to Tom Ridge, the Homeland Security Director, is that correct? As well as, of course, to you first.

Mr. THOMPSON. And then we report to the White House on a daily basis, in fact more frequently than on a daily basis, as to what is going on. And then each morning NIH, CDC, and FDA, and all of us have a morning telephone conference at 9 in the morning with Dr. Koplan and Dr. Tony Fauci and Bernshwetz and Dr. Henderson and myself.

Chairman TAUZIN. Okay. That is the daily routine?

Mr. THOMPSON. That is the daily routine.

Chairman TAUZIN. Can you also explain to us the status of the national disaster medical system itself?

Mr. THOMPSON. Pardon?

Chairman TAUZIN. The national disaster medical system itself. Perhaps, Dr. Koplan, you can assist us here.

Mr. THOMPSON. The national——

Chairman TAUZIN. Disaster medical system.

Mr. THOMPSON. That is under the Office of Emergency Preparedness. That is headed up by Art Lawrence, and that reports directly to the Assistant Secretary of Health, who has been nominated but has not been approved.

Chairman TAUZIN. Has not been appointed yet. That is right.

Mr. THOMPSON. And they report directly to me.

Chairman TAUZIN. All right. Do you support the creation of a new Office on Vaccines at HHS? We have been told that that is a proposal being made.

Mr. THOMPSON. I don't think we need one because what we are doing under Dr. Henderson, we are putting in an individual by the name of Phil Russell, who is the former—he is the retired Commandant at USAMRIID. And he is an expert in vaccines, and he works with Dr. Henderson and makes any advice and any suggestions possible. Plus, we have a Vaccine Advisory Committee set up through NIH, CDC, FDA, which meets regularly. They met all last week in regards to the——

Chairman TAUZIN. NIH is vitally involved in this also.

Mr. THOMPSON. Very much so, on a daily basis.

Chairman TAUZIN. Members have asked that question of me. Would you mind, Mr. Secretary, passing the mike to Dr. Henderson. I want to ask a question that I think is on the minds of——

Mr. THOMPSON. Absolutely.

Chairman TAUZIN. [continuing] most Americans and probably most citizens of the world, Dr. Henderson. You oversaw the enormously important work to eradicate smallpox as the disease that kills so many people in this world. And yet our country and the Soviet Union decided to keep that disease, to keep the biological agents, and literally to experiment with them I suppose over those years as potential weapons.

Could you comment on the rationale and the insanity of those decisions?

Mr. HENDERSON. Thank you, Mr. Chairman. I am happy to do so. May I say I appreciate very much the recognition. The program of smallpox eradication was a major effort with a lot of people, including Dr. Koplan, who spent a good bit of time in the field himself. And it was a great achievement, but—and certainly right now I would say we are more worried than we have ever been before about smallpox returning.

The question of what to do with the smallpox virus is one which was taken up by a World Health Organization committee beginning as early as 1980. And in the course of this there was the thought in mind that some day it might be possible to destroy the virus. This was a difficult question to wrestle with. Were we in a position to destroy a species?

Many efforts were made to identify the genetic material that was involved with sequencing of the virus, with libraries of fragments of the virus, and many organizations were consulted about the advisability of doing this. In the meantime, laboratories around the world were solicited about, did they have the virus, and were per-

suaded, some with great difficulty, to either destroy it themselves or transfer it to one of the two laboratories which had been working with the World Health Organization in this program, one at the Centers for Disease Control and one in Russia.

As we moved along, it became clear that we had pretty good cooperation. We couldn't absolutely be sure that every laboratory had turned in their virus, and there was no way by which you could verify this. The little vials are only about as big as your finger. They can be lost in the bottom of a deep freeze, and there is no way to inspect these things.

But countries I think made a good effort to get rid of the virus, and I think there is—it is possible there is virus elsewhere. We can't really say for sure. But we had doubts that there were very many places at least.

As we came to move into the time of 1998 to year 2000, the question came, would it be possible to develop a drug which could be used in the treatment of smallpox? Some felt this would be a good idea. Some felt irrespective of what we might find it would be desirable to destroy the virus.

And so after much discussion, it was decided to retain the virus, for the two countries with laboratories to review their research programs regularly with a special World Health Organization committee, for that committee to have oversight and approve all research that was done, and to investigate to be sure that there was very close watch kept on those stocks.

And so at this time there is research going on with regard to smallpox, but it is focused on getting an antiviral drug. The committee will be meeting in the first week of December again to review this, and meanwhile the World Health Assembly has agreed that the virus be retained up to but not later than the year 2002. That is interpreted as December 31, 2002. And that decision will be reviewed annually.

Chairman TAUZIN. My time has expired, but I would love to put you on the record with a very simple question. How certain, how assured are you and the World Health Organization, today, that we know where any of this virus may be located, and whether anyone may have access to it who would do harm to the people of this planet?

Mr. HENDERSON. Mr. Chairman, we cannot be sure. We do not know how many places might have it. We know that it is almost certainly in three places in Russia. There is a place—CDC, of course, has it. And it is possible that there are other countries. It has been suggested that Iraq may have it, that North Korea may have it. The data on this are uncertain.

Chairman TAUZIN. Thank you, sir.

The Chair recognizes the ranking minority member, Mr. Dingell, for a round of questions.

Mr. DINGELL. Mr. Chairman, thank you.

Mr. Secretary, welcome. I am going to—I have a lot of questions, and I am going to ask you, to the degree you possibly can, that you give me a yes or a no answer.

Mr. Secretary, which is the bigger contamination problem, domestically produced food or imported food?

Mr. THOMPSON. Pardon?

Domestic or imported?

Mr. DINGELL. Yes. Which is the greater source of risk for contamination, domestically produced food or imported food?

Mr. THOMPSON. Yes.

Mr. DINGELL. Pardon? Yes is fine but not responsive. We have a Food and Drug Administration here. We don't have one overseas.

Mr. THOMPSON. I think it has got to be imported food that I am the biggest concerned about, Congressman.

Mr. DINGELL. Thank you, Mr. Secretary. Now, Mr. Secretary, food inspection officials in the State of New York have informed the staff that 80 percent of the food recalls they issued last year were contaminated imported food. Contamination included pathogens, heavy metal, pesticides, illegal additives. Is this a fair and a representative statement?

Mr. THOMPSON. I am not sure. I can tell you that last year we had over 372,000 individuals that suffered from food pathogens. Five thousand individuals were hospitalized and—20,000 were hospitalized, 5,000 people died from food poisoning in America. So it is possible, but I am not sure.

Mr. DINGELL. Is there any information that you have that refutes the findings that New York has communicated to us with regard to the risk of contamination of imported food?

Mr. THOMPSON. I didn't hear the first part of that.

Mr. DINGELL. I said is there any information you have about recalls in other States that refutes the findings that New York has communicated to my staff?

Mr. THOMPSON. Not that I know of, Congressman.

Mr. DINGELL. Now, Mr. Secretary, is it true that only one—rather, seven-tenths of a percent of imported food is inspected by FDA?

Mr. THOMPSON. That is my understanding, and that is what FDA tells me. We have 300 ports of entry that come into the United States, 299 to be exact, and we have 150 inspectors. And so it is pretty near impossible when you only have less than one inspector per site where food is entering into the United States to be able to inspect much.

Mr. DINGELL. Now, Mr. Secretary, you have asked for additional money, but most ports operate I note on 24 hours a day, 7 days a week. Isn't that true?

Mr. THOMPSON. Most of them do, but a lot of the food coming in is limited to 12 hours, from 9 until 8 in the evening.

Mr. DINGELL. So I am going to submit you a question here for the record that will involve how many in fact you really can give full inspection to.

Now, Mr. Secretary, how many FDA inspectors would it take to cover all 307 ports, or 299 ports, where food enters the United States commerce on a 24-hour-a-day basis?

Mr. THOMPSON. We have 150.

Mr. DINGELL. You have 150, which is probably about a sixth the number you need. Is that right?

Mr. THOMPSON. We are requesting—we think that we can do a much better job with an additional 200, so we would have 350. And then with an additional 100 backup in the laboratories, we think we could do an adequate job, not an excellent job but a much better job than we are doing right now, Congressman.

Mr. DINGELL. Not excellent, but better. Now, Mr. Secretary, I note that USDA requires meat to be inspected at only 30 points of entry rather than the 307 ports where FDA-regulated food enters U.S.

Mr. THOMPSON. That is correct.

Mr. DINGELL. Do you have authority to stipulate that FDA will inspect imported food at only certain ports as U.S. Department of Agriculture has done?

Mr. THOMPSON. I do not have that authority.

Mr. DINGELL. Would that be helpful to you in allocating your resources?

Mr. THOMPSON. There are some big trade issues involved in that. I have inquired about that, but there are some big trade problems and trade issues for that. But it is something that I am certainly willing to consider. The Department——

Mr. DINGELL. Why would there be trade problems at FDA and not trade problems at Department of Agriculture? Department of Agriculture has communicated no such concerns to us.

Mr. THOMPSON. Because we have so much——

Mr. DINGELL. Everybody seems to be happy, and yet you can't control it, and you have got a big trade issue. What are you telling us here?

Mr. THOMPSON. Well, Congressman, all I can tell you is that the tradeoffice has indicated to me that there would be some trade implications, some trade problems with it, and we have a lot more food coming in than the Department of Agriculture. They have 20 percent; we have about 80 percent of the food coming into the United States.

And I am certainly willing to look at it. It is something that I raised with you, Congressman, at a closed hearing once, that this is something that we should consider.

Mr. DINGELL. Mr. Secretary, my differences I don't think are so much with you as they are with the administration. But also, with some of the big food importers and processors who don't seem to like the idea of being regulated. Now, I understand——

Mr. THOMPSON. I am sure that is true.

Mr. DINGELL. Now, Mr. Secretary, I understand FDA was inspecting about 8 percent of all food imports in 1992, rather than the seven-tenths of a percent it currently inspects. Is that correct?

Mr. THOMPSON. That is my understanding.

Mr. DINGELL. What caused that shift?

Mr. THOMPSON. Well, because of the expansion of food coming into the United States and a complete cap on the number of inspectors we had, Congressman. You can well imagine the increased amount of food that has come into the United States on a yearly basis since 1992. And when you have the same number of inspectors, you are going to have less opportunity to inspect food.

Mr. DINGELL. Now, Mr. Secretary, I would——

Chairman TAUZIN. The gentleman's time has expired. The gentleman would ask additional time?

Mr. DINGELL. No, Mr. Chairman. I would just like to get this one little question in.

Chairman TAUZIN. Get it in, Mr. Dingell.

Mr. DINGELL. Just so we have a perspective. Mr. Secretary, you asked for additional money. Did you get all that you requested?

Mr. THOMPSON. I requested $61 million, and that is what——

Mr. DINGELL. That is the amount you requested?

Mr. THOMPSON. That is right.

Mr. DINGELL. And that is the amount you got?

Mr. THOMPSON. That is correct.

Mr. DINGELL. You didn't request more money?

Mr. THOMPSON. I felt that I was—I was very appreciative to get that much, Congressman, because I asked for it—I had asked for it before and didn't get it.

Mr. DINGELL. This is going to leave you able only, however, to inspect——

Mr. THOMPSON. Pardon?

Mr. DINGELL. This is going to leave you able, Mr. Secretary, only to inspect 2 percent of the food and not have other authorities.

Mr. THOMPSON. Well, we are hoping with the expanded authorities that we are going to be able to have detention, that we are going to be able to have notice, so that the companies, the importers are going to have to notify us hours before so we can get inspectors there, places we don't have inspection.

We also are hoping to be able to have some of the other authorities that we have put in there that is going to be helpful, plus including an improved computer system called OASIS, which is very important, plus an improved PulseNet, which tracks down the pathogens and describes the DNA, and be able to characterize and be able to find that, plus increased laboratories' help by an additional 100 people, which would be very helpful for the inspectors that are at the border.

Mr. DINGELL. I appreciate that.

I have some other fine questions, Mr. Chairman. I will defer further questioning.

Chairman TAUZIN. I thank the gentleman. The record will, of course, stay open after this hearing for the submission of written questions, and the gentleman will be certainly welcome to do so.

The Chair is now pleased to recognize the chairman of the Health Subcommittee, from Florida, Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Mr. THOMPSON. Thank you, Mr. Chairman.

Well, I think there is some good news for you in terms of our draft.

Mr. THOMPSON. Good. Thank you.

Mr. BILIRAKIS. Mr. Secretary, you made, in responding to the questions asked by the chairman a few minutes ago, three leading recommendations, and I just wanted to tell you that all three were met in our draft—Sections 302, 303, and 305.

Mr. THOMPSON. Thank you so very much, all of you.

Mr. BILIRAKIS. Mr. Secretary—and I see that Ms. Capps is not here, and I wish she had been—but there are others—Ms. DeGette, Mr. Whitfield, Mr. Ehrlich, who is not here right at this moment either—who have all been concerned about the workforce problems.

Before the events of September 11, we heard a lot about shortages of health care professionals in various areas, including nursing, pharmacy, and medical technology. There has been an ongoing

debate over the ability of the market to correct for these shortages and the role that government should play.

I know that you have been concerned about this as well, Mr. Secretary. You have taken action, for which we are grateful. In late September, you announced $27.4 million to address the emerging nursing shortage, for instance, and we thank you again for seeing a need and responding swiftly and appropriately.

However, in the wake of September 11, there is a grave concern that I know you share about the ability of our public health system to respond to an emergency. There have been questions about the effect that various workforce shortages may have on our ability to respond as a nation, and it is important that we are able to respond in all capacities.

The Department, through HRSA, the Health Resources and Services Administration, has the ability to determine the workforce necessary to respond to potential bioterrorism attacks, and we have been talking to those people. They have been very helpful and very cooperative.

Would providing additional monies through HRSA help the Department determine where vital workforce shortages currently occur and help train and educate individuals in those areas? And, additionally, would a general approach such as this allow the Department the flexibility to plan broadly for our public health response to a possible emergency?

Mr. THOMPSON. Yes, it would.

Mr. BILIRAKIS. Are you familiar with workforce legislation? Mr. Secretary—forgive me for interrupting you—regarding particularly the nursing shortage and the other areas? And as Ms. Capps has already said, we have been working—I mean, we spent a lot of time with her and her staff trying to work out——

Mr. THOMPSON. I know you are working on a bipartisan bill.

Mr. BILIRAKIS. Yes.

Mr. THOMPSON. I know that my office has reviewed it. I personally have not had the time to, but I know the gist of it, and I am very supportive of it. I also would point out that the Secretary of Labor, Elaine Chao; Secretary of Education, and myself, are working on a joint cooperative effort between the three departments of labor, education, and health and human services, to determine the workforce problems in the health care field, and to develop a concerted and coordinated plan to try and come up with ways to get the dollars, get the scholarships, and direct individuals who are trying to encourage young people to get into the health care fields, not only nursing, lab technicians, pharmacy, and dentistry, all which need—which have big shortages.

Mr. BILIRAKIS. Mr. Secretary, how much legislation is needed to be able to address these problems compared to what the Department is able to do without legislation, and is in the process of doing without it?

Mr. THOMPSON. How much money?

Mr. BILIRAKIS. Legislation.

Mr. THOMPSON. How much legislation?

Mr. BILIRAKIS. Authority.

Mr. THOMPSON. How much authority?

Mr. BILIRAKIS. Congressional authority, yes.

Mr. THOMPSON. The more discretionary, of course, the better able we are to do our job, Congressman Bilirakis. And the proposal, as I understand it, that you are working on with Ms. Capps is one that gives us that authority and that discretion, and that is the one that we would——

Mr. BILIRAKIS. I wish she were here, because I would want her to hear your response, although I don't know what it is. But I know one area that she feels very strongly about is creating another national health service corps, only it would be a national nursing health service corps.

How do you feel about that? And do you feel that it is necessary to have an additional nursing service corps? Have you studied that? I don't mean to put you on the spot here, but it is important that we know these things. Can what we all want to accomplish be done without creating an additional service corps?

Mr. THOMPSON. Congressman, whatever we can do to encourage young people to go into the nursing field is important. If it is a nursing corps, fine, but it is—but I think what we have to do is we have to start encouraging young people that this is a great profession, and which it is, and one in which we need more young people to go into. And I don't think we have done a very good job of publicizing that and encouraging people to go in that—to be the professional of choice.

And saying that, we also have to do the same thing for lab technicians, for pharmacists, and for dentists. And these are the shortages that we have right now that are going to be more acute in the years to come. And if it is the nursing corps, that is fine. I just know that we have to do a much better job and be more aggressive in regards to recruiting young people to get into it.

Mr. BILIRAKIS. All right. My time has expired. Thank you, Mr. Secretary.

Chairman TAUZIN. I thank the gentleman. The Chair is pleased to recognize the gentleman from Massachusetts, Mr. Markey, for a round of questions.

Mr. MARKEY. Thank you, Mr. Chairman, very much.

Today's New York Times reports that in Al-Qaeda headquarters in Kabul blueprints for a Nagasaki-like nuclear bomb have been found. And as we know, the Attorney General has been consistently warning our country that terrorists consider nuclear powerplants in the United States to be a target which the terrorists would highly value if they could launch a successful attack against it.

Now, I don't believe that bin Ladin as yet has access to nuclear weapons capability. I believe that if he did he would have already used them.

Mr. THOMPSON. I agree.

Mr. MARKEY. However, I do believe that we, as part of the preparation which we make in our country, should be prepared to protect our population in the event that they do gain access to the materials or they launch a successful attack on a nuclear powerplant somewhere in the United States.

So my question focuses in on that level of preparation. Potassium iodide is something that was distributed in Poland after the Chernobyl accident. They did not have it available in the Soviet

Union. Thousands of thyroid cancers as a result occurred, especially in children, in that country.

So my question to you is this: notwithstanding the fact that the Nuclear Regulatory Commission has made a decision to allow each individual State to decide whether or not to stockpile potassium iodide inside of the radius—let us just say it is a 10-mile radius of a nuclear powerplant, although we know depending upon the plume of a cloud that would—of an accident that it could go far beyond 10 miles. But do you believe that there should be a stockpiling inside of the most vulnerable areas, especially in schools? Dr. Koplan or——

Mr. THOMPSON. Dr. Koplan will—let me start out, and then I will have Dr. Koplan respond as well. First, I will thank you for the question.

We are putting in the President's package $47 million for chemical antidotes. That also includes potassium iodide. And that is part of that package, and it—what you are saying I think has a great deal of merit, and we certainly want to review that.

Second, we have a review committee at CDC and NIH that works with the Veterans Department that takes a look at what is in our push packages. And we change periodically the kinds of medicines and medical equipment that we put in these push packages, and we are going to hopefully, in this bipartisan package, have enough money to increase the number of push packages from eight to 12, which would increase the number of medical supplies from 400 tons to 600 tons. And of that, that question about potassium iodide is being considered by the committee and being able to place in our push packages.

Mr. MARKEY. Now, potassium iodide is the Cipro for nuclear exposure.

Mr. THOMPSON. You are absolutely correct.

Mr. MARKEY. It would only cost $3.9 million to make it available to all of the people who live within a 10-mile radius of every nuclear powerplant in the United States. And I do believe that the Nuclear Regulatory Commission is not the right agency to be making the decision, as a precautionary measure, as to whether or not that antidote should be made available.

And if I can just take it a step further, in the event that there is an exposure, the national pharmaceutical stockpile, in my opinion, should also include sulfhydryl compounds such as amylphostine, which minimizes radiation damage to human cells and could be used to protect emergency responders, so that after the fact, if they are exposed, that there would be that stockpile in place as well.

So I would ask for your reaction to the stockpiling of those compounds as well, so that we do have the available means of dealing with the effect on the public or the responders?

Mr. THOMPSON. We are reviewing all of those things, Congressman, through Dr. Henderson and Dr. Koplan. And I think a better person to respond to that would be Dr. Koplan.

Mr. MARKEY. Okay. Thank you.

Dr. Koplan?

Mr. KOPLAN. Thank you, Mr. Markey. As Secretary Thompson said, we regularly review these compounds, and we would be glad

to talk some more with you and your staff about other ones you might think would be useful and subject that to further review and see what we can do.

We participate, as you have—as I am sure you know, as part of the Federal radiologic emergency plan, with about 17 other Federal agencies, and likely the leads would be, in an event such as the type you described, either the Nuclear Regulatory Commission, the Department of Defense, Department of Energy, or EPA. But we, the Department of Health and Human Services, would play a major public health role in that event. Because of that, Secretary Thompson has had us beefing up our own capabilities in response to that.

Mr. MARKEY. The reason that I am more recently concerned, Doctor, is that in The Washington Post on October 30 there was an interview with this captured Al-Qaeda member that the Northern Alliance has had imprisoned for a number of years. And it is just a full page interview with him in which he says quite graphically in America there are more important places, like atomic plants and reactors, that could be attacked.

So they are delivering the message to us, either in the headquarters in Kabul, or we find evidence of attempts to make nuclear weapons, or interviews with Al-Qaeda members that say that nuclear powerplants would be targets. And so I would urge you to ensure that potassium iodide and other antidotes are available inside at least a 10-mile radius.

Chairman TAUZIN. The gentleman's time has expired.

Mr. MARKEY. Thank you.

Chairman TAUZIN. I thank the gentleman. The Chair recognizes the gentleman, Mr. Upton, for a round of questions. And Mr. Bilirakis will be in the Chair.

Mr. UPTON. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, for your testimony. This is clearly a nightmare that is not going away. And as we look for wins on the battlefield overseas, we obviously have to have them here at home as well. And I know that all of us appreciate your hard work and your commitment to make sure that that nightmare somehow goes away.

I know that a number of our pharmaceutical companies have offered to donate new antibiotic products that will help with bioterrorism attacks—whether it be anthrax or anything else. And I am curious to know where are we in terms of trying to expedite and speed up the approval pipeline for some of those drugs. And I am wondering if you need any more authority so that we can help you in terms of the development and approval process for some of these drugs.

Mr. THOMPSON. I think FDA is working extremely hard, Congressman, in regards to this. Every morning we have a teleconference with CDC and FDA and NIH, and probably a week does not go by that we do not discuss the possibility and the need for expediting drug approval. And FDA is putting more resources into this as we speak.

Whether or not new authority would be helpful, I certainly would like to look at it and get back to you after I have had a chance to review it with FDA, as well as with the attorneys in the Depart-

ment of Health and Human Services. But I would probably say, without seeing that language, that, yes, additional authority for the Department would be advisable.

Mr. UPTON. Over the last couple of weeks, I have sat down with my local hospital administrators, emergency workers, and police folks, and obviously they, at the State and local level, are the first responders in case anything bad happens at home. As chairman of the Telecommunications Subcommittee, too, I have had plenty of presentations on telehealth and all of the advantages of being able to communicate electronically with any of those first responders.

I know that at an oversight hearing a couple of weeks ago, there was a question that was posed to the CDC about the levels of funding for State and local public health departments to electronically connect them. And the response was, "That is a good question." In other words, it wasn't enough.

I note that the administration is planning to eliminate the Office of the Advancement of Telehealth as well, and I am just wondering if that is such a good idea in times like these. And I am wondering maybe, Dr. Koplan, if you can respond to that, and maybe Secretary Thompson as well.

Mr. THOMPSON. I believe it is just being moved. It is not being eliminated.

Mr. UPTON. It is not being eliminated? Okay. Well, that is good news. That is good news.

Mr. THOMPSON. But can I respond a little bit? Just a little bit in regards to communication to your local public health. This has been something that CDC, through the Health Alert Network, has really done an outstanding job on. And we need to expand that. We need to get more information down to the emergency wards and into the county health departments and to regional and the State, and with up-to-date information, and we have found that during this nightmare that we have gone through for the last 6 weeks.

But the Health Alert Network has been extremely good, and it has been a great investment. We just need to expand it and be able to do it. Each week Dr. Koplan and I, for the last 3 weeks, we have had weekly conferences, teleconferences, with the State health departments and with the State medical departments and the emergency workers. And it has been extremely well received by those individuals.

So what you are talking about is something that we are doing. We would just like to be able to expand it, Congressman.

Mr. UPTON. Well, that is exactly right, and that is why, particularly as I look at the announcement this morning for Michigan of this new support team that can integrate with our State and local folks, how critical it is to have that information online.

And even as we—there are a lot of news stories about our own blackberries in terms of how we are able to communicate here with each other, particularly when in time of a crisis. Often cell phones go down and it is that type of communication that our local folks have to have as they begin to think about dealing with any emergency that might be out there.

The last question that I have—and you cited just a brief reference to it in your testimony—good news about increasing the amount of dosages to 300 million for smallpox, with a goal to do

that in the next year versus what was originally targeted to be a 5- to 8-year process. How would we do this?

There was some talk of diluting it by up to, what, 20 percent, which would quintuple the amount of reserves. But tell me—if you can tell us what your——

Mr. THOMPSON. Really, only after September 11, we sat down—Dr. Henderson and with the FDA and with some other individuals, and we have mapped out a plan on how we could accelerate that. And then we called in ACAMBIS, who has the contract to deliver 40 million doses, and they were not going to start manufacturing until 2004 and delivery date was 2005.

We asked them—and we sat down with FDA, with CDC, NIH, and with our Department, and we mapped out a plan under which they will be able to start manufacturing next year and will start delivering sometime in June, July, August of next year, of the 40 million. For that, we increased their contract from 40 million to 54 million doses, and they are to deliver next year the 54 million doses.

Then, we put out a request for information to seven companies to see whether or not they could come up and accelerate, so that we could have some additional smallpox vaccines up to the 300 million. Doing that, we had 10 companies that came back, and now we are in the process of negotiating a contract with some of those companies, and that process is ongoing. And we are hoping to be able to complete it relatively quickly.

Part of the terms are to be able to have the vaccines delivered next year, and actually start manufacturing for the preliminary doses sometime in the month of December. That is how fast we are moving. And on top of that, we have asked NIH to take a look at our existing stock of 15.4 million doses to see if they could distill it down 5 to 1 and still have the same kind of coverage rate.

And they are doing the studies and the research right now, and we are expecting to have that analysis done sometime in January, latter part of January, early part of February. And if it comes back the way the preliminary analysis indicates, we will have 77 million doses on hand in January or February of this year of current stock, and then we will expand that to the 300 million doses, Congressman.

Mr. BILIRAKIS [presiding]. The gentleman's time has expired. Good show, Mr. Secretary.

Mr. Brown, to inquire.

Mr. BROWN. Thank you, Mr. Chairman.

Dr. Henderson, thank you especially for being here. You really are a hero to a lot of us, and thank you for joining us.

Mr. Secretary, you noted several times in your negotiations with Bayer on Cipro that your current authority to break patents under imminent domain law poses financial risk. Compensation to the brand-name company is determined after the fact, according to law now based on vague criteria, creating the possibility that the Federal Government would have to have spent a great deal more money than we hoped for.

Putting a compulsory license in place would allow for prospective determination of compensation. It would not require wrangling in the courts the way present law would, to determine fair compensa-

tion for the brand-name drug manufacturer in the event of a public health emergency. What are your thoughts on this? To give you the tools to do this without the threat of government having to spend a great deal more money?

Mr. THOMPSON. I am not in favor, Congressman, of breaking the patent law. And I felt that we were able to negotiate with Bayer a very fair contract and saved over $50 million doing the negotiations in regards to that. And I think within the patent law we still can be able to drive down the costs of pharmaceutical drugs in America. But I am more than happy to look at your language and your legislation, which I haven't personally reviewed yet, but I would be more than happy to, to get back to you as our response.

Mr. BROWN. Okay. I appreciate that. And you have always done that in good faith in your time here. Beyond the cost—and I think you did a good job negotiating. I don't think you had—I think if you had had a better law to negotiate from you would have had more of a position of strength to bring the price closer to the 45 cents that some public hospitals have been paying, but that is another issue.

But the supply problem is also an issue, and you were able to reduce the goals for Cipro from I believe 1.2 billion to 100 million, in large part because of purchases of Doxycycline, which is obviously a much less expensive Tetracycline class of antibiotics.

Now, if there is a problem of antibiotic resistance to Penicillin or Tetracycline, or a Tetracycline drug like Doxycycline, we need to act—you are going to need to act fast, and you are going to need to act fast within a budget or within just the constraints of some number of dollars. Don't you think you need at some point an ability to more quickly, in an anticipatory way, be able to move—you can say break a patent, but bring it—in this case I guess it is breaking a patent, but it is in a public health emergency, to get these drugs made quickly online at a relatively inexpensive price.

Mr. THOMPSON. Congressman Brown, I, along with Dr. Henderson and a couple of other individuals from NIH, we have met with the pharmaceutical companies, and they have indicated that they will turn over their manufacturing concerns for any type of an emergency in order to produce as many antibiotics as necessary.

We have had also several companies that have indicated they would like to donate for nothing antibiotics. Just yesterday Phizer donated $2 million worth of Doxycycline to the government to be used for any kind of emergency dealing with anthrax whatsoever. And so other companies have done that as well.

Did you want to say something, Dr. Henderson?

Mr. HENDERSON. I think we have felt that rather too much emphasis has been placed on that Ciprofloxicin is virtually the only answer for treatment, and this certainly is not so. In fact, there are real—very powerful reasons of using Doxycycline, which is a generic drug now and made by a number of different companies. It is associated with fewer side effects than the Cipro, and that certainly is an advantage. And all of the strains are sensitive to this drug.

In addition, there are a number of other fluoroquinilones which are drugs of this family of Ciprofloxicin, and those are being tested, if you will, for comparability. We have every reason to believe that

they will be equally as effective as Ciprofloxicin. So as one looks at the problem, we see at this point in time that we have got enough drugs or access to enough drugs to deal with this situation.

Mr. BROWN. Okay. I appreciate that. Let me shift for a moment. The administration has proposed spending $300 million for State and local public health preparedness. State health departments have told us that they need $250 million just for anthrax, you know, worried well, whatever, preparedness.

The Wall Street Journal had an article today. Senator Sam Nunn called for a new marshal plan separately. A bioterrorism expert at Dr. Henderson's Johns Hopkins calculated America needs to invest $30 billion to properly protect itself from these dangers. I mean, I don't know if it is $30 billion. Who knows? But is $300 million—and not just bioterrorism, but some diseases like tuberculosis have little to do with bioterrorism. Tuberculosis, which killed 5,500 people in the world on September 11, 5,500 on September 12, 5,500 on September 13, and every day since, is $300 million enough? Isn't the administration trying to do this on the cheap?

Mr. THOMPSON. The answer would be no, if that is all that was going to take place. But the administration is asking for $300 million now, Congressman, plus an additional $100 million for local and State public health efforts in the appropriation bill for fiscal year 2002, which is $400 million to be spent this year, in fiscal year 2002.

That is not the total story. We are going to have to come back, and we are going to have to get more money for fiscal year 2003 if we really want to do a job to strengthen and make the local and State public health departments as effective as I know you want to and as I want to and America. We are going to have to invest more money in the future. But for fiscal year 2002, we think the $400 million, including the appropriation bill, is an excellent start.

Mr. BROWN. One more brief——

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. BROWN. [continuing] question. Dr. Koplan, could you——

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. BROWN. I will ask——

Mr. BILIRAKIS. Do it quick.

Mr. BROWN. [continuing] real quick. How do you envision a national antibiotic resistance surveillance network, Dr. Koplan?

Mr. THOMPSON. My God, a quick——

Mr. BROWN. That was a quick question. The answer is going to be pretty long.

Mr. THOMPSON. Quick question, but not a quick answer.

Mr. BROWN. And I can do that in writing, Mr. Chairman. I will——

Mr. BILIRAKIS. Why don't we do that. Thank you. Appreciate that.

Mr. BROWN. Thank you.

Mr. BILIRAKIS. Mr. Greenwood, to inquire.

Mr. GREENWOOD. Thank you, Mr. Chairman. And thank you, Mr. Secretary, for your service to the country at this time. It is—we are very fortunate to have you at the helm at these very trying times, and it is an extraordinary thing—process for the country to go through this process of trying to contemplate every imaginable vul-

nerability against an enemy that is—whose intentions and whose capabilities are very difficult to decipher.

But it is probably a good process. I think the country will be safer in its health infrastructure and every other part of our infrastructure for decades to come as a result of this complicated process.

The vulnerability that I want to ask you about has to do with how we protect some of our medicine, critical medicines. Now, I know that—I am informed that the National Guard is protecting the facility where anthrax vaccine will be manufactured. Am I—is that correct?

Mr. THOMPSON. The National Guard, they are what? I am not sure they are there today, but they were——

Mr. GREENWOOD. But they will be. That is the intention. Okay.

Mr. THOMPSON. They were there. I don't know if they still are, Congressman.

Mr. GREENWOOD. Okay. Okay.

Mr. THOMPSON. I know the security at Bioport has been increased considerably.

Mr. GREENWOOD. Okay. I am interested in the security at the facility where the smallpox vaccine is stored. And I would like to discuss that with you. I have studied it. I have met with the people in charge of it, and I think we need to strengthen it. And I think we need to strengthen it with either National Guard personnel and/or regular military personnel.

I don't think that that needs to be a permanent situation. But I do think it is of immediate concern, and I would like to have either one of you, any one of you, respond to—and I hope in the next few minutes make a commitment to me that we will do something in one of those ways.

Mr. THOMPSON. Thank you so very much for your comments. Dr. Henderson is going to be back this afternoon to talk to some of you in private about the smallpox, but right now I would ask Dr. Koplan to respond.

Mr. KOPLAN. Thank you. Mr. Greenwood, we are—we currently have security forces, people there. We are negotiating with the company as we speak as to how that will transit and take place over a longer period of time. But we will share all of that information with you.

Mr. GREENWOOD. Okay. Well, for the record, and as I said I have met with the security folks, and I have discussed their capabilities and I know about these negotiations, but I am persuaded that what we need there for the immediate future is well-armed and well-trained military personnel. It is just—I think it is a prudent thing to do. I don't think it needs to be a massive force, but I think it needs to be done and done well.

Let me, while I have some time left, talk to the question about liability protection for vaccine manufacturers. The administration has asserted that it has authority to provide liability protection under an Executive Order that is more than 40 years old. And the vaccine manufacturers tell us that they don't think there is enough protection there, that there is discretionary authority within the Executive Order, that it is limited to activities that are "unusually

hazardous"—that is a quote—or "nuclear in nature." And it may require the manufacturer to exhaust insurance coverage first.

If we are going to suddenly require vaccination of a large percentage of the population as a result of a potential smallpox breakout, for instance, there are going to be some adverse consequences. We know that the statistics tell us that. Should we—what is your recommendation in this regard? And do you need additional—do you think we need additional legislation to enhance and update and modernize the Executive Order?

Mr. THOMPSON. I don't think it would hurt, Congressman Greenwood. But right now we are in the process of, as you know, negotiating with several companies dealing with the smallpox vaccine. And this is going to be part of the negotiations that will be ongoing over the course of the next several days.

So I don't think the legislation would be able to get passed in time to have an impact whatsoever on the smallpox vaccine. We are going to have to move ahead with that, and we think the Executive Order gives us enough authority and flexibility to negotiate that with the company or companies.

But future legislation, I certainly don't think it would be harmful because I believe the Executive Order law was passed in the 1950's. And I think any time that a law has been passed that long ago there is no harm in——

Mr. GREENWOOD. Well, I think it was—it is not even statutory. It is an Executive Order that is 40 years old.

Mr. THOMPSON. Right.

Mr. GREENWOOD. My time has expired.

Mr. BILIRAKIS. I thank the gentleman. Ms. DeGette, to inquire.

Ms. DEGETTE. Thank you, Mr. Chairman. And I want to thank my colleagues on the Democratic side for allowing me to question before they did.

Mr. Towns—we are all really stretched in this time, and Mr. Towns asked me if I would sub in for him at a hearing at 1 on cyber security as ranking member on Consumer Protection. So we are all running around, and I do want to thank my colleagues for their comity.

Secretary Thompson, I have a couple of questions for you about an issue that we haven't talked about too much this afternoon. That issue is drug reimportation. And I assume that you know about the Oversight Subcommittee's investigation of the adulterated, misbranded, and counterfeit drugs that are entering our market and on which our subcommittee had a hearing on June 7th. Are you aware of that issue and those hearings?

Mr. THOMPSON. Yes, I am somewhat. I don't know how detailed you want to get into——

Ms. DEGETTE. Well, one thing we talked about, which I am sure you are aware of, because there is a recent report about that there are shipments now reaching the incredible level of 2 million entries into this country per year. A lot of these are very dangerous counterfeit drugs, or substances that we don't even know what they are. Are you aware of that?

Mr. THOMPSON. Yes, I am.

Ms. DEGETTE. And are you also aware that you and your agency have the authority to stop those dangerous drugs from coming into this country?

Mr. THOMPSON. I think FDA has attempted to do so, Congresswoman.

Ms. DEGETTE. FDA has implemented a rule stopping the reimportation?

Mr. THOMPSON. They are working on it, I know. I don't know if——

Ms. DEGETTE. Okay. Well——

Mr. THOMPSON. They are working. I don't know if it has been implemented yet. I can check that out and get back to you.

Ms. DEGETTE. Right. I mean, let me update you. On June 7th, Mr. Hubbard, who is an FDA Commissioner, he was the witness, and he told us that the FDA had recommended to you—that Mr. Hubbard had recommended to you verbally and in writing that these shipments be stopped. And then Mr. Greenwood, who is the chairman of that subcommittee, asked for a public response within 60 days. And we have not heard anything formal.

We did get a memo that was written recommending the halting of these imports. Are you aware of that?

Mr. THOMPSON. I am aware of the fact that they have submitted a plan and it is under review.

Ms. DEGETTE. Okay. What is the time table for implementation of that plan?

Mr. THOMPSON. I would say hopefully very soon.

Ms. DEGETTE. All right. Well, the thing that we are concerned about, obviously, you did order a halt of shipments claiming to be Cipro, because you suspected that unscrupulous exporters might be shipping in counterfeits of Cipro in light of the recent anthrax attacks. Did you not order stopping those drugs?

Mr. THOMPSON. I didn't order that. FDA did that on their own.

Ms. DEGETTE. FDA did. Okay. So were you also concerned that the terrorists might use the internet to advertise cheap Cipro and then try to poison Americans by importing substances that really were not Cipro?

Mr. THOMPSON. That is why FDA took the action they did.

Ms. DEGETTE. Now, it seems to me that if we are concerned about importation of counterfeit drugs purporting to be Cipro that aren't, that either are nothing or, worse, poison, we should be concerned about all imports of drugs of that nature.

Mr. THOMPSON. We are.

Ms. DEGETTE. You are.

Mr. THOMPSON. Very much so.

Ms. DEGETTE. Okay. In that case, it seems to me, with all due respect, Mr. Secretary, we should put implementation of the FDA policy that we talked about back in June on a fast track for implementation. Would you agree?

Mr. THOMPSON. It is on a fast track, Congresswoman.

Ms. DEGETTE. Okay. What kind of timeframe are we talking about, then?

Mr. THOMPSON. I can get back to you this afternoon or tomorrow exactly the time level, but I can assure you——

Ms. DEGETTE. I would appreciate that. And I am not—I am quite concerned that——

Mr. THOMPSON. I understand that.

Ms. DEGETTE. [continuing] we had folks from our subcommittee who went out to Dulles Airport and saw large piles of substances that the FDA could not even identify what they were. And the concern, of course, is if terrorist groups from Iraq or Russia or other countries wanted to send in these shipments under the guise that they were legitimate medications, that this could be a real threat to the health of our American citizens.

Mr. THOMPSON. Thank you very much.

Ms. DEGETTE. Would you agree with that?

Mr. THOMPSON. I agree with you.

Ms. DEGETTE. Great. So perhaps we can work, then, with your office to find a deadline under which these rules could be implemented.

Mr. THOMPSON. You can work with my office. You can work with FDA. And we will get back to you relatively quickly.

Ms. DEGETTE. This afternoon, I would love to get some timeframe from the FDA as to when we are going to implement the recommendation. Thank you very much, and I yield back the balance of my time.

Chairman TAUZIN. I thank the gentlelady.

Mr. THOMPSON. I personally won't be able to get back to you this afternoon. I am going to be on Capitol Hill. But I will have somebody——

Ms. DEGETTE. That is fine.

Mr. THOMPSON. Okay.

Ms. DEGETTE. Thank you, Mr. Secretary.

Chairman TAUZIN. I thank the gentlelady. The Chair recognizes the vice chairman of the full committee, the gentleman from Carolina, Mr. Burr.

Mr. BURR. Thank you, Mr. Chairman.

Mr. Secretary, before I ask questions, I want to thank you. For the past several weeks, you have made many members of your staff, as well as the White House staff, available to us as we have tried to craft the bioterrorism legislation. It could not have been done, and we couldn't complete it without the help of folks from HHS and from the White House, as the Senate has found out as they have gone through it as well. And my hope is that we will be in a position very shortly to introduce that legislation.

Dr. Koplan, let me cover something that I know——

Mr. THOMPSON. First, thank you for your comments.

Mr. BURR. Thank you. You spoke about—to us in Atlanta, which I think Ms. Harmon and I found shocking at the time, was that a third of our public health entities were not technologically connected to the CDC. What challenge does that cause to the Centers for Disease Control in our ability to respond to potential threats and alerts?

Mr. KOPLAN. Thank you, Mr. Burr, and thank you for visiting us recently. Communication, as has been discussed many times, is a key part of public health responsiveness. And whether it is food safety or a flu outbreak or a bioterrorist event, the ability of people who know something about that event, whether it is the first cases

or a response to those cases or the fact there are other cases elsewhere, need to share that information, so that a county and a State needs to share it with other counties in that State.

That State needs to share it with the other States around, and then they need to get information back from whether it is a Federal level or a State level. And so that is why that communication network—and, indeed, some redundancy to that communication network—is important. And it is important for us to have all of our local and State health departments—we have all of our State health departments, but all of the local health departments within that jurisdiction linked up together and communicating and do so easily and securely and on a regular basis.

Mr. BURR. As this committee has learned in the past several months as we have looked at bioterrorism and the attacks of the 11, we have also learned a lot about the health care data bases that exist within the country today. In most cases, those data bases within private entities that maintain and manage that data base for certain purposes, how do you see the potential use of those private data bases by the CDC, by the State health—public health entities? And could we, if we technologically connected all of the local public health entities, could we plug them into that data base as well?

Mr. KOPLAN. I think those are very good points and ones that we see bits and pieces of that taking place in some parts of the country. An example would be some of the surveillance activities that have been going on in New York and in the Washington metro area in regards to the anthrax attacks have included something we call symptom surveillance where we are looking at clusters of symptoms and getting information it. And that includes many private hospitals, public hospitals out collecting the information together.

We are right now talking to a number of health care companies, managed care plans, health systems, to see whether some of that data that they have might be used in a way that would be helpful for the type of surveillance you are talking about—laboratory data from companies that just do laboratory work. So I think it pays to both think outside the box and think creatively, how can we use some of this other information that is out there toward these ends?

Mr. BURR. Do you see some of that data potentially being useful in identifying a potential biologic attack?

Mr. KOPLAN. Absolutely. An example would be—and when we look at these clusters of symptoms, the earliest evidence of an attack might be an unusual increase in persons with rash or fever. It might be an unusual increase in certain pneumonia-like entities which then, when inspected, one finds is a bioterrorist attack. So these can be very important.

Mr. BURR. And with the passage of HIPAA, we limit the zip code amount that these private entities can cover. But if they were to contract with a Federal agency, like CDC, we can actually include the entire nine-digit zip, then, because there is a provision in HIPAA that allows us to get around that. Which means that if you did have a release we could potentially narrow it down to a city block within a given town. Is that correct?

Mr. KOPLAN. I am not sure on that particular item. But our goal is certainly to identify a locality in as fine an area as we can, and usually within a household when we can do that.

Mr. BURR. Mr. Secretary, there has been much focus on bioterrorism since September 11, and I think sometimes people forget there are other real and maybe even more likely threats, including chemical attacks or radiological attacks. Is everything that the House and the Senate is working on at least structurally in place that we could also handle chemical and biologics, or should we put more concentration on chemical——

Chairman TAUZIN. The gentleman's time has expired, but the panel would be pleased to answer.

Mr. THOMPSON. I certainly think, Congressman, that we should be beefing up our responses in chemical and radiological. And the President's bill has an additional $47 million in it. The Senate proposal also has something, but I know that you are also working on that. And I don't think that you are off the mark. I think, in fact, you are right on the mark in regards to that. I am sometimes more concerned about those things happening than I am the biological.

Mr. BURR. Thank you very much.

Chairman TAUZIN. I thank the gentleman. The two people I want to thank before I recognize Mr. Deutsch—one of them is the gentleman who just preceded me, Mr. Burr. The committee is working on two paths, as you know, Mr. Secretary. One of them is this path——

Mr. THOMPSON. Yes.

Chairman TAUZIN. [continuing] the path of bioterrorism legislation that we are trying to resolve in a bipartisan fashion and hopefully file very soon. The second is the work of the Oversight and Investigations Subcommittee in terms of very privately, in closed hearings, examining such issues as sensitive security issues and other issues.

I want to thank on a second level, Mr. Koplan, and yourself, for assisting us in understanding those separate issues as we work through the legislative path as well.

Mr. THOMPSON. Thank you, Mr. Chairman.

Chairman TAUZIN. The Chair is pleased to recognize Mr. Deutsch for a round of questions.

Mr. DEUTSCH. Thank you, Mr. Chairman.

Dr. Henderson, if you can, in a relatively compressed time, give us a sense of what the destruction or the potential destruction of America would be of, let us say, five self-induced people getting—giving themselves smallpox and purposely trying to infect the United States of America, if that were to happen tomorrow.

Mr. HENDERSON. Well, I think if I may suggest the likelihood of, let us say, people being infected with smallpox and then wandering the country is I think a scenario that has appeared in a number of publications. It seems a little unlikely to us, very unlikely to us. What happens with smallpox, there is an infection of the individual, and then for 10 to 12 days he will feel perfectly well, and he can't spread the disease at all during this time.

Mr. DEUTSCH. Right. Until you are infected—or until you actually show symptoms.

Mr. HENDERSON. And not only that, he has to have fever for two or 3 days, and then begins to develop a rash. It is only when the rash begins that he is able to transmit the disease.

Mr. DEUTSCH. Right.

Mr. HENDERSON. And at the time the rash develops the individual is really pretty darn sick.

Mr. DEUTSCH. Right. Again—and I only have 5 minutes, so I am going to just——

Mr. HENDERSON. Okay.

Mr. DEUTSCH. [continuing] try to dialog a little bit with you, because I want to get to Secretary Thompson specifically. I understand exactly what you are saying. I have read extensively what you have written as well.

So we are relying upon the security of tens of millions, potentially even 100 million Americans, on the fact that people who we have already seen are suicidal are not willing to get up when they are sick, and for that matter put makeup on, for that matter, to cover smallpox and go on a plane and try to infect 100 people on a plane, 200 people on a plane. Is that our line of defense?

Mr. HENDERSON. Well, it could be done. And could we do something about it? Yes, I think we could. I think we could move fairly quickly to——

Mr. DEUTSCH. And how would we move fairly quickly, since we only have 15 million vaccines?

Mr. HENDERSON. Well, it is not 15. As the Secretary said, I think the dilution of the vaccine by fivefold is there.

Mr. DEUTSCH. But we haven't done it. Is that correct?

Mr. HENDERSON. The vaccine sits in a vial, and it is dried. And it depends on how much diluent you put in as to whether you dilute it five-fold.

Mr. DEUTSCH. Dr. Henderson, I guess the point—and I think it is serious enough—that, in fact, if there were five suicidal people today who wanted to inflict catastrophic damage on the United States of America, they could do it. And we are talking about not thousands or even ten thousand lives, but literally millions of lives. Do you think that is an accurate statement?

Mr. HENDERSON. With all due respect, I do believe that with—that we could respond quickly enough and with the vaccine we have to head that off with——

Chairman TAUZIN. Excuse me, sir. Whoever has the phone ringing, would you please—is it out of the room now?

Mr. DEUTSCH. Dr. Henderson, let me just ask you one question. And I can say it on a—I hate to personalize questions. But if you were advising your family, if there was one outbreak of smallpox tomorrow in America, what would you advise them to do?

Mr. HENDERSON. I wouldn't advise them to be vaccinated at that point.

Mr. DEUTSCH. I know that. But what would you advise them to do?

Mr. HENDERSON. If there is an outbreak of smallpox——

Mr. DEUTSCH. One smallpox case in America tomorrow. What would you advise your family to do?

Mr. HENDERSON. I don't think I would have any particular advice to offer them.

Mr. DEUTSCH. I tell you what I would, I would say, "Stay in your home until you get vaccinated." And if that means a year, if that means 2 years, if that means 3 years, literally that would be the advice that I would give my family, my children, my wife, and anyone who is listening to me. And I think as you are shaking your head, that would probably be the same advice that you would give as well.

Mr. HENDERSON. Let me just suggest, we have had a lot of experience with smallpox and its ability to spread in a great many countries. And it does not spread like influenza. I think many people think of it spreading like a wildfire across the country. It is not going to do that. With smallpox——

Mr. DEUTSCH. But our experience is with cases, not with terrorists. And, again, the last case in the United States in New York was a case that was controlled with hundreds of thousands of vaccines, I guess in the 1940's. But that was a case of, again, a person, not a terrorist.

Secretary Thompson, if I can follow up, when do you expect to have a signed contract from one of the three drug companies you are negotiating with?

Mr. THOMPSON. I hope, Congressman, that we will be able to have a contract negotiated, I don't know if it will be signed, by right after Thanksgiving.

Mr. DEUTSCH. So not until after Thanksgiving is the date that you are telling us at this point. And that is negotiated, not signed.

Mr. THOMPSON. Well, I don't know if we can get it signed or not by that time.

Mr. DEUTSCH. When are we going to have a contract to produce the 300 million or the 250 million vaccines that you have said and you acknowledge that are necessary to have on the stockpile for the United States of America?

Mr. THOMPSON. Congressman, I also would like to point out that when we started a couple of months ago, there was not supposed to be any smallpox delivered until 2005. And we have accelerated that, and we should be able to have the 300 million next year. We are working. We are moving faster. Dr. Tony Fauci has said, and I quote him, that there has never been a contract that has moved as rapidly in Department of Health and Human Services in the 30 years that he has been there.

Mr. DEUTSCH. Okay.

Mr. THOMPSON. We are working almost around the clock in order to get it done.

Mr. DEUTSCH. Mr. Secretary, can I just—and, again, and the last sort of two things, can you say with very near certainty that a contract will be signed that will allow for the development of approximately 300 million doses of vaccine within the next 12-month period?

Mr. THOMPSON. If we can reach an agreement, yes.

Mr. DEUTSCH. So you can't say with certainty that this is going to happen.

Mr. THOMPSON. I can say with all probability we will have a contract negotiated next week.

Mr. DEUTSCH. You know, if I can just close in 10 seconds to say that what we have just described is the potentiality of tens of mil-

lions of deaths, which is not an unhypothetical reality. We have talked about—and Dr. Henderson directly talked about a vial of smallpox being the size of less than a thumb.

Mr. THOMPSON. I understand that.

Mr. DEUTSCH. Okay. We have just gone through a scenario that could kill tens of millions of Americans, with hundreds of billions of dollars, trillions of dollars of damage, and yet this is the attitude that we have. I, you know, again talk about that. I think we are totally missing the boat. I mean, and, again, I know you——

Chairman TAUZIN. The gentleman's time has expired. Would the gentleman kindly——

Mr. THOMPSON. If I could just quickly respond. You don't realize how hard we are working to get this thing done and how far we have accelerated this. There has never been a contract like this in over 30 years in the Department. In fact, in the history of the Department, no contract has moved as rapidly as the smallpox. No acceleration, no—we have got people from all the agencies have come in for seven straight days to work this thing out. It is a very complex thing.

I agree with you, it is a serious thing. And we want to be able to respond. We want to get those 300 million. But I want to tell you, we are not letting any stone unturned to get it done as expeditiously and as correctly and as safely as we possibly can.

Mr. DEUTSCH. And I——

Chairman TAUZIN. The gentleman's time has expired. I have got to honor the rules of the committee. The gentleman, Mr. Whitfield, is recognized for 3 minutes, for 5 minutes rather. Excuse me.

Mr. WHITFIELD. Thanks, Mr. Chairman. I am glad you didn't cut me to 3 minutes, since I didn't make an opening statement to help out on time.

Mr. Secretary, I also want to welcome you to this committee, and want to commend you and the Department for the good work that you are doing in trying to expedite the availability of these vaccines. And I know that it is a difficult issue.

One question that I wanted to ask is that the Vaccine Injury Compensation Program, which is administered by HHS and, I understand, the Department of Justice, has generally benefited the national immunization policy of the U.S. And I was just curious, do you believe that there should be a similar program designed to compensate someone who has an adverse reaction to a vaccine or a countermeasure administered in response to a bioterrorism attack?

Mr. THOMPSON. Congressman, off the cuff, I would have to say yes.

Mr. WHITFIELD. Yes.

Mr. THOMPSON. But I haven't dwelled on that, and I haven't given it much consideration as of this point in time. And I certainly think that you are raising a very valid question.

Mr. WHITFIELD. I would just ask, Dr. Henderson, if, say, 1,000 people were given a smallpox vaccine, what has been the experience in the adverse reaction? What percent of people would have an adverse reaction? Or do you know?

Mr. HENDERSON. How we define an adverse reaction is let us say an adverse reaction can be very mild, and that does not require——

Mr. WHITFIELD. Well, what about death?

Mr. HENDERSON. [continuing] anything like hospitalization.

Mr. WHITFIELD. What about death?

Mr. HENDERSON. If you are looking at 1,000 people, you are probably looking at something like three or four at the most adverse reactions.

Mr. WHITFIELD. Okay. All right.

Mr. HENDERSON. Not something that would put the people in the hospital. But we must bear in mind that we do have—we would expect a death rate of perhaps 3 or 4 persons per million vaccinated.

Mr. WHITFIELD. Right.

Mr. HENDERSON. Now that doesn't seem like very many, but I would say from the standpoint of the public reaction to this, we have had a major reaction against one paralytic case of polio per 3 million vaccinations. And so there is a perception out there and a problem of how much risk do you take with a vaccine like this versus what is the risk of the disease?

Mr. WHITFIELD. Right. And does Russia, at this time, have a smallpox vaccine that—in large quantities or——

Mr. HENDERSON. We do not know what Russia has with regard to quantities of vaccine. The question has been asked, but the government has failed to respond.

Mr. WHITFIELD. Okay.

Mr. HENDERSON. There is a belief that they don't have very much, if they have any reserve at all. But it is not very much, so far as we know.

Mr. WHITFIELD. Okay. Mr. Secretary, any time we talk about bioterrorism and the events that have happened on September 11 and since, we have this balancing act between privacy and constitutional protection of freedoms versus trying to protect the public.

And when we talk about food safety, I think that definitely becomes an issue, and I know that you have asked for additional authority for FDA to help deal with this problem, to detect adulterated food, and so forth. In the bill that the committee is coming forth with, there is a directive in there that the Secretary take precautions that records of proprietary information, formulas, so forth, are not inappropriately released, which I know that you would not want to happen anyway.

I mean, your goal is to protect the public, and that is what our goal is. But you would not be opposed to that sort of provision in our bill, would you? I don't think it was specifically listed in your bill. And would you consider even putting language like that, say, in the regulations?

Mr. THOMPSON. I don't have any difficulty with that. I would like to see the language, Congressman.

Mr. WHITFIELD. Right.

Mr. THOMPSON. And work with you on the language.

Mr. WHITFIELD. Okay. Okay. Well, on this Section 319, emergency authority that you have, it is my understanding that you—have you already used that on one occasion?

Mr. THOMPSON. Yes, I have.

Mr. WHITFIELD. I am not sure I know what the background of that was. Could you just briefly tell me?

Mr. THOMPSON. I used it immediately after the airplanes went into the World Trade Center Towers, North and South. And we decided that it was very necessary in order to move all of the pharmaceutical drugs, the push packages, and so on, to declare an emergency. We are still operating under that public health emergency given the authority under Chapter 319.

Mr. WHITFIELD. Okay.

Mr. THOMPSON. And it is still in existence, and we have used it very effectively in being able to get everybody alerted to the difficulties. It was also helpful with CDC alerting all of the State and local health departments—the fact that there is an emergency. We also feel because of the anthrax that it is important to keep the public health awareness emergency in front of us.

Mr. WHITFIELD. And you are asking that that be expanded in some ways, is that correct, the 319 authority?

Mr. THOMPSON. No. We are satisfied with it.

Mr. WHITFIELD. Okay. You are satisfied. Okay.

Chairman TAUZIN. The gentleman's time has expired. The Chair thanks the gentleman, and the Chair would recognize—who is next, Mr. Sawyer? Ms. Eshoo? The gentlelady from California, Ms. Eshoo, is recognized for 5 minutes.

Ms. ESHOO. Thank you, Mr. Chairman, again, for having this hearing. And to our guests, thank you for your patience in listening to all of the opening statements and your fortitude in answering the questions.

I want to bring up three points, one about smallpox; one to you, Mr. Secretary, about the UPL, which may seem like a side bar issue, but it has everything to do with so many of the things that you have presented today, where we strengthened our public health system, the foundation that it sits on, and what we have done in California and how we believe we need to protect that; and a few words about food safety.

Let me start out with the issue of smallpox. It is my understanding—and because I have read about it and heard about this—and this is to you, to both of the doctors—about the effort to build, obviously, a smallpox vaccine stockpile. What I would like to know is if the CDC and the Department are looking into medical treatments for smallpox other than vaccines.

I am aware of cidofovir—excuse me if I am not pronouncing it correctly—which has demonstrated promise in treating smallpox. There is the before and there is the after. This really deals with the after case. And I understand that the CDC and the DOD are in the process of acquiring this drug for Federal employees who work with smallpox.

So what I would like to know is, what are the steps that the CDC is taking to add promising alternative treatments, such as this—the one that I mentioned to our national pharmaceutical stockpile?

And I also understand that in testimony, as they say over in the other body, that Dr. Fauci spoke to this as well. So could you comment on that?

Let me get just my questions out, and then—I don't think the chairman is going to cut any of you off, but he will cut me off.

So, you know, when you hang around here long enough, you get to know the unwritten rules of the road.

The other——

Chairman TAUZIN. You have learned well, I want to tell you.

Ms. ESHOO. Just at the foot of a master, Mr. Chairman.

On the UPL, the upper payment limit, Mr. Secretary, you know the case very well. I think that we have an issue, or you may have an issue, with obviously—and we all should—wherever there is any kind of abuse or waste or misuse, misplacement of Federal dollars.

But I am pleading with you, pleading with you, to recognize that California and any other State that has followed the rules of the road should not be made to bear the burden of any kind of misuse or abuse by any other State or its lack of systems. There is a post-September 11 case to be made here, and I don't want to wrap those words around the case simply to heighten it. I think it is just a pragmatic reality.

So I don't know when this proposed rule is going to come out, but we need you to be an advocate for us. I think that your voice would really count. If you want to say something about it, I would welcome it.

And on the issue of food safety, you know, we are considering things today that have been floating around the Congress for a while. I introduced a food safety bill not to penalize countries that want to trade with us, but, rather, to protect the American people, what they put on the kitchen table.

Mr. Secretary, you have a woefully inadequate workforce to deal with this. You have got to get the money in order to overhaul the system and to have the highest level of people that are in charge of it. I would refer your staff back to testimony that was given in the Senate in the last Congress. This system has even been corrupted.

There was a witness there of—one of the food inspectors that was—his trial—he had already been adjudicated. He was going off to jail. But he was giving—he gave testimony as to where all of the cracks were and what was going on. We have to do much better in this country, and not just the pre-September 11, but upgrade it that much more. This is part of the army on this issue and part of the war on it.

So I look forward to your telling me about it. Can you get to the smallpox issue and comment about UPL? And are you going to go for more? You don't have enough money to do the wonderful things that you have talked about today, with all due respect. I don't think you have the resources. But who wants to start, and who wants to answer?

Mr. KOPLAN. Thank you.

Chairman TAUZIN. The gentlelady's time has expired, but——

Ms. ESHOO. See, I told you. I told you. All right.

Chairman TAUZIN. But if one of you would like to respond. Dr. Koplan?

Mr. KOPLAN. I will respond to that briefly. On the issue of antimicrobials for smallpox.

Congresswoman, I began my public health career testing a reputed agent against smallpox, and that is where I first met Dr. Henderson in Bangladesh in 1973. An issue with testing

antimicrobials for smallpox is—frequently you will find things that look like they work in a laboratory, but don't work in patients, when you go to put them, as with many other medications.

In the last several months, as Dr. Henderson indicated, we have been working with DoD and others looking at potential antimicrobial agents against smallpox, and also trying to improve diagnostic tests.

And there are promising agents there, and we will be pursuing them, but I think that the mainstay of our defense is a very effective vaccine, and we shouldn't hold out any great hopes, or make any large investment I don't think, in agents for treatment.

Ms. ESHOO. Thank you.

Mr. THOMPSON. Congresswoman, in regards to upper payment limits, I think you should talk to OMB.

Ms. ESHOO. No, I want you to. I want you to be our advocate.

Mr. THOMPSON. I have.

Ms. ESHOO. I understand that you have a problem, and we are going to solve it.

Mr. THOMPSON. Second, in regards to food safety, I have only been here for 8 months, but I immediately have recognized an immediate problem with food safety. I can agree with you, and I am passionate about it, that we need to do more.

We are doing a woefully inadequate job, and I have testified in front of this committee before. I thanked the Congressman, the chairman, and I thank you, and everybody else who wants to upgrade the food safety system in America. It needs to be done.

And 372,000 people got sick last year, and those are just the ones that came in and said that I have got food poisoning. You know, 20,000 ended up in the hospital, and 5,000 died. I mean, that is——

Ms. ESHOO. That is not acceptable.

Chairman TAUZIN. I thank the gentleman. I was one of those that did not report to you in, but I had a bad case of it. The Chair recognizes the gentleman from Iowa, Mr. Ganske——

Mr. THOMPSON. There is no food poisoning in Louisiana, Mr. Chairman.

Chairman TAUZIN. They have it in Florida actually. The gentleman, Mr. Ganske, is recognized for 5 minutes.

Mr. GANSKE. No food poisoning from any of that Canjun food anyway, just good food. Mr. Secretary, I thank you for coming. I know how busy you have been, and how hard you and our department has been working, night and day basically, with an unprecedented situation.

And I also wanted to thank you and the administration for working hand-in-hand with Senator Frist and with Senator Kennedy on their bill, as well as with our committee. I know that you have been putting in a lot of time in consultation with them on their bill.

Just a little while ago, Senator Frist, probably the leading authority in the Senate on this issue of bioterrorism said, "Their bill," which is a bill that I and Congressman Marion Berry will introduce this afternoon as a companion bill, "authorizes approximately $3.2 billion in fiscal year 2002, and it includes the administration's priorities."

Senator Frist went on to say that the "$3.2 billion in funding in this bill takes us from an unprepared to a prepared state. We believe that this is the money that we need to do this job."

And then both Senator Frist and Senator Kennedy said that they have worked closely with you, appreciate that, and appreciate the input from President Bush on this, and that, "We expect to have administration support of our bill."

So I have a proposal. Unfortunately, we have seen some gridlock on Capitol Hill on the economic stimulus package. I am told that as I am speaking we are having a conference meeting on aviation security and so maybe something is happening in that regard. I hope so. We have seen some gridlock on that.

But this issue of bioterrorism I think we should get past a gridlocked situation, and so I would propose that the President endorse the Frist-Kennedy bill today if possible. Thanksgiving is coming up. Many items in this bill are going to take some time for you to implement.

There are really good provisions that relate to food safety, and earlier I had mentioned Senator Hagel, and I know Senator Pat Roberts has had a great deal of input into those food safety provisions. There are things in this bill, Mr. Secretary, that I think would help you do your job as Secretary.

Mr. THOMPSON. It would.

Mr. GANSKE. And help coordinate the other Departments—for instance, Defense, the USDA—in order to have a coordinated approach. This is a well thought out bill, and I fear that sometimes we end up with fingerpointing between the House and the Senate.

And this is one issue that I think we can move on, because I don't see anything in this bill that is as contentious as, for instance, "the Federalization" of security screeners.

I think really what we are talking about are some funding levels.

And one thing that I wanted to ask you about, because you are a former Governor, but one of the advantages of what I see of the Frist-Kennedy bill is that it does provide some support to the States and the localities for the public health.

You as a former Governor know that the States are really strapped right now, their public health departments in particular, and I think they need that help. And I wondered if you would make a comment on that particular item.

Mr. THOMPSON. Let me just start out, Congressman Ganske, by thanking you, thanking you for your passion, and for public health, and strengthening public health in America. It needs to be done.

And I also want to thank Senators Frist and Kennedy, because you and the chairman, and Senators Kennedy and Frist have worked very closely with the Department and with the administration to try and develop a really strong viable public health bill for America.

The question is whether or not we need to do the full $3.2 billion immediately, or whether or not it can be spread over several years. The administration feels that we have to live within the $40 billion cap, and we certainly are complying with that.

And we also recognize the importance, however, of continuing to build on our public health system and come back next year with another part of the funding necessary to make that doable.

The programs that are outlined in the Kennedy-Frist-Ganske bill, as well as Chairman Tauzin's mark, are very much in line with what the administration wants. And in regards to block grants, you know me.

I was the No. 1 Governor that was sort of a pain, because I always talked about block granting everything to the States, and there is no question that block grants would be very helpful to the States.

My only proviso in the block granting, and please spare me this little bit since I have been out here, to deviate a little bit from my automatic universal support for block grants, is that I want to make sure that that money is spent for local and State public health systems.

It is so important. We have not invested the necessary resource in the last 25 years in the State public health system, and if there is going to be a good consequence of what took place of the horrific acts of September 11, it may be a renewed vigor on a bipartisan effort to come up with a strong, stable, aggressive public health system. And I am very appreciative of that effort on your part and the chairman's, and this committee's part.

Chairman TAUZIN. The gentleman's time has expired. The Chair is pleased to recognize Mr. Stupak for a round of questions for 5 minutes.

Mr. STUPAK. Thank you, Mr. Chairman. Mr. Secretary, I am pleased to hear you say that about getting it back to the local level, because we have had a number of hearings here, and thus far what we have heard in the last fiscal year is that readiness on terrorism was $8.7 billion, but only $314 million ever made it outside the Beltway.

So we have to do more to get it back to the local units of government, public health and hospitals especially, no matter where they are, in rural Northern Michigan where I am from, or Wisconsin, where you are from, of course.

So you testified earlier that you have $300 million for State and local preparedness. But what percentage is that of your total budget for preparedness?

Mr. THOMPSON. I don't know the percentage. Are you talking about the total Federal budget, or are you just talking about the $1.6 billion?

Mr. STUPAK. Okay. So of that $1.6 billion then, $300 million will go for local preparedness?

Mr. THOMPSON. That is correct.

Mr. STUPAK. Will the rest of it stay within the Beltway then?

Mr. THOMPSON. No. The rest of it is—there is $509 million for the smallpox vaccine, and there is $643 million for improving the antibiotics, the cipro and the other things dealing with anthrax and so on. So that is about $1.2 billion of the $1.6, and the 300 goes to the local and States.

Mr. STUPAK. All right. Dr. Claire Broome testified on November 1st about the NEDSS system, the National Electronic Disease Surveillance System, and quite frankly there were about three people on the panel, and she was the only one who was in favor of it.

And once again the local units of government were saying that we don't need another computer system which requires us to hire

people and put a room aside for this surveillance and infrastructure that comes with it.

They would rather not see a NEDSS system. Again, that is a lot of money, and we would rather see it back at a local level.

Mr. THOMPSON. I would like to have Dr. Koplan address that.

Mr. STUPAK. Sure.

Mr. KOPLAN. I wasn't here, but my understanding was—and we work closely, and I mean daily, hourly, with local and State health organizations and their officials, and they are very much in favor of the NEDSS. They have played a crucial role in developing it.

This provides the highways in which we put the health of our network to provide a secure up to date framework for the infrastructure for our communication. What I think the local health departments are not in favor of is having a lot of new private—new construction of these things that they would have to buy into.

The NEDSS system is one that they have contributed to. It meets their standards, and it builds on what they have already got. So I believe that at least in our regular communications with them that they are very supportive.

Mr. STUPAK. Well, when we asked the follow-up question, like it is obvious from us up here after the panel got done that there was not a lot of support for it because of the costs.

I mean, you may help with the initial costs of getting the system in place, but then that hospital or that public health agency has to hire a person, and a constant update, and get the computers, and things like this.

And quite frankly, they can't afford it. When Ms. DeGette was asking you about or explained about releasing something over Bronco Stadium up there during a Denver football game, that was the example used.

And her people from Denver were testifying that they were not in favor of the system. So I just wanted to make sure that before we start pushing new systems that, No. 1, the locals are covered for the costs; and, No. 2, they are in support of it, because on November 1st, most people were not in favor of NEDSS. That's the reason that I bring it up.

Mr. Secretary, what authority do you have to reprogram monies and things like this? Since September 11, we have had new concerns in this country called bioterrorism, and in looking at the budget—and I don't mean that this isn't a good program, but the AIDS and sexually transmitted disease has over a billion dollars in it.

But in bioterrorism, we have only about 18 or 17 percent of that budget, like $180 million. Do you have any authority, or what authority do you need to reprogram, or call it block granting within your own department, or however you want to call it, but reprogram some of that money so when needs come up we can move resources immediately within the existing framework?

Mr. THOMPSON. Thank you so very much for that question. I didn't think that I would ever get that question. I don't have very much. I have less than most departments.

And I requested this year of going from 1 percent to 3 percent, and it was not universally received, and in fact nobody but you

have ever supported that. But I think, and especially now, the Department certainly needs more flexibility.

We have to scrimp and scrap from every place we can to get Dr. Henderson on.

Mr. STUPAK. Right.

Mr. THOMPSON. And it would be nice to be able to redelegate, and to bring up with the notification of the Congress what we are doing. But we don't have very much.

Mr. STUPAK. Well, if you submit a proposal, I think many of us up here would like to help you on that.

Mr. THOMPSON. Thank you.

Chairman TAUZIN. The gentleman's time has expired. The Chair recognizes Mr. Shimkus from Illinois for 5 minutes.

Mr. SHIMKUS. Thank you, Mr. Chairman, and again it has really been enlightening, and we are glad to have you here. A question that I was asked at another hearing, and I think it was on the other side of the The Hill was did the U.S., or do we know the number of laboratories that can weaponize anthrax.

And if we don't, why don't we, and should there be a certification process, or some type of accounting for labs that have or are doing research on that type of stuff.

Mr. THOMPSON. Congressman, we don't have the authority to request that.

Mr. SHIMKUS. Would you like the authority?

Mr. THOMPSON. We are asking for it in this proposal.

Mr. SHIMKUS. Is that in the chairman's mark if you know?

Mr. THOMPSON. I hope it is. I don't know if it is. It is in the proposal that we sent up here. We have the authority as a department to set rules for the transportation of biological agents, but not the possession, or the storing or the use of them.

But we do have—I think there was a law passed in 1996 or 1998 that gave us the—'97—to give us the authority to regulate the transportation, but not the possession or use, and that just seems to me an oversight that needs to be done, especially now. CDC needs that. Do you want to address that, Joe?

Mr. SHIMKUS. I am being advised that we do have that in the chairman's mark on the bill, and so I will follow up and see what all that is.

Dr. Henderson, just a follow-up. I know that your expertise is in smallpox, but just that scenario that the Federal Government should probably have some accountability, and not just on the transportation issue, but the location of laboratories. You probably would think that would be a good idea would you not?

Mr. HENDERSON. Yes, I think it would it would. I think we have to be careful how we do it. We don't want to extend a number of organisms to an extreme range, but I think it would be good for a select number to have that.

Mr. SHIMKUS. Okay. Thank you. Mr. Secretary, I have a bill, and I am sure that I will be followed by my friend, Lois Capps, who will talk about her provisions. But you did address, and Chairman Bilirakis mentioned shortages in personnel.

We have been addressing, or I have been working on a laboratory tech shortage, which is just as great. And if we expand laboratory

facilities, and we don't have laboratory technicians, then we are not going to get the work done.

I would hope that you would help us as we move legislation and look at those provisions that help us staff up, and that would encourage people to go into those fields to help provide the needed expertise that we need in these areas.

Mr. THOMPSON. I certainly will and it needs to be done. I mean, laboratory technicians are on par with nurses as it relates to the shortage in America. And we are putting more money into the laboratories, and to security, and to expansion, which they badly need, but we need technicians also to be able to be hired. And the CDC—Jeff, did you want to add something?

Mr. KOPLAN. I would just add that I agree with you. It is hired, recruited, and retained. I think the retention of people, because it is extraordinarily expensive to provide up to date training in some new area.

And a good example is some of these agents we are concerned about here is every year or so we get some new tests and there is a new opportunity to train people. If those people then leave the lab tech field to do so something else, you start from zero again. So there needs to be an investment in keeping these people happy and doing good work in the laboratory.

Mr. SHIMKUS. And I have been real surprised about how technology has come into that field, too, and really allowed people to do more with less, but then the need is going to be greater.

Let me end up on this comment about one of the most enjoyable things about being a Member of Congress—I have only been serving now for 5 years—is my involvement with community health centers, and the fact that in Illinois there is 25.

And since I have been a member, we have gotten three in my district, and they provide a great benefit, especially those uninsured, or those underinsured. Connecting them to the health alert network and the national electronic disease surveillance system aspect is critical, and I think that is probably going to cost money with technology and stuff.

But they are on the front lines, and when I always get a chance I like to promote the community health centers, and hope that they are part of this equation of service in this era.

Mr. THOMPSON. Community health centers are absolutely vital, and the proposal that is in our fiscal year 2002 budget request, we are requesting an additional $125 million to expand them.

We would like to grow from 3,200 community health centers to 4,400 in America, and from serving 11 million people, to 20 million, and that is absolutely the front line of defense, especially for the uninsured, and especially for minorities in America. It is an investment that is badly needed, and it pays many dividends to the American taxpayer.

Chairman TAUZIN. The gentleman's time has expired. I want to associate myself, however, with the gentleman's comments. Electronically connecting those community health centers to the emergency information system is critical, Dr. Koplan, and I hope that is your goal.

Mr. KOPLAN. That is very much a goal of ours as well.

Chairman TAUZIN. Thank you very much. You should also know by the way that I think we have an agreement, Mr. Secretary, to move the community health bill out of this committee, and we are working on the final elements of it.

But I think we will be moving it out really quickly now, and I thank you. The gentleman from Ohio, Mr. Sawyer, is recognized for 5 minutes.

Mr. SAWYER. Thank you, Mr. Chairman. I just have to remark on the last item. What looks like a small number of incidents locally, when aggregated nationally, can look like an epidemic, and the ability to recognize events as they are occurring in real time is an extraordinary asset in all of this.

Mr. Secretary, you keep getting referred to as a former Governor. I suspect that if you have ever been a Governor that you are probably always a Governor, and that gives me great comfort.

I used to be a mayor of a mid-range city, a quarter of a million, in a community of a half-million, and I would like to ask you a couple of management questions. I am glad you are where you are.

I want to ask about how to get local funding to where it needs to go and give you the flexibility to react in a highly fluid environment, and to keep track of those dollars as we go. You have put together cooperative agreements in five major areas that deal with bioterrorism, and is incorporating this into a larger bioterrorism bill that gives both that capacity to flow dollars and to be accountable for them, is that the best way to take advantage of the work that has gone on so far?

Mr. THOMPSON. I really think that the best way to do it is to set up an Assistant Secretary for Bioterrorism, or health care preparedness in America, and bring all these groups together, and put them under one leader that then is accountable to the Secretary, and to the administration, and to Congress.

It seems to me that that makes a lot more sense. We really have not addressed that particular question, Congressman, and I am very happy that you are bringing it up, because it is a management question, and getting money back to the local municipal governments is usually by formula, and sometimes those formulas don't work and don't meet the necessities.

Mr. SAWYER. There is a lot of jealously involved in that, and it is not a criticism. It is just human nature.

Mr. THOMPSON. Right.

Mr. SAWYER. When you try and set up mutual assistance packs, and you have fireworks with fire, and police with police, but when you try to move across disciplines, and across jurisdictions, it becomes enormously difficult.

You can play a critical role in establishing the kind of cooperative command and control structures necessary to react quickly in the event of the kinds of occurrences that we have seen recently. I have gotten very good reports from my public health people about the role that has been played by the health alert network, and how good they have been in alerting the professionals.

I have gotten a sense from the reports of my colleagues that that has not always worked as well, in terms of public communication across the country. It has worked well some places and not well in others. Do you have any thoughts about how best we can elevate

that communication capacity with the public and not just with the professionals?

Mr. THOMPSON. What we did, Mr. Sawyer, is we probably should have done it right at the beginning. But what we are now doing is that we have daily briefings from the Department, with as many of the press people that wants to hook up.

And we usually have Dr. Koplan, or Dr. Falchiez, or the Surgeon General, and we put that out. Dr. Koplan and I have been having very regular meetings, and teleconferences with the State health departments. I think we have had three so far.

We then had a teleconference with all the State laboratories, and we had a teleconference with the Governors, and we had a teleconference with the American Medical Association, and American Hospital Association, the National Conference of State Legislative Leaders.

Mr. SAWYER. We won't hold you responsible for that one.

Mr. THOMPSON. I guess I was. but we have been doing a lot more research than we did at the beginning, and I think it has paid a lot more dividends.

Mr. SAWYER. Let me mention ne in particular. My local health director is the past president of the American Association of Public Health Directors. So it is not as though he is in a badly informed man. In fact, I think he is well informed.

But virtually every health director in my district was only marginally aware of the Center for Health Preparedness in my own State of Ohio. It seems to me that integrated training opportunities, while not immediate, represents an important long term, on going effort.

Can you talk a little bit about how we might elevate that into——

Mr. THOMPSON. I would really rather have Dr. Koplan talk about that, because this is one of his expert areas.

Chairman TAUZIN. Let me do something while Dr. Koplan does that. Mr. Secretary, we are not grounded to these seats like you are while you testify. If you would like to take a personal break while Dr. Koplan testifies at this time, we would be delighted to accommodate you.

Mr. THOMPSON. You are a gentleman and a scholar, sir. But I think I will stick it out for a couple of more minutes.

Mr. KOPLAN. I was about to say how long do you want me to talk. Ohio actually has a terrific health department. We have Dick Baird, who is the head of it, has done a great job, and in the course of just the last couple of years, once has seen a transformation of—I guess it was about 2 years ago, and we will have to check on the dates, but virtually none of the county health departments were linked electronically to the health alert network.

And today they all are and that makes a huge difference. But you have identified one of several pieces of what makes for a competent capacity for a health department. One of them is communication capabilities. One of them is training capabilities and staff.

And there is an interplay between this work force issue and training capabilities, and getting people up to date. And then there is surveillance, epidemiologic capability, and lab. And unless all of those are at a level of competence, then that local jurisdiction,

whether it is a State or a county, really is a weak link in the overall web of the system.

Now, what we are trying to do is upgrade all of those components across the country to a level where we provide safety to our neighbors about the virtue of our own competence in that. Thank you very much.

Chairman TAUZIN. The gentlelady from New Mexico is recognized for 5 minutes.

Mrs. WILSON. Thank you, Mr. Chairman, and I appreciate you staying here so long to answer questions today. Dr. Kaplan, how many Level-4 labs are there in the country that are handling the most dangerous toxins?

Mr. KOPLAN. There surely is just a couple. We have a major Level-4 laboratory, and the Army has a Level-4 laboratory, and there are other Level-3 plus laboratories that are capable of doing fair numbers of things.

Mrs. WILSON. Do we need more of them?

Mr. KOPLAN. I think there is a tradeoff. As you add more, then there is a lot of investment and energy that has to take place around a Level-4 lab to keep it going. Its design is very difficult, and the people that work in them have to take extraordinary precautions, and are at considerable risk themselves as they work in them. So there is value in having a few, but there is also a tradeoff as you add these units.

Mrs. WILSON. As you look at the expansion of laboratory capacity, which is one of the things that clearly we don't have enough of, and I think you both acknowledged that we don't have enough of, is there going to be a preference for funding efforts that they themselves integrate things like the State Epidemiologists that is trained by the CDC, and university centers, and the crime and OMI laboratories, so that you are not only pooling resources, but that brings together in the same facility the experts that in any time of crisis you want to be together?

Mr. KOPLAN. Very much so. I think that is a very good point, and we have some very good examples of it. We have a network of emerging infection laboratories that are often in academic centers, but very closely tied up with local health departments, State health departments, and the epidemiology units.

And that combination of skills is extremely helpful and effective toward early recognition of health problems, and then early control or prevention of them.

Mrs. WILSON. I am very much encouraged, and particularly as we work on this legislation, to—you know, sometimes the carrot encourages things that the carrot of Federal assistance, or matching funds, or participation, can encourage the expansion of capacity in ways that makes sense in time of crisis, which might not otherwise occur.

And I very much encourage you to explore and promote that approach, and I certainly welcome a legislative point of view. With respect to your ability to know who has these biological agents, which Mr. Secretary, you do not have that authority now and I understand that. You only deal with the transfer of them, but you don't have authority for possession, storage, and use.

Do you have that authority with respect to the transportation of materials held by other Federal agencies, or should you have that authority over Federal labs that are military, NASA, Department of Energy, laboratories, or do you only have authority over private labs, Department of Health labs, and those kinds of things? What is the extent of your authority or your potential authority, that you are looking at?

Mr. KOPLAN. The select agent laws that are currently written applies to all bodies, all laboratories, that have these agents and ship them or receive them, including Federal.

Mrs. WILSON. So you currently have authority over the military laws for that purpose?

Mr. KOPLAN. They have to register with us if they are shipping or receiving.

Mrs. WILSON. Do they comply?

Mr. KOPLAN. I would have to check and make sure, but I would think so. If we can get back to you on the details on that.

Mrs. WILSON. With respect to the ideas that you have been kicking around about registry of possession and use of storage, is it also your concept to have cultures so that you can get the genetic sequences of those materials, or just that a university would say, yes, we have anthrax or certain bacillus?

Mr. KOPLAN. I am not sure whether there are plans to get genetic breakdown of what everyone has. It would be more of a listing of what they have got. That would take a considerable investment, and some of these places have already characterized what they have in stock.

Mrs. WILSON. Do you see an advantage in having a repository of those sequences?

Mr. KOPLAN. I am not sure. I would have to think about it some more and discuss it with some other people. I think it is a complex issue. The issue of these laboratories and their contents are complex in the sense that these are living organisms, in the sense of security that comes around, and knowing that they have some there can be a false one, in the sense that those organisms can multiply, and you can have twice as much at one point or half as much at another point.

Nevertheless, there is real value as you have indicated in knowing which laboratories have which agents. A detailed sequencing of individual agents is certainly worth looking into.

Mrs. WILSON. With respect to research and development of real time monitoring and getting away from the——

Chairman TAUZIN. The gentlelady's time has expired. She can complete that question.

Mrs. WILSON. Thank you, Mr. Chairman, and this will be my last question. Mr. Chairman, I appreciate your tolerance. Q-tips, and cultures, and moving beyond that to real time monitoring, is there an effort, an interagency effort in the Federal Government to identify technologies developed in other agencies for other purposes to apply to this problem very rapidly, and test and deploy those?

Mr. THOMPSON. It has not been very good in the past, but since September 11 it has gotten much better.

Mrs. WILSON. Thank you, Mr. Chairman.

Chairman TAUZIN. I thank the gentlelady. The gentleman from New York, Mr. Engel, is recognized for 5 minutes.

Mr. ENGEL. Thank you, Mr. Chairman. Gentlemen, I want to read a story that appeared in today's New York Post, and I would like you to comment on it. It says, "Deadly Nerve Gas is a Phone Call Away."

"For $130 almost anyone can order the chemicals needed to develop deadly nerve gases a prominent chemist warns. If you want to do it, you could just do it, Rice University organic chemist, James Tour, told The Post."

"After a Defense Department analyst tried to downplay the problem to him last year, Tour said he was able to order enough chemicals to make nearly 300 grams of serine, the nerve gas used in attacks on Japan's subway system in 1995. It killed 12 people."

"Tour said that is enough serine to kill 7,500 people in a crowded subway system within 60 seconds, or 150 a minute in an office building. After his secretary placed the order with Sigma Aldrich, no one from the St. Louis-based company asked a question, not even for verification that the professor was the one ordering the chemicals."

"The order simply arrived at his office in Houston a day later. It is frightening said Tour, who served 2 years on a Defense Department panel studying the possibility of chemical/biological terrorism."

"Tour said that he shared his concerns with Federal officials, but claims to have been politely dismissed. Tour said that the Federal Government should do background checks and grant licenses to chemists who want to purchase chemicals that can be used as weapons."

"Some chemical industry officials say it would be onerous for those who legitimately use the chemicals and would do little to deter terrorists from getting them on the black market. A Sigma Aldrich spokesman said it did not check on Tour because of his reputation and his history with the company."

"But Tour and other experts insist most suppliers do just minimal screening of customers. Tour is calling on the Federal Government to restrict the sale of chemicals that could be used as deadly agents. Tour's concerns were first raised in the most recent issue of Scientific American Magazine, which 2 weeks ago was able to order the chemicals needed to mix Serine for delivery to its New York city office."

"Ron Kellier, a spokesman for Sigma Aldrich, said that his company would support the tighter regulations Tour is seeking." And I am wondering, Mr. Secretary, if you or anyone else can comment on that, because to me it is frightening.

Mr. HENDERSON. I would say that it is welcome to the 21st century. We have now a broader number of people educated in more ways and have more access to the internet to do more things than one can possibly imagine.

And I think the fact is that in the field of biology, we are obviously going to have to effect more in the way of controls than we had before, because people are able to do recontaminant technology very simply in very many ways, and very many places.

And I think that the same can be said with the chemical agents as well, and we have not really given this much thought up until now, and I think we are only beginning to explore this, but it is a challenge, and I think it means some further restrictions in freedoms if we are going to have a greater security.

Mr. THOMPSON. Congressman, I think Dr. Henderson outlined the difficulties, but let's face it. If we are going to be secure, we are going to have to have background checks, and if you are going to purchase gas, you are going to have to have some investigations, and it is going to require some degree of Federal authority, whether it be a Congressional law, or Federal rule, or whatever the case may be.

But it seems to me that we have an opportunity now since September 11 to be able to do a lot of things that is going to make our homeland much more secure, and this is a particular problem, and it is not the only problem out there facing us.

There are a lot of problems dealing with a lot of chemicals, and a lot of agents that can cause a great deal of harm top a lot of Americans. And if we are going to be secure, we are going to have to start looking at ways to register and doing background checks.

But it also is going to require the Congressional delegation to make some tough decisions. How far do you want to go. We will implement the laws that you pass.

Mr. ENGEL. Well, I would hope that we would hold hearings on these things specifically, and I would certainly intend to introduce legislation to deal with this, because I think that this is obviously a time bomb that cannot wait. We need to act on it immediately.

Mr. THOMPSON. The same thing with food pathogens and it is the same thing as Congresswoman Wilson talked about in laboratories dealing with biological agents.

Mr. ENGEL. On another matter——

Chairman TAUZIN. The gentleman's time has expired.

Mr. ENGEL. Okay. I guess we will do another matter another time, Mr. Chairman. Thank you.

Chairman TAUZIN. I thank the gentleman. The Chair recognizes the gentlelady from California, Ms. Capps.

Ms. CAPPS. Thank you, Mr. Chairman, and Mr. Secretary and your colleagues, I commend you for your staying power. I am very impressed with that you would hear each of us out, and I also note with great interest your focus on the importance of local resources in this whole topic. It is right on in my opinion.

Mr. THOMPSON. Thank you.

Ms. CAPPS. And I want to thank my Chairman, Mr. Bilirakis, for engaging you in a conversation earlier about the nursing shortage, which if there is anything——

Mr. THOMPSON. He did an excellent job supporting you, and I want you to know that.

Ms. CAPPS. I know that, and that's partly why I wanted to follow up, because if there is anything local, more local than nurses, I don't know what it is. And other health officials.

The work force that does man and staff our hospitals and our public health facilities, and right now we are woefully short, as I know that you are well aware. You mentioned expanded resources, and expanding authorities, to address the situation.

Many of these I have included in a bill introduced many months ago, and it has a counterpart in the Senate of the Nurse Investment Act. It has over 220 co-sponsors, and I called this entity for lack of a better term, and it can be called anything, but a National Service Nurse Service Corps.

Whatever it is that will give incentives and scholarships, and loan forgiveness, to encourage people coming into the field, who will then guarantee work, particularly in under- served areas, for a time.

If you would expand on that even more if you will, and if there is a way that we can do this, also keeping in mind the need for a career ladder track if you will, harkening to what Dr. Koplan said, that you train people and then there is new technology, and you have got to train them further.

We want the basic education there, but we also want people to have opportunity to go into advanced practice and into public health.

Mr. THOMPSON. Congresswoman, I am speaking to the choir.

Ms. CAPPS. Yes, you are.

Mr. THOMPSON. And I applaud you and thank you for your leadership on this effort. As you know, I handed out $27 million I think about 6 weeks ago out at the Georgetown Nursing School toward nursing scholarship students, or several nursing schools.

I think one thing we should do is put in—part of your proposal should be to get to the high school counselors.

Ms. CAPPS. Yes.

Mr. THOMPSON. And do some PR to get out to a lot of individuals, and also now that we are going to reauthorize TANF, it would be a great opportunity for us to talk about the need for educating single women in——

Ms. CAPPS. And men. And men.

Mr. THOMPSON. And men, absolutely. But individuals that are still in TANF to be able to go into the health care field. And it is not only nursing. It is the laboratory technicians are probably No. 1, and nurses are probably No. 2. I am not speaking of categories.

I am just telling you that we have got a shortage of a lot of health care fields, and pharmacists, and so on, and all of these individuals need to be taken care of, and we have got to encourage more people, more young people, men and women, to get involved in the health care fields.

And I think a public relations effort by you, by Congress, by the Department, however we do it, on a bipartisan basis, is to get out to our high school students that are going into college and saying that these are the fields that are badly needed. And they are great professions, and we need you to take a look at them.

Ms. CAPPS. Thank you, and you being able to say this in the context of combating bioterrorism makes a lot of sense and will help us with this. I appreciate your leadership on it.

Mr. THOMPSON. Thank you very much.

Ms. CAPPS. Thank you. I yield back the balance of my time.

Chairman TAUZIN. I thank the gentlelady. Mr. Secretary, your staff has informed me that you have a meeting with Speaker Hastert at some point?

Mr. THOMPSON. Yes, I do.

Chairman TAUZIN. Are you late for that meeting now, sir?

Mr. THOMPSON. I am afraid so.

Chairman TAUZIN. I know that we have several of the members who would like to ask questions. What are your wishes here? I don't want to unnecessarily delay the Secretary from his meeting. Tim, can we do that, and then I will recognize you again for questions to Dr. Koplan and Dr. Henderson. Mr. Strickland, can we do this quickly?

Mr. STRICKLAND. Yes. I have a very, very short question. I have heard—and I apologize if this has been covered, but I have heard from some doctors in my district who are concerned that the emphasis on bioterrorism and being prepared for that problem, and specifically the focus on smallpox vaccine could mean that other, perhaps more basic, vaccines such as for measles and the flu, will be left behind and we will have resulting shortages. Is this a legitimate concern?

Mr. THOMPSON. First off, Congressman, thank you for your lovely letter, and thank you for your wonderful comments about me personally, and I appreciate that very much. I don't think so.

What we have done is we have set up a scientific committee composed of a bunch of scientists from the pharmaceutical companies, and from NIH, and from CDC, headed by Dr. Henderson to take a look at all vaccines.

Not only the existing vaccines, but also new vaccines that we need. We need to develop some new vaccines for the plague, and for the hemorrhagic viruses, and for emboli, and for all of these that are out there.

We should be really doing more of a concerted effort to develop the vaccines, and a lot of companies have gotten out of the field of producing vaccines, and we are trying to find a way to encourage them back into producing vaccines, not only for measles and chicken pox, and now smallpox, but also anthrax and so on.

Chairman TAUZIN. Mr. Doyle and Ms. Harman, do you have a question that you need to ask? If not, then with the—Mr. Doyle, you had one brief one? If you will make it very quickly, sir.

Mr. DOYLE. Thank you. Mr. Secretary, thank you. A few years ago, Congress, with the support for the Centers for Disease Control, set up a program called the Centers for Public Health Preparedness, and the goal was to use accredited schools of public health, and provide a one-stop shop network of training and professional resources for public health professionals, primary and secondary health care providers, and the general public.

Now, currently we have seven such centers funded at a total of just over $2 million, which is sort of partial funding and despite that rather modest investment, they have been able to produce about a hundred training products for various aspects of public health work force, which is very encouraging.

I understand that there is a move to put on eight additional centers, and eight additional centers have been approved, in addition to the seven that already exist. But there is not anymore additional funding, and I am just wondering with the $2 million budget how we intend to get these 15 centers off the ground, and are you asking for more resources to do that?

Mr. KOPLAN. The centers are excellent, and they are very effective. Just some recent examples is that there is center at Columbia, at the Mellman School of Public Health, that has been very prominent and been very helpful in the recent New York disasters.

The centers in Florida have been very helpful to identifying anthrax to physicians in health departments in Florida, and they serve as a very important training base for a variety of other activities.

The schools of public health are really an untapped resource, because there are many more of them doing things. Dr. Henderson has had this experience before at Hopkins. There are a number of other places that could play a role. So I think it is a fertile area for growth and expansion.

Mr. DOYLE. But what is the status of these eight centers that have been approved, but not funded? Are they in limbo now?

Mr. KOPLAN. When funds are available, they can be supported. It is much like research grants, where you get a larger number of things that have merit and could be approved, but if the funding isn't there, you can't extend it to them.

Mr. DOYLE. Have you asked for additional funding?

Mr. KOPLAN. I think additional funding is under consideration in the coming budget years.

Mr. DOYLE. Okay. Thank you, Mr. Chairman.

Chairman TAUZIN. I thank the gentleman, and Secretary Thompson, we deeply appreciate your appearance, and your patience here today. I want to say something before you leave though. I don't know if America fully appreciates how hard you and your department are all working to protect our citizens. I want them to know that today.

We are privy to very private briefings with you, and we know perhaps even more deeply than this hearing has indicated how hard you are working, and what you are doing to make sure that we face these threats with as much security and as much capacity as possible to protect American lives.

And American lives are truly in your hands, and I want to commend you for understanding the seriousness of these threats and for dealing with them as you are. You have this committee's full support as you know in those efforts, and as your needs become clearer as we go forward, you have many allies on this committee, and we are prepared to help you, sir.

Mr. THOMPSON. Thank you.

Chairman TAUZIN. Thank you very much, Secretary Thompson.

Mr. THOMPSON. Thank you very much, Congressmen.

Mr. KOPLAN. Mr. Chairman, thank you.

Chairman TAUZIN. Thank you, sir. If Dr. Henderson and Dr. Koplan will stay just a second, let me make sure. Do any members have questions of either of these two gentlemen? Then I thank you very much.

And before we adjourn, I have two items that I want to put in to the record. One is a letter to the committee from the various food and food processor associations in support of the draft of language that we are preparing.

And a statement by Representative Mac Thornberry regarding the Committee on Commerce's hearing today; and a General Ac-

counting Office GAO report on the Centers for Disease and Control and Public Health Protection.

And without objection, all of these documents will be made a part of the record. And again I want to express my appreciation to the Department for its agreement to forward to our Oversight and Investigations Subcommittee the documents on CDC security which we requested, as well as the other additional information on agents.

We will hold the record open for further questions and further submittals for approximately 30 days, and if there is no further business to come before the committee, with my appreciation to the staff, and to the witnesses, the committee stands adjourned.

[Whereupon, at 2:07 p.m., the committee was adjourned.]

[Additional material submitted for the record follows:]

*November 14, 2001*

The Honorable W. J. TAUZIN
*Chairman*
*House Energy and Commerce Committee*
*U.S. House of Representative*
*Washington DC 20510*

DEAR MR. CHAIRMAN: As the Committee begins to address the issue of bioterrorism, we appreciate your focus on enhancing food security through additional resources targeting any new legal authorities to well-defined risks.

The food industry supports a strong, effective regulatory system that has sufficient resources to accomplish its core mission. As you know, food safety and security have long been a top priority for the food industry. Our industry has a proven track record of working closely with the states, federal regulatory agencies and the Congress to develop risk-and science-based solutions to food security challenges. Because of these efforts of the food industry, Americans enjoy the safest food supply in the world.

The federal government, through Food and Drug Administration (FDA) and the U.S. Department of Agriculture (USDA), already have vast legal authority and numerous enforcement tools to police our food safety system. At a time when concerns are being raised about the security of our food supply, both industry and government have increased their vigilance. We support the appropriation of resources to enable federal agencies to fully exercise their legal responsibilities. We applaud the targeting of these new resources to improved systems and methods for rapid detection of foodborne pathogens and other significant risks; enhanced facilities, equipment and integrated information management systems for effective food safety surveillance, inspection analysis; and strengthened personnel resources and training, including for inspection of imported foods.

While we are not fully convinced that new additional authorities are necessary at this time, we appreciate your efforts to carefully circumscribe new authorities to address well-defined risks to food security. Specifically:

- Any additional detention authorities granted to the FDA should be limited to those circumstances which present a genuine public health emergency as declared under the Public Health Services Act, and relate directly to an adulteration that presents a threat of serious adverse health consequences.
- The Secretary of Health and Human Services should only have the authority to debar individuals who are convicted of a felony resulting from the importation of unsafe food into the United States.
- Any additional authority expanding government access to company records should be linked directly and strictly limited to the documents needed to investigate the specific occurrence of adulteration that poses a threat of serious adverse health consequences. If a company treats a document as "confidential" so should the government, and steps should be taken to ensure the protection of such information.
- Any new prior notice requirements for the importation of food products should be designed to ensure that the free flow of commerce is protected and to protect the U.S. food supply from shortages from undue commercial disruptions.
- Any new grants made to state or territories for the purpose of conducting food inspections should be confined to those circumstances in which a genuine public

health emergency related to food adulteration has been declared under the Public Health Services Act.

We believe your draft legislation is generally consistent with these principles, and offer our assistance to you and the Committee in the continuing effort to enhance consumer confidence in food safety through science- and risk-based solutions to current and emerging threats.

Several legislative initiatives exist that would vastly expand FDA and USDA authorities over domestic and imported foods. These proposals have little, if any relevance to addressing well defined risks to public health and safety and are outside the parameters of current legislative efforts to address bioterrorism. Aside from presenting significant trade and regulatory concerns, we strongly believe that they would not enhance food security.

Thank you for the thoughtful approach you have taken thus far and for considering our concerns. Americans are continuing to count on both the food industry and the government to ensure a safe, secure and affordable food supply. Industry has a food safety infrastructure in place today staffed by thousands of food scientists whose mission is to focus exclusively on analyzing current and potential hazards to food. We stand ready to assist in this effort in any way we can.

Sincerely,

AMERICAN BAKERS ASSOCIATION; AMERICAN FEED INDUSTRY ASSOCIATION; AMERICAN FROZEN FOOD INSTITUTE; ASSOCIATION OF FOOD INDUSTRIES, INC.; ASSOCIATED NEW YORK STATE FOOD PROCESSORS; CHEESE IMPORTERS ASSOCIATION OF AMERICA; FOOD MARKETING INSTITUTE; FOOD DISTRIBUTORS INTERNATIONAL; GROCERY MANUFACTURERS OF AMERICA, INC.; INTERNATIONAL DAIRY FOODS ASSOCIATION; MISSOURI FOOD PROCESSORS ASSOCIATION; NATIONAL COUNCIL OF CHAIN RESTAURANTS; NATIONAL FISHERIES INSTITUTE; NATIONAL FOOD PROCESSORS ASSOCIATION; NATIONAL GROCERS ASSOCIATION; NATIONAL RENDERERS ASSOCIATION; NATIONAL RESTAURANT ASSOCIATION; NATIONAL SOFT DRINK ASSOCIATION; NORTHWEST FOOD PROCESSORS ASSOCIATION; AND THE UNITED FRESH FRUIT AND VEGETABLE ASSOCIATION.

cc: The Honorable John D. Dingell, Ranking Member

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PREPARED STATEMENT OF HON. MAC THORNBERRY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

I am pleased to provide this statement on proposals to combat bioterrorism. As you may know, I—along with Rep. Wilson, Rep. Norwood, and Rep. Gene Green—recently introduced H.R. 3239, a bill to amend the Robert T. Stafford Disaster Relief and Emergency Assistance Act to ensure continuity of medical care following a national disaster. This bill, also cosponsored by Rep. Whitfield, Rep. Hayworth, Rep. Weller and Rep Crane, makes private, for-profit medical facilities, including hospitals and long term care facilities, eligible for federal disaster assistance.

In many parts of the country, investor-owned health care hospitals and long term care facilities are the only places for the public to receive care. Now more than ever, we are trying to make sure that our hospitals and other medical providers are able to give proper care and treatment in the event of an emergency. Therefore, it makes sense for all medical facilities to be afforded the same access to federal disaster assistance so that wherever a disaster strikes, our entire medical system can help those in need.

Currently, the 1974 Stafford Act precludes FEMA funds from benefitting for-profit institutions—even if facilities owned by these institutions treat patients. This preclusion is short-sighted. Disaster strikes without respect to hospital or long term care facility ownership. In many communities, for-profit hospitals serve as the safety net or sole-community providers. The current law could have the chilling effect of indirectly determining which community providers will continue to operate following a disaster, without any direct relationship to a community's particular needs. This simply does not make sense. If a disaster occurs in or around a specific community, every single health care facility in the area that provides care should be able to access federal disaster funds if needed.

This bill is supported by the Federation of American Hospitals, the American Hospital Association, the American Health Care Association, as well as a number of state hospital associations around the country, including: Arizona, California, Colorado, Florida, New Mexico, Oklahoma, Pennsylvania, Texas, Kentucky, and Utah—just to name a few.

The current events relating to anthrax and September 11th demonstrate the need for this Nation to prepare—and to prepare quickly—for the possibility of large-scale

bioterrorist attacks on our homeland. However, we should also approach this issue in a thoughtful and reasoned way.

It is my strong hope that any kind of package this Committee puts together to address the emerging threats of bioterrorism will include the provisions of H.R. 3239. My colleagues and I believe that this bipartisan, budget-neutral proposal is sound policy to help reflect the current state of medical care in our Nation.

I thank Chairman Tauzin and the Committee members for their efforts to improve and strengthen our public health system. I look forward to working with this Committee, the Congress and the Administration on this important legislation, as well as additional ways to improve the continuity of care available to communities affected by a national disaster.

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PREPARED STATEMENT OF JOHN R. CADY, PRESIDENT AND CEO NATIONAL FOOD PROCESSORS ASSOCIATION

Thank you, Mr. Chairman, for the opportunity to submit this testimony for your hearing today on various legislative proposals to prevent and effectively respond to bioterrorist threats or incidences. First, let me thank you and the distinguished ranking member of the Committee, Representative Dingell, for holding this hearing and your leadership on food safety issues. We encourage the House of Representatives to fully exercise its legislative responsibilities in order to send to the President legislation that reflects not only the collective wisdom of the Congress, but helps achieve our goal of a truly science- and risk-based food safety system.

NFPA is the largest food-only trade association in the United States, representing the $500 billion U.S. food processing industry on scientific and public policy issues involving food safety, nutrition, technical and regulatory matters, consumer outreach and international affairs. NFPA's members produce and package the branded and private-label food and beverage products found in retail and wholesale stores using a variety of processing and packaging technologies. With three laboratory centers in the United States—including one just three blocks from the White House—our mission is to provide the best scientific and technical assistance to food processors, and translate our unique food safety and food science expertise into sound public policy.

*Overview*

There are a number of legislative vehicles that have been proposed to grant additional federal enforcement powers as well as to authorize or appropriate additional resources to the Food and Drug Administration (FDA) to help prevent and respond to possible threats to our food security. However, given the vast powers and numerous enforcement tools already at the disposal of federal regulatory agencies, Congress should first focus on providing adequate resources to meet any new potential threats to our food security before exploring new legislative authorities. These resources should be focused on helping the agency prevent and detect possible threats. These resources should also support crisis communication efforts between the agencies and industry on how industry can better assist in combating and preparing for these new threats. Additional resources are needed to upgrade and improve FDA's information tracking system for imported foods, called OASIS (Operational and Administrative System for Import Support), and enhance testing at the border.

Food safety and security has long been a top priority for the food industry. Our industry has a long history of working with regulatory agencies and the Congress to develop risk- and science-based solutions to food safety challenges. The food industry has a food safety infrastructure in place today staffed by thousands of microbiologists, chemists, food scientists and quality assurance experts whose mission is to focus exclusively on analyzing current and potential hazards to food. We and our member companies focus on food safety and food security issues daily. Since September 11th our industry has come together as never before to educate others and ourselves on how best to redouble our efforts and ensure we are prepared for any potential risks.

The federal government should have the resources and authorities essential to continue to ensure the safety and security of our food supply. It is vital that we maintain the highest consumer confidence in our food supply, which is among the safest in the world. Likewise, our food safety system, which is responsible for our nation's safe, wholesome, abundant and affordable food supply stands as a model throughout the world. That is why we have long supported additional resources for the FDA to ensure that it can fulfill its core mission to protect public health and safety. Any new authorities must be carefully scrutinized and focused on giving the

federal government germane and defined powers that enable it to respond effectively in the event of a public health emergency.

Millions of Americans are counting on both the food industry and the government to continue to ensure a safe, yet abundant and affordable food supply. It is essential that the changes being considered regarding our industry be practical , and constructive, while balancing the needs to enhance food security while ensuring our economic health and the free flow of commerce, both between the United States and other nations as well as within our own borders.

*The Administration Proposal*

Secretary of Health and Human Services, the Honorable Tommy Thompson on October 18th transmitted to the Speaker the "HHS Bioterrorism Prevention and Emergency Response Act of 2001." Our views of the food provisions of most concern follows.

*Sec. 101. Emergency Administrative Detention*

We believe existing authorities currently employed by states have worked well and remain adequate. However, in the event of a public health emergency that is declared under Section 319 of the Public Health Service Act, we do not object to enhanced powers for the Secretary to detain adulterated foods that pose the threat of serious adverse health consequences to humans or animals.

The duration of detention as outlined under Sec. 101 (2)(A) should be consistent with current detention authority for the US Department of Agriculture, which is 20 days. We also urge insertion of the following language (to provide an appeal option) before the quotation mark at line 2, page 3: "(B) The person may appeal the detention order to the United States District Court in any district in which the detained article is located.

*Sec. 102. Tampering with Consumer Products: Emergency Administrative Detention*

We believe this section is redundant of Section 101 and should be stricken.

*Sec. 103 Debarment for Repeated or Serious Food Import Violations*

To supplement the Secretary's substantial existing authorities, we have no objection to additional authority that would permit the Secretary to debar individuals who are convicted of a felony related to importing a food into the United States. However, as currently drafted, the Administration's provision would broadly permit debarment of a person who "repeatedly or deliberately" imported or offered for import adulterated or misbranded foods. Our concern is that the severity of the offense is not adequately limited to those violations of a public health significance. As drafted this section would include such violations as misplaced commas on the nutrition facts label; the appearance of unapproved synonyms on food labels; and economic adulteration that does not involve any threat to public health or safety—clearly issues well outside the scope of combating terrorism. We suggest that authority to debar individuals based on a felony conviction related to importing a food represents a strong "one strike and your out" provision.

*Sec. 104 Maintenance and Inspection of Records*

We strongly oppose the Administration provision. The language provides the Secretary with a very low threshold for access to the private property of a food company and no problem with the existing balance of authorities has been demonstrated. This provision is far broader than needed to address potential bioterrorism threats. Any authority expanding government access to company records should be strictly limited to the documents needed to investigate a specific occurrence of adulteration that poses a threat of serious adverse health consequences. If a company treats a document as "confidential" so should the government, and steps should be taken to ensure the protection of such information. Government access to the confidential information of a person in the food business does not justify government release or publication of that information.

*Sec. 105 Prior Notice of Imported Food Shipments.*

This provision is unnecessary due to 19 USC § 1484, which authorizes the Secretary of Treasury to specify time frames within which import documents must be submitted to determine compliance with applicable law. Moreover, no purpose for the prior notification is stated to serve as an appropriate limitation on the exercise of the proposed authority. Moreover, any new prior notice requirements for the importation of food products should be designed to ensure that the free flow of commerce is protected and to protect the U.S. food supply from shortages from undue commercial disruptions.

*Additional Proposals*

The Honorable John Dingell, ranking member of the House Commerce Committee, has introduced the HR 3075, the Imported Food Safety Act of 2001. While we greatly appreciate Representative's Dingell's long-standing interest in strengthening our food security, we cannot support his legislation as drafted. Here are our concerns about major provisions in his legislation and others that we understand may at some time be considered by the Committee.

*FDA Prior Approval for Imported Foods Required*

NFPA does not support this provision of HR 3075. Under current law, FDA exercises its discretion in determining when an imported food must be examined. FDA makes a determination as to whether a food should be detained and sampled based upon whether it "appears" to be in violation of the Federal Food, Drug and Cosmetic Act (FD&C Act). This provision of H.R. 3075 would be much more burdensome if enacted because the basis of denial of entry is so subjective that it would be tantamount to complete agency discretion. If someone once imports a food labeled with an unapproved synonym it could indicate that they have a history of noncompliance and FDA could prohibit future entries of foods offered for admission by the importer. Moreover, H.R. 3075 would require all food importers to wait in line for FDA's approval before their product could be released into interstate commerce. Finally, it is unclear how FDA approval would be given (e.g., whether sampling of every imported food would be required).

*Equivalence Requirements for Imported Food*

NFPA strongly opposes this provision of the HR 3075. Efforts to justify establishment of FDA equivalence authority by referencing to the equivalence authority for meat and poultry products regulated by USDA overlook the fundamental differences in the two regulatory programs. Unlike USDA, FDA presently has a more rigorous standard for imports than domestically produced foods. Under Section 801 of the FD&C Act, a food product regulated by FDA may be refused entry if it *appears* to be in violation of the Act, while domestic products are actionable if they are in violation of the Act. Meat and poultry products in commerce are actionable if they are in violation of the Act. Thus, FDA now has a more rigorous standard for food imports than USDA. Moreover, FDA implementation of an equivalence program of the sort employed by USDA would be an undertaking of massive scope and expense that would take many years (probably decades) to complete with no appreciable food safety benefit. USDA regulates just meat and poultry, while FDA has responsibility for the full range of other foods. There is economic incentive to export meat or poultry products to the U.S. from only a very limited number of countries. FDA regulated foods are imported from the vast majority of the countries in the world. The time and expense of FDA personnel that would be required to implement an equivalence program for various foods from various countries would be a tremendous distraction from meaningful food safety activities.

This provision of H.R. 3075 could invite retaliation by foreign countries. Moreover, for countries without an equivalent regulatory system or that deny U.S. inspection, H.R. 3075 would require testing for pathogens and pesticides in all cases, regardless of the likelihood such pesticides or pathogens would appear on or in the food.

*Recall Authority*

The FD&C Act does not provide FDA with mandatory recall authority for foods. The recall provision of H.R. 3075 would permit FDA to mandate a recall based solely on the belief that the imported food has been intentionally adulterated. FDA would not have to establish adulteration.. Therefore, FDA could require companies to undertake massively expensive recalls when food has not been adulterated.NFPA has opposed granting such recall authority to the FDA because the current system for recalls works well. For more than ninety years, the foundation of Federal food safety policy has been that food companies—their executives and employees—are primarily responsible for the safety of the food they process. Existing law provides strict penalties for companies who market adulterated or misbranded food products. We challenge the FDA to demonstrate instances where food companies have not readily complied with a request by the agency to recall foods that may post a threat of serious adverse health consequences. There is simply no evidence that this new authority will enhance food safety.

*Limits On Ports Of Entry*

Under the HR 3075, FDA would be authorized to limit the ports of entry into the U.S. for all or certain foods or from particular points of origin or with particular chains of distribution, if FDA determines that such action is necessary to carry out provisions of H.R. 3075. NFPA opposes this provision.

The limits on ports of entry may raise constitutional issues, since Article 1, section 9, clause 6 of the U.S. Constitution prohibits preference to be given to the ports of one state over another and states that vessels coming into one port shall not "be obliged to enter, clear, or pay duties in another." The only justification for limiting ports of entry is due to the lack of personnel or other resources to exercise the government's full legal authorities and responsibilities—we believe this issue is best addressed through additional appropriations to the agency, not through potentially unconstitutional provisions such as these.

*Country of Origin Labeling*

H.R. 3075 would deem misbranded any food for which its retail labeling does not indicate the country in which the food was grown, prepared, packed, manufactured, or processed. Country-of-origin labeling would not be required for foods sold at the retail level by restaurants. For all imported foods that are packaged when sold at retail this provision is redundant of existing Customs requirements. However, H.R. 3075 would prohibit the current practice of marketing unpackaged fruits and vegetables without country of origin marking. The most significant effect of this provision would be to require country of origin marking of domestically produced foods. There is no evidence that such labeling mandates would advance food safety or enhance prevention or response to bioterrorist threats or incidents. NFPA strongly opposes this provision.

*User Fees for Import Inspections*

These provisions in HR 3075 would establish fees on persons because they are subject to mandatory regulatory activities intended to protect public health and welfare. Thus, they are not traditional user fees imposed on persons who choose to avail themselves of a discretionary government service to the user. In addition, these fee provisions invite scrutiny under international trade agreements for their discriminatory effect on food imports. Furthermore, this provision is unrelated to the prevention and response to threats of bioterrorism. NFPA strongly opposes these user fee provisions.

*Physical Presence at the Ports*

We also understand that consideration may be given to legislation that would require the physical presence of an FDA inspector at the ports. Currently, FDA is notified by Customs on every imported food shipment, and the agency, based on the prior record of the importer, type of food, and other priorities established by the agency, determines whether the product should be sampled and tested and/or detained. We believe a provision requiring a physical presence is inconsistent with a science- and risk-based food safety inspection system, and may arbitrarily take away the Secretary's discretion to shift scarce resources to address actual threats to food security. Therefore, we would strongly oppose such a provision.

*Prohibiting Products from Terrorism Sponsoring Countries*

We understand that legislation may be considered that would direct the Secretary of Health and Human Services to deny approval for the entry into the United States of any food from a country that the Secretary of States determines has supported or otherwise "aided or abetted one or more acts of international terrorism." The President already has authority to impose unilateral sanctions on state sponsors of terrorism, including powers to bar commerce with such countries. This provision takes the form of a trade sanction, rather than a food safety regulatory measure. NFPA respectfully urges that efforts intended to achieve food safety objectives should be risk-based measures that respond to unique facts regarding a food. The considerations regarding institution of trade sanctions are beyond the scope of testimony we are prepared to present today.

Mr. Chairman and Representative Dingell, thank you again for your leadership and this opportunity to comment on proposals to prevent and respond to threats and incidences of bioterrorism. The food industry stands ready to assist you in any way possible to advance the cause of science- and risk-based solutions to current and emerging threats to our food security.

INSTITUTE OF FOOD TECHNOLOGISTS
*November 15, 2001*

The Honorable BILLY TAUZIN
*Chairman, House Committee on Energy and Commerce*
*2125 Rayburn House Office Building*
*United States House of Representatives*
*Washington, D.C. 20515-6115*

Re: IFT's Role in Assisting the Continued Assurance of the Integrity of the U.S. Food Supply

DEAR MR. CHAIRMAN: Anthrax, the deadly disease currently at the forefront of American consciousness, is only one of dozens—realistically hundreds—of biological diseases, chemical toxicants and physically debilitating attacks that boast the potential of disabling our nation's economy and threatening the collective health of its citizens. Each could have crippling and devastating effects if introduced into the U.S. food supply.

For this reason, the Institute of Food Technologists (IFT) has established a cadre of highly qualified professionals with renowned expertise in food microbiology, chemistry, engineering, packaging, toxicology, food market manufacture and quality assurance, food service and retail operations, food distribution and delivery systems, crisis management, and risk communication to lead and direct IFT activities on topics directly relating to food bioterrorism. As a non-profit society with 28,000 individual members working in food science, technology, and related professions in industry, academia, and government, IFT brings sound science to the public discussion of food issues. IFT does so by drawing on the breadth of expertise comprised within its vast membership base. IFT has a proven record of assembling panels of experts to evaluate and assess prescribed issues in food safety and nutrition and delivering comprehensive reports and advice on a timely basis. IFT respectfully requests that this document be entered as part of the record of the full committee public hearing on November 15, 2001 to review federal Biosecurity Programs and Authorities. We are eager for the House Committee on Energy and Commerce to be aware of the efforts of the scientific community to contribute to protections against bioterrorist activities, especially as they might be directed toward the U.S. food supply.

IFT extends its nationally recognized expertise to provide services that directly assist in risk characterization, the pursuit of objective risk assessment, and risk communication. Furthermore, IFT offers its assistance in identifying the potential magnitude of intentional adverse events, should any occur, and the traceability required to define raw materials and identify contamination sources. Additionally, to deter potential catastrophic attacks and minimize their impact if they occur, IFT offers: food safety education, critical to reducing the risk of foodborne illness whether linked with normal, unintentional contamination; human health hazard assessments, paramount to reducing the risks to our populace; and, development of effective food security assurance programs, critically important throughout the food system.

IFT's cadre of experts are in the unique position to provide comprehensive assessments on microbiological, chemical, and physical hazards that could detrimentally affect the safety of our supply. Furthermore, IFT's group of experts can provide valuable insight to not only prevent, but effectively control contamination of the food supply, whether introduced during food product manufacture, distribution, retail, or preparation in foodservice or the home.

In summation, the Institute of Food Technologists stands ready to work in conjunction with—and in advisement to—federal safety and security agencies, national and international food manufacturers,, and national mass communications organizations to provide insight, expertise, and advisement on the myriad of food security challenges confronting the future health and well-being of our great nation and its citizens.

Sincerely,

PHILIP E. NELSON, PH.D.
*President*

United States General Accounting Office

GAO

Testimony

Before the Committee on Energy and Commerce, House of Representatives

For Release on Delivery
Expected at 10:00 a.m.
Thursday, November 15, 2001

# BIOTERRORISM

# The Centers for Disease Control and Prevention's Role in Public Health Protection

Statement for the Record by Janet Heinrich
Director, Health Care—Public Health Issues

GAO-02-235T

Mr. Chairman and Members of the Committee:

I appreciate the opportunity to submit this statement for the record discussing our work on the Centers for Disease Control and Prevention's (CDC) activities to prepare the nation to respond to the public health and medical consequences of a bioterrorist attack.[1] The country is now dealing with anthrax exposures resulting from the agent being sent through the mail and the consequences of dealing with even limited exposures have proven to be quite significant. Prior to the recent anthrax incidents, a domestic bioterrorist attack had been considered to be a low-probability event, in part because of the various difficulties involved in successfully delivering biological agents to achieve large-scale casualties.[2]

On September 28, 2001, we released a report[3] that describes (1) the research and preparedness activities being undertaken by federal departments and agencies to manage the consequences of a bioterrorist attack, (2) the coordination of these activities, and (3) the findings of reports on the preparedness of state and local jurisdictions to respond to a bioterrorist attack. This statement will summarize our findings in the September report regarding CDC's research and preparedness activities on bioterrorism and augments our previous work on combating terrorism.[4] Specifically, we will focus on CDC's research and preparedness activities on bioterrorism, and remaining gaps that could hamper the response to a bioterrorist event.

[1]Bioterrorism is the threat or intentional release of biological agents (viruses, bacteria, or their toxins) for the purposes of influencing the conduct of government or intimidating or coercing a civilian population.

[2]See *Combating Terrorism: Need for Comprehensive Threat and Risk Assessments of Chemical and Biological Attacks* (GAO/NSIAD-99-163, Sept. 14, 1999), pp. 10-15, for a discussion of the level of difficulty a terrorist would face in attempting to cause mass casualties by making or using chemical or biological agents without the assistance of a state-sponsored program.

[3]See *Bioterrorism: Federal Research and Preparedness Activities* (GAO-01-915, Sept. 28, 2001). This report was mandated by the Public Health Improvement Act of 2000 (P.L. 106-505, sec. 102). We conducted interviews with and obtained information from the Departments of Agriculture, Commerce, Defense, Energy, Health and Human Services (including CDC), Justice, Transportation, the Treasury, and Veterans Affairs; the Environmental Protection Agency; and the Federal Emergency Management Agency.

[4]See the list of related GAO products at the end of this statement.

In summary, CDC has a variety of ongoing research and preparedness activities related to bioterrorism. Most of CDC's activities to counter bioterrorism are focused on building and expanding public health infrastructure[5] at the federal, state, and local levels. These include funding research on anthrax and smallpox vaccines, increasing laboratory capacity, and building a national pharmaceutical stockpile of drugs and supplies to be used in an emergency. Since CDC's bioterrorism program began in 1999, funding increased 43 percent in fiscal year 2000 and an additional 12 percent in fiscal year 2001. While the percentage increases are substantial, they reflect only a $73 million increase in overall spending because many of the activities initially received relatively small allocations. Gaps in CDC's activities could hamper the response to a bioterrorist attack. For instance, laboratories at all levels can quickly become overwhelmed with requests for tests. In addition, there is a notable lack of training focused on detecting and responding to bioterrorist threats.

## Background

Although many aspects of an effective response to bioterrorism are the same as those for any form of terrorism, there are some unique features. For example, if a biological agent is released covertly, it may not be recognized for a week or more because symptoms may not appear for several days after the initial exposure and may be misdiagnosed at first. In addition, some biological agents, such as smallpox, are communicable and can spread to others who were not initially exposed. These characteristics require responses that are unique to bioterrorism, including health surveillance,[6] epidemiologic investigation,[7] laboratory identification of biological agents, and distribution of antibiotics to large segments of the population to prevent the spread of an infectious disease. However, some aspects of an effective response to bioterrorism are also important in responding to any type of large-scale disaster, such as providing emergency medical services, continuing health care services delivery, and, potentially, managing mass fatalities.

[5]The public health infrastructure is the underlying foundation that supports the planning, delivery, and evaluation of public health activities and practices.

[6]Health surveillance systems provide for the ongoing collection, analysis, and dissemination of data to prevent and control disease.

[7]Epidemiological investigation is the study of patterns of health or disease and the factors that influence these patterns.

The burden of responding to bioterrorist incidents falls initially on personnel in state and local emergency response agencies. These "first responders" include firefighters, emergency medical service personnel, law enforcement officers, public health officials, health care workers (including doctors, nurses, and other medical professionals), and public works personnel. If the emergency requires federal disaster assistance, federal departments and agencies will respond according to responsibilities outlined in the Federal Response Plan.[8]

Under the Federal Response Plan, CDC is the lead Department of Health and Human Services (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.[9] Each of these functions is described in table 1.

[8]The Federal Response Plan, originally drafted in 1992 and updated in 1999, is authorized under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act; P.L. 93-288, as amended). The plan outlines the planning assumptions, policies, concept of operations, organizational structures, and specific assigement of responsibilities to lead departments and agencies in providing federal assistance once the President has declared an emergency requiring federal assistance.

[9]A vector is a carrier, such as an insect, that transmits the organisms of disease from infected to noninfected individuals.

**Table 1: CDC's Functions Under the Federal Response Plan**

| Function | Description of function |
|---|---|
| Health surveillance | Assist in establishing surveillance systems to monitor the general population and special high-risk population segments; carry out field studies and investigations; monitor injury and disease patterns and potential disease outbreaks; and provide technical assistance and consultations on disease and injury prevention and precautions. |
| Worker health and safety | Assist in monitoring health and well-being of emergency workers; perform field investigations and studies; and provide technical assistance and consultation on worker health and safety measures and precautions. |
| Radiological, chemical, and biological hazard consultation | Assist in assessing health and medical effects of radiological, chemical, and biological exposures on the general population and on high-risk population groups; conduct field investigations, including collection and analysis of relevant samples; advise on protective actions related to direct human and animal exposure, and on indirect exposure through radiologically, chemically, or biologically contaminated food, drugs, water supply, and other media; and provide technical assistance and consultation on medical treatment and decontamination of radiologically, chemically, or biologically injured or contaminated victims. |
| Public health information | Assist by providing public health and disease and injury prevention information that can be transmitted to members of the general public who are located in or near areas affected by a major disaster or emergency. |
| Vector control | Assist in assessing the threat of vector-borne diseases following a major disaster or emergency; conduct field investigations, including the collection and laboratory analysis of relevant samples; provide vector control equipment and supplies; provide technical assistance and consultation on protective actions regarding vector-borne diseases; and provide technical assistance and consultation on medical treatment of victims of vector-borne diseases. |

Source: The Health and Medical Services Annex in the Federal Response Plan, April 1999.

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.[10] As part of this effort, several CDC centers, institutes, and offices work together in the agency's Bioterrorism Preparedness and Response Program. The principal priority of CDC's program is to upgrade infrastructure and capacity to respond to a large-scale epidemic, regardless of whether it is the result of a bioterrorist attack or a naturally occurring infectious disease outbreak. The program was started in fiscal year 1999 and was tasked with building and enhancing national, state, and local capacity; developing a national pharmaceutical stockpile; and conducting several independent studies on bioterrorism.

[10]Beyond CDC, other offices and agencies within HHS are involved in this effort, including the Agency for Healthcare Research and Quality, the Food and Drug Administration, the National Institutes of Health, and the Office of Emergency Preparedness.

## CDC's Research and Preparedness Activities on Bioterrorism

CDC is conducting a variety of activities related to research on and preparedness for a bioterrorist attack. Since CDC's program began 3 years ago, funding for these activities has increased. Research activities focus on detection, treatment, vaccination, and emergency response equipment. Preparedness efforts include increasing state and local response capacity, increasing CDC's response capacity, preparedness and response planning, and building the National Pharmaceutical Stockpile Program.

## Trends in CDC's Funding for Bioterrorism Activities

The funding for CDC's activities related to research on and preparedness for a bioterrorist attack has increased 61 percent over the past 2 years. See table 2 for reported funding for these activities.

**Table 2: Reported Funding for CDC's Bioterrorism Preparedness and Response Program Activities (Dollars in millions)**

| Program/initiative[a] | Fiscal year 1999 | Fiscal year 2000 | Fiscal year 2001 |
|---|---|---|---|
| **Research activities** | | | |
| Research and development | 0 | $40.5 | $42.9 |
| Independent studies[b] | $1.8 | $7.7 | $2.6 |
| Worker safety | 0 | 0 | $1.1 |
| **Preparedness activities** | | | |
| **Upgrading state and local capacity** | **$55.0** | **$56.9** | **$66.7** |
| Preparedness planning | $2.0 | $1.9 | $5.8 |
| Surveillance and epidemiology | $12.0 | $15.8 | $16.1 |
| Laboratory capacity | $13.0 | $9.5 | $12.8 |
| Communications | $28.0 | $29.7 | $32.0 |
| **Upgrading CDC capacity** | **$12.0** | **$13.9** | **$20.4** |
| Epidemiologic capacity | $2.0 | $1.8 | $4.0 |
| Laboratory capacity | $5.0 | $7.6 | $11.4 |
| Rapid toxic screening | $5.0 | $4.5 | $5.0 |
| **Preparedness and response planning** | **$1.0** | **$2.3** | **$9.2** |
| **Building the National Pharmaceutical Stockpile Program** | **$51.0** | **$51.8** | **$51.0** |
| **Total** | **$120.8** | **$173.1** | **$193.9** |

Note: We have not audited or otherwise verified the information provided.

[a]CDC also received funding in fiscal year 1999, fiscal year 2000, and fiscal year 2001 for bioterrorism deterrence activities, such as implementing regulations restricting the importation of certain biological agents. That funding is not included here.

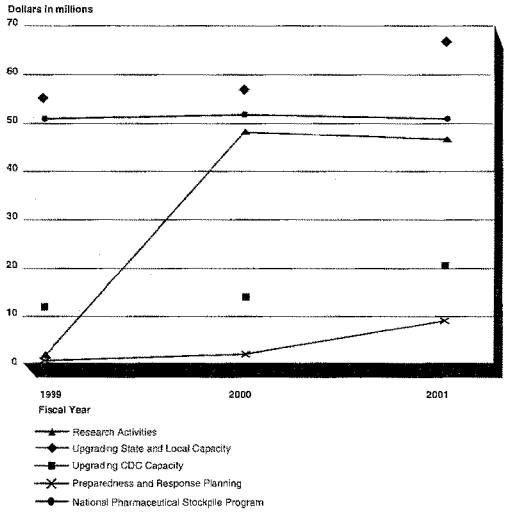
[b]For instance, $1 million was specified in the fiscal year 2000 appropriations conference report for the Carnegie Mellon Research Institute to study health and bioterrorism threats.

Source: CDC.

Funding for CDC's Bioterrorism Preparedness and Response Program grew approximately 43 percent in fiscal year 2000 and an additional 12 percent in fiscal year 2001. While the percentage increases are significant, they reflect only a $73 million increase because many of the programs initially received relatively small allocations. Approximately $45 million of the overall two-year increase was due to new research activities.

Relative changes in funding for the various components of CDC's Bioterrorism Preparedness and Response Program are shown in Figure 1. Funding for research activities increased sharply from fiscal year 1999 to fiscal year 2000, and then dropped slightly in fiscal year 2001. The increase in fiscal year 2000 was largely due to a $40.5 million increase in research funding for studies on anthrax and smallpox. Funding for preparedness and response planning, upgrading CDC capacity, and upgrading state and local capacity was relatively constant between fiscal year 1999 and fiscal year 2000 and grew in fiscal year 2001. For example, funding increased to upgrade CDC capacity by 47 percent and to upgrade state and local capacity by 17 percent in fiscal year 2001. The National Pharmaceutical Stockpile Program experienced a slight increase in funding of 2 percent in fiscal year 2000 and a slight decrease in funding of 2 percent in fiscal year 2001.

**Figure 1: CDC's Bioterrorism Preparedness and Response Program Funding**




Source: GAO analysis of CDC data.

## Research Activities

CDC's research activities focus on detection, treatment, vaccination, and emergency response equipment. In fiscal year 2001, CDC was allocated $18 million to continue research on an anthrax vaccine and associated issues, such as scheduling and dosage. The agency also received $22.4 million in fiscal year 2001 to conduct smallpox research. In addition, CDC oversees a number of independent studies, which fund specific universities and hospitals to do research and other work on bioterrorism. For example, funding in fiscal year 2001 included $941,000 to the University of Findlay in Findlay, Ohio, to develop training for health care providers and other

hospital staff on how to handle victims who come to an emergency department during a bioterrorist incident. Another $750,000 was provided to the University of Texas Medical Branch in Galveston, Texas, to study various viruses in order to discover means to prevent or treat infections by these and other viruses (such as Rift Valley Fever and the smallpox virus). For worker safety, CDC's National Institute for Occupational Safety and Health is developing standards for respiratory protection equipment used against biological agents by firefighters, laboratory technicians, and other potentially affected workers.

## Preparedness Activities

Most of CDC's activities to counter bioterrorism are focused on building and expanding public health infrastructure at the federal, state, and local levels. For example, CDC reported receiving funding to upgrade state and local capacity to detect and respond to a bioterrorist attack. CDC received additional funding for upgrading its own capacity in these areas, for preparedness and response planning, and for developing the National Pharmaceutical Stockpile Program. In addition to preparing for a bioterrorist attack, these activities also prepare the agency to respond to other challenges, such as identifying and containing a naturally occurring emerging infectious disease.

### Upgrading State and Local Capacity

CDC provides grants, technical support, and performance standards to support bioterrorism preparedness and response planning at the state and local levels. In fiscal year 2000, CDC funded 50 states and four major metropolitan health departments for preparedness and response activities. CDC is developing planning guidance for state public health officials to upgrade state and local public health departments' preparedness and response capabilities. In addition, CDC has worked with the Department of Justice to complete a public health assessment tool, which is being used to determine the ability of state and local public health agencies to respond to release of biological and chemical agents, as well as other public health emergencies. Ten states (Florida, Hawaii, Maine, Michigan, Minnesota, Pennsylvania, Rhode Island, South Carolina, Utah, and Wisconsin) have completed the assessment, and others are currently completing it.

States have received funding from CDC to increase staff, enhance capacity to detect the release of a biological agent or an emerging infectious disease, and improve communications infrastructure. In fiscal year 1999, for example, a total of $7.8 million was awarded to 41 state and local health agencies to improve their ability to link different sources of data,

such as sales of certain pharmaceuticals, which could be helpful in detecting a covert bioterrorist event.

Rapid identification and confirmatory diagnosis of biological agents are critical to ensuring that prevention and treatment measures can be implemented quickly. CDC was allocated $13 million in fiscal year 1999 to enhance state and local laboratory capacity. CDC has established a Laboratory Response Network of federal, state, and local laboratories that maintain state-of-the-art capabilities for biological agent identification and characterization of human clinical samples such as blood. CDC has provided technical assistance and training in identification techniques to state and local public health laboratories. In addition, five state health departments received awards totaling $3 million to enhance chemical laboratory capabilities from the fiscal year 2000 funds. The states used these funds to purchase equipment and provide training.

CDC is working with state and local health agencies to improve electronic infrastructure for public health communications for the collection and transmission of information related to a bioterrorism incident as well as other events. For example, $21 million was awarded to states in fiscal year 1999 to begin implementation of the Health Alert Network, which will support the exchange of key information over the Internet and provide a means to conduct distance training that could potentially reach a large segment of the public health community. Currently, 13 states are connected to all of their local jurisdictions. CDC is also directly connected to groups such as the American Medical Association to reach healthcare providers.

CDC has described the Health Alert Network as a "highway" on which programs, such as the National Electronic Disease Surveillance System (NEDSS) and the Epidemic Information Exchange (Epi-X), will run. NEDSS is designed to facilitate the development of an integrated, coherent national system for public health surveillance. Ultimately, it is meant to support the automated collection, transmission, and monitoring of disease data from multiple sources (for example, clinician's offices and laboratories) from local to state health departments to CDC. This year, a total of $10.9 million will go to 36 jurisdictions for new or continuing NEDSS activities. Epi-X is a secure, Web-based exchange for public health officials to rapidly report and discuss disease outbreaks and other health events potentially related to bioterrorism as they are identified and investigated.

## Upgrading CDC Capacity

CDC is upgrading its own epidemiologic and disease surveillance capacity. It has deployed, and is continuing to enhance, a surveillance system to increase surveillance and epidemiological capacities before, during, and after special events (such as the 1999 World Trade Organization meeting in Seattle). Besides improving emergency response at the special events, the agency gains valuable experience in developing and practicing plans to combat terrorism. In addition, CDC monitors unusual clusters of illnesses, such as influenza in June. Although unusual clusters are not always a cause for concern, they can indicate a potential problem. The agency is also increasing its surveillance of disease outbreaks in animals.

CDC has strengthened its own laboratory capacity. For example, it is developing and validating new diagnostic tests as well as creating agent-specific detection protocols. In collaboration with the Association of Public Health Laboratories and the Department of Defense, CDC has started a secure Web-based network that allows state, local, and other public health laboratories access to guidelines for analyzing biological agents. The site also allows authenticated users to order critical reagents[11] needed in performing laboratory analysis of samples.

The agency has also opened a Rapid Response and Advance Technology Laboratory, which screens samples for the presence of suspicious biological agents and evaluates new technology and protocols for the detection of biological agents. These technology assessments and protocols, as well as reagents and reference samples, are being shared with state and local public health laboratories.

## Preparedness and Response Planning

One activity CDC has undertaken is the implementation of a national bioterrorism response training plan. This plan focuses on preparing CDC officials to respond to bioterrorism and includes the development of exercises to assess progress in achieving bioterrorism preparedness at the federal, state, and local levels. The agency is also developing a crisis communications/media response curriculum for bioterrorism, as well as core capabilities guidelines to assist states and localities in their efforts to build comprehensive anti-bioterrorism programs.

CDC has developed a bioterrorism information Web site. This site provides emergency contact information for state and local officials in the event of possible bioterrorism incidents, a list of critical biological and chemical

[11] A reagent is a substance used to detect the presence of another substance.

agents, summaries of state and local bioterrorism projects, general information about CDC's bioterrorism initiative, and links to documents on bioterrorism preparedness and response.

## Building the National Pharmaceutical Stockpile Program

The National Pharmaceutical Stockpile Program maintains a repository of life-saving pharmaceuticals, antidotes, and medical supplies, known as 12-Hour Push Packages, that could be used in an emergency, including a bioterrorist attack. The packages can be delivered to the site of a biological (or chemical) attack within 12 hours of deployment for the treatment of civilians. The first emergency use of the National Pharmaceutical Stockpile occurred on September 11, 2001, when in response to the terrorist attack on the World Trade Center, CDC released one of the eight Push Packages.

The National Pharmaceutical Stockpile also includes additional antibiotics, antidotes, other drugs, medical equipment, and supplies, known as the Vendor Managed Inventory, that can be delivered within 24 to 36 hours after the appropriate vendors are notified. Deliveries from the Vendor Managed Inventory can be tailored to an individual incident. The program received $51.0 million in fiscal year 1999, $51.8 million in fiscal year 2000, and $51.0 million in fiscal year 2001. CDC and the Office of Emergency Preparedness (another agency in HHS that also maintains a stockpile of medical supplies) have encouraged state and local representatives to consider stockpile assets in their emergency planning for a biological attack and have trained representatives from state and local authorities in using the stockpile. The stockpile program also provides technical advisers in response to an event to ensure the appropriate and timely transfer of stockpile contents to authorized state representatives.[12] Recently, individuals who may have been exposed to anthrax through the mail have been given antibiotics from the Vendor Managed Inventory.

[12]For more information on the National Pharmaceutical Stockpile Program, see *Combating Terrorism: Accountability Over Medical Supplies Needs Further Improvement* (GAO-01-463, Mar. 30, 2001).

## Gaps in CDC's Research and Preparedness Activities for Bioterrorism

While CDC has funded research and preparedness programs for bioterrorism, a great deal of work remains to be done. CDC and HHS have identified gaps in bioterrorism research and preparedness that need to be addressed. In addition, some of our work on naturally occurring diseases also also indicates gaps in preparedness that would be important in the event of a bioterrorist attack.

### Research Activities

Gaps in research activities center on vaccines and field testing for infectious agents. CDC has reported that it needs to continue the smallpox vaccine development and production contract begun in fiscal year 2000. This includes clinical testing of the vaccine and submitting a licensing application to the Food and Drug Administration for the prevention of smallpox in adults and children.[13] CDC also plans to conduct further studies of the anthrax vaccine. This research will include studies to better understand the immunological response that correlates with protection against inhalation anthrax and risk factors for adverse events as well as investigating modified vaccination schedules that could maintain protection and result in fewer adverse reactions. The agency has also indicated that it needs to continue research in the area of rapid assay tests to allow field diagnosis of a biological or chemical agent.

### Preparedness Activities

Gaps remain in all of the areas of preparedness activities under CDC's program. In particular, there are many unmet needs in upgrading state and local capacity to respond to a bioterrorist attack. There are also further needs in upgrading CDC's capacity, preparedness and response planning, and building the National Pharmaceutical Stockpile.

#### Upgrading State and Local Capacity

Health officials at many levels have called for CDC to support bioterrorism planning efforts at the state and local level. In a series of regional meetings from May through September 2000 to discuss issues associated with developing comprehensive bioterrorism response plans, state and local officials identified a need for additional federal support of their planning efforts. This includes federal efforts to develop effective written planning

[13]Previous plans were for 40 million doses of the vaccine to be produced initially, with expected delivery of the first full-scale production lots in 2004. The department now plans to expand and accelerate production significantly.

guidance for state and local health agencies and to provide on-site assistance that will ensure optimal preparedness and response.

HHS has noted that surveillance capabilities need to be increased. In addition to enhancing traditional state and local capabilities for infectious disease surveillance, HHS has recognized the need to expand surveillance beyond the boundaries of the public health departments. In the department's *FY 2002—FY 2006 Plan for Combating Bioterrorism*, HHS notes that potential sources for data on morbidity trends include 911 emergency calls, reasons for emergency department visits, hospital bed usage, and the purchase of specific products at pharmacies. Improved monitoring of food is also necessary to reduce its vulnerability as an avenue of infection and of terrorism. Other sources beyond public health departments can provide critical information for detection and identification of an outbreak. For example, the 1999 West Nile virus outbreak showed the importance of links with veterinary surveillance.[14] Initially there were two separate investigations: one of sick people, the other of dying birds. Once the two investigations converged, the link was made, and the virus was correctly identified.

HHS has found that state and local laboratories need to continue to upgrade their facilities and equipment. The department has stated that it would be beneficial if research, hospital, and commercial laboratories that have state-of-the-art equipment and well-trained staff were added to the National Laboratory Response Network. Currently, there are 104 laboratories in the network that can provide testing of biological samples for detection and confirmation of biological agents. Based on the 2000 regional meetings, CDC concluded that it needs to continue to support the laboratory network and identify opportunities to include more clinical laboratories to provide additional surge capacity.

CDC also concluded from the 2000 regional meetings that, although it has begun to develop information systems, it needs to continue to enhance these systems to detect and respond to biological and chemical terrorism. HHS has stated that the work that has begun on the Health Alert Network, NEDSS, and Epi-X needs to continue. One aspect of this work is developing, testing, and implementing standards that will permit surveillance data from different systems to be easily shared.

[14]See *West Nile Virus Outbreak: Lessons for Public Health Preparedness* (GAO/HEHS-00-180, Sept. 11, 2000).

During the West Nile virus outbreak, while a secure electronic communication network was in place at the time of the initial outbreak, not all involved agencies and officials were capable of using it at the same time. For example, because CDC's laboratory was not linked to the New York State network, the New York State Department of Health had to act as an intermediary in sharing CDC's laboratory test results with local health departments. CDC and the New York State Department of Health laboratory databases were not linked to the database in New York City, and laboratory results consequently had to be manually entered there. These problems slowed the investigation of the outbreak.

Moreover, we have testified that there is also a notable lack of training focused on detecting and responding to bioterrorist threats.[15] Most physicians and nurses have never seen cases of certain diseases, such as smallpox or plague, and some biological agents initially produce symptoms that can be easily confused with influenza or other, less virulent illnesses, leading to a delay in diagnosis or identification. Medical laboratory personnel require training because they also lack experience in identifying biological agents such as anthrax.

## Upgrading CDC Capacity

HHS has stated that epidemiologic capacity at CDC also needs to be improved. A standard system of disease reporting would better enable CDC to monitor disease, track trends, and intervene at the earliest sign of unusual or unexplained illness.

HHS has noted that CDC needs to enhance its in-house laboratory capabilities to deal with likely terrorist agents. CDC plans to develop agent-specific detection and identification protocols for use by the laboratory response network, a research agenda, and guidelines for laboratory management and quality assurance. CDC also plans further development of its Rapid Response and Advanced Technology Laboratory.

As we reported in September 2000, even the West Nile virus outbreak, which was relatively small and occurred in an area with one of the nation's largest local public health agencies, taxed the federal, state, and local laboratory resources. Both the New York State and the CDC laboratories were quickly inundated with requests for tests during the West Nile virus outbreak, and because of the limited capacity at the New York

[15] See *Bioterrorism: Review of Public Health Preparedness Programs* (GAO-02-149T, Oct. 12, 2001).

laboratories, the CDC laboratory handled the bulk of the testing. Officials indicated that the CDC laboratory would have been unable to respond to another outbreak, had one occurred at the same time.

**Preparedness and Response Planning**

CDC plans to work with other agencies in HHS to develop guidance to facilitate preparedness planning and associated investments by local-level medical and public health systems. The department has stated that to the extent that the guidance can help foster uniformity across local efforts with respect to preparedness concepts and structural and operational strategies, this would enable government units to work more effectively together than if each local approach was essentially unique. More generally, CDC has found a need to implement a national strategy for public health preparedness for bioterrorism, and to work with federal, state, and local partners to ensure communication and teamwork in response to a potential bioterrorist incident.

Planning needs to continue for potential naturally occurring epidemics as well. In October 2000, we reported that federal and state influenza pandemic plans are in various stages of completion and do not completely or consistently address key issues surrounding the purchase, distribution, and administration of vaccines and antiviral drugs.[16] At the time of our report, 10 states either had developed or were developing plans using general guidance from CDC, and 19 more states had plans under development. Outstanding issues remained, however, because certain key federal decisions had not been made. For example, HHS had not determined the proportion of vaccines and antiviral drugs to be purchased, distributed, and administered by the public and private sectors or established priorities for which population groups should receive vaccines and antiviral drugs first when supplies are limited. As of July 2001, HHS continued to work on a national plan. As a result, policies may differ among states and between states and the federal government, and in the event of a pandemic, these inconsistencies could contribute to public confusion and weaken the effectiveness of the public health response.

**Building the National Pharmaceutical Stockpile**

The recent anthrax incidents have focused a great deal of attention on the national pharmaceutical stockpile. Prior to this, in its *FY2002 – FY 2006 Plan for Combating Bioterrorism*, HHS had indicated what actions would be necessary regarding the stockpile over the next several years. These

[16]See *Influenza Pandemic: Plan Needed for Federal and State Response* (GAO-01-4, Oct. 27, 2000).

included purchasing additional products so that pharmaceuticals were available for treating additional biological agents in fiscal year 2002, and conducting a demonstration project that incorporates the National Guard in planning for receipt, transport, organization, distribution, and dissemination of stockpile supplies in fiscal year 2003. CDC also proposed providing grants to cities in fiscal year 2004 to hire a stockpile program coordinator to help the community develop a comprehensive plan for handling the stockpile and organizing volunteers trained to manage the stockpile during a chemical or biological event. Clearly, these longer range plans are changing, but the need for these activities remains.

## Contact and Acknowledgments

For further information about this statement, please contact me at (202) 512-7118. Robert Copeland, Marcia Crosse, Greg Ferrante, David Gootnick, Deborah Miller, and Roseanne Price also made key contributions to this statement.

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