Noting that CDC has chosen not to recommend the mass vaccination of the civilian population; and

Noting that the US Department of Health and Human Services designated the Centers for Disease Control and Prevention (CDC) to lead the effort to upgrade national public health capability to counter potential acts of bioterrorism and that in September 1999, CDC provided $40 million to fund 127 bioterrorism-related projects at state and local health departments to build public health infrastructure for both routine and emergency use;[2] and

Understanding that the CDC, in cooperation with the working group on domestic and international surveillance for possible bioterrorism, is providing public health leadership[3-5] to strengthen public health readiness to address bioterrorism through (1) surveillance to detect unusual events; (2) investigation and containment of outbreaks; (3) laboratory diagnosis; (4) coordination and communicating with the Department of Justice, Office of Emergency Preparedness, Food and Drug Administration, National Institutes of Health, Department of Defense, Federal Emergency Management Agency, and others; and (5) preparedness and planning; therefore,

1. Supports federal government efforts to provide financial resources to build state and local capacity of health departments and urges the federal government to allocate new dedicated funding to assure minimum nationwide capacity in all state and local health departments; and
2. Supports the activities of CDC in providing national public health leadership in surveillance, investigation and containment of outbreaks, laboratory diagnosis, coordination and communication, and preparedness and planning; and
3. Supports the activities of state and local health departments in providing local public health leadership in surveillance, investigation, and containment of outbreaks; laboratory diagnosis; coordination and communication; and preparedness and planning; and
4. Supports training of public health professionals in their preparation for and response to emerging and re-emerging infectious diseases, including bioterrorism and similar events; and
5. Urges that the planning for public health emergencies, such as emerging and re-emerging infectious disease, including bioterrorism, include public health professionals as a full partner with sufficient autonomy to protect the public's health; and
6. Calls on DHHS to develop a participatory process to fully evaluate whether the current funding for building capacity of the public health infrastructure and training the public health work force has been sufficient to protect the public from all outbreaks of infectious disease, including bioterrorism; and
7. Urges that this process include an objective characterization of the bioterrorist threat; an evaluation of alternatives for threat reduction; an assessment of measures necessary to guarantee that "defensive" programs do not promote offensive capabilities; an examination of other ways to primarily protect U.S. and global populations from deliberately-induced, naturally occurring, or re-emerging infectious diseases, including strengthening public health infrastructure; an analysis of potential effects on civil liberties; and, if CDC should reconsider mass vaccination of civilians populations, a scientifically rigorous assessment of the effectiveness of mass vaccinations for organisms that could be genetically modified prior to use as weapons; and
8. Reaffirms APHA's support of federal resources for security being directed to building the global capacity of the public health infrastructure to strengthen laboratories, surveillance, and technology; and
9. Urges the federal government to allocate new funding for protection of the public from emerging and re-emerging infectious diseases, including bioterrorism, that does not divert resources allocated for other human needs, underscoring APHA's long-standing commitment to the provision of adequate nutrition, housing and health care as a central tenet of public health protection.

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200017: Confirming Need for Protective National Health-Based Air Quality Standards

The American Public Health Association,

Recognizing that more than 25 million children and more than 14 million seniors over the age of 65 live in areas that fail to meet federal standards for healthy air; and that over 6.5 million people with asthma and 7.2 million people with chronic lung diseases live in these same areas; and that these populations represent those most vulnerable to high levels of ground-level ozone pollution;[1] and

Understanding that children diagnosed with asthma are especially sensitive to high levels of particulate air pollution, and are more likely to develop both acute and persistent lower respiratory tract symptoms such as increased phlegm production and bronchitis;[2] and

Understanding that many children grow up in urban and suburban areas with persistent elevated summertime ground-level ozone concentrations, and that exposure to ozone over a period of several years results in diminished lung function and increased respiratory symptoms;[3,4] and

Recognizing that elevated ozone levels are correlated with increased numbers of hospital admissions and visits to emergency rooms for asthma and other respiratory problems;[5] and that young people with asthma are more likely to visit emergency rooms for asthma treatment on days following elevated ozone levels;[6] and

Recognizing that people who exercise outdoors on days with elevated ozone pollution levels experience decreased lung function, shortness of breath, wheezing, and chest tightness;[7,8] and

Recognizing that exposure to elevated levels of particulate air pollution has been positively associated with premature mortality from cardiopulmonary conditions and reduced heart rate variability, and has been observed to exacerbate pneumonia and chronic obstructive pulmonary disease;[9-13] and

Recognizing that the largest sources of ozone and particulate air pollution are automobiles, diesel trucks, and buses, and coal-fired electricity generating plants;[14] and

Recognizing that the US Court of Appeals in May 1999 remanded to the US Environmental Protection Agency (EPA) the stricter federal ozone and fine particulate health-based standards promulgated by EPA in 1997 for further review of the constitutional limits on EPA's discretion to set the health-based standards;[15] and

Recognizing that the US Court of Appeals did not question the health science supporting EPA's decision to tighten the ozone and fine particulate standards;[16] and

Further recognizing that the US Supreme Court will review in 2000 the lower courtís decision prohibiting EPA from setting revised health standards; with a decision expected before June 2001; and

Understanding that feasible and affordable solutions exist to significantly improve air quality nationwide;[17] therefore

The American Public Health Association

1. Affirms the importance of national health-based air quality standards to offer health protection to susceptible populations, including children, from the harmful effects of air pollution, as well as the importance of basing such standards on the latest science; and

2. Urges EPA to proceed with finalizing and implementing national emission reduction strategies aimed at reducing ozone-forming pollutants, as well as other pollutants of concern such as particulate matter, using their authority under existing standards.

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200018: Public Health Impacts of Job Stress

The American Public Health Association,

Recognizing that workers in the United States are taking fewer and shorter vacations, and are working more hours over the course of a year, surpassing even Japan as the leader among major developed nations in annual hours worked per person,[1] and

Recognizing that 20% of American workers saw his or her job disappear during the 1980s, and downsizing and layoffs have continued through the end of the 1990s, despite an unprecedented economic boom, with income disparities rising to their highest levels in over a century,[2] and

Recognizing that in the US, many previously secure and well-paying jobs in diverse manufacturing industries have been exported oversees, leaving workers in the US to take lower wage nonunionized jobs,[3] and

Recognizing that more people in the US feel stressed now than in 1985, because of time urgency and worries about gaining a sense of control over their lives;[4] most with job stress rooted in heavy workloads and job insecurity combined with a lack of control over schedules and other factors;[4] jobs which constrict learning and skill development; and they are characterized by a lack of free time and reduced energy, resulting in individual isolation, passive, destructive behavior, increased drug use, as well as a decline in participation in social and political institutions;[5] and

For example, finding that health care workers, particularly those working in managed care institutions, are now finding that their job latitude and control which include their use of personal judgment is being undermined; yet these factors are critical to job satisfaction and to their own and their patients' health; and

Recognizing that how much control a person has over his or her work is important because it affects how well he or she copes with the demands of his job;[6] and that jobs that offer restricted opportunity to use skills combined with high job demands result in a high strain situation with heavy psychosocial costs in physical and mental health.[7] The so-called job demand-control hypothesis that high decision latitude and low-to-moderate work demands are good for health and that high job demands and low decision latitude are bad; similarly, the effort-reward hypothesis postulates that the risk of ill-health is increased by an imbalance between efforts and rewards;[8] such poorly-designed jobs are associated with negative health effects, including increased blood pressure;[9] heart disease,[10-14] fatigue and sleep disturbance,[15,16] musculoskeletal disorders,[17] absenteeism, job turnover, and increased acute injury rates,[18,19] and adverse effects on family and social life outside the workplace;[5] and

Realizing that additional types of job strain, such as lean production, in particular, cutting the number of workers while at the same time speeding up production, are associated with increased injury rates;[20] many of these involve non-standard shifts associated in some studies with adverse health outcomes including heart disease;[21] and

Whereas APHA has previously recognized the right to a healthful working environment[22] and the need to increase occupational disease prevention and increasing worker and union rights;[23] therefore urges that,

1. Reducing job strain and providing quality jobs are key to improving the health of workers; and
2. Improved job design depends on sustainable principles of social equity instead of short-term profitability and "lean production".[24]
3. That the Congress provide for additional occupational safety and health funding to:
   - convene employers and other professional organizations to develop research strategies and intervention methods to reduce job stress;
   - conduct further research on job stress and the mechanism of the observed increase in cardiovascular disease;
   - support investigation into job stress and its relationship to depression;
   - evaluate occupational differences and gender and ethnic differences in prevalence of job stress and resulting adverse health affects.

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