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200019: Public Health Role of the National Fire Protection Association in Setting Codes and Standards for the Built Environment

The American Public Health Association,

Having adopted Policy Statement 9916, Public Health Role of Codes Regulating the Design, Construction and Use of Buildings,[1] and recognizing the need to update and expand the policy to address other public health issues related to housing and other buildings; and

Concerned that the International Code Council (ICC) continues to compromise its process and its model codes to the detriment of public health, especially regarding home safety;[2]* and

Recognizing that the National Fire Protection Association (NFPA) has a long tradition, beginning in 1896, of reducing the burden of fire on the quality of life;[3] and

Noting that NFPA develops its standards and codes using widely recognized American National Standards Institute (ANSI) consensus procedures;[3-4] and

Pleased that in 1999, NFPA fundamentally expanded its mission statement "to reduce the worldwide burden of fire and other hazards on the quality of life by advocating scientifically-based consensus codes and standards, research, training and education";[5] and

Noting that, in late 1999 and early 2000, NFPA announced its intentions to develop a full set of codes for the built environment, including a model building code, NFPA 5000;[6] and

Acknowledging that NFPA has taken a lead in educational efforts directed at prominent injury hazards for children and elderly persons;[7]** and

Recognizing that in its educational programs, advocacy, coalition participation, and standards development, NFPA has dealt with controversial, major injury-control issues;[8-22]*** and

Concerned that, in its potential expanded role in developing a full set of codes and standards for the built environment, NFPA will be subject to greater pressure from industry organizations to compromise requirements to the detriment of public health;[6,19-23] therefore

1. Encourages NFPA to build on its leadership role by providing a clear alternative[6] to the International Codes produced by the ICC; by including public health professionals on NFPA consensus committees, by remaining true to the expanded NFPA mission statement; and by emphasizing the reduction of hazards on the quality of life through a public health approach;
2. Encourages NFPA to expand the scope of its Life Safety Code, ANSI/NFPA 101, to be more true to its title by dealing with life safety in buildings in a comprehensive fashion;
3. Encourages NFPA and other organizations to develop codes and standards requiring automatic fire sprinkler protection that is cost-effective for new homes and other buildings;****
4. Encourages NFPA and other organizations to develop codes and standards requiring home stairways to be designed and constructed so that steps and railings provide at least the same level of usability and safety from falls as do stairs and railings in other buildings;
5. Encourages NFPA, in its development of codes and standards, to utilize generally a "universal design" or inclusive design philosophy, which maximizes safety and usability for the largest range of people, including elderly persons or those of any age with disabilities;
6. Encourages collaboration and support by organizations sharing NFPA's goals for reduction of preventable injuries through scientifically-based consensus codes and standards, research, evaluation, training, and education; and
7. Urges federal, state and local government organizations to adopt progressive, responsive standards and codes, that make public health a first priority.

* Unlike the National Fire Protection Association (NFPA), the ICC has given advantage to industry interest groups, notably the National Association of Home Builders (NAHB) in relation to home safety, for example, by appointing a significant number of NAHB representatives to committees while rejecting code-development committee memberships by persons with a public health background and perspective.

** Educational programs "Risk Watch" and "Remembering When" deal, respectively, with children and elderly persons. The latter program, initiated in 1999, was developed in collaboration with the Centers for Disease Control and Prevention (CDC).

*** Prominent, in relation to ANSI/NFPA 101 (the Life Safety Code), are deliberations on requirements for sprinklering of homes, life safety for persons with disabilities, and upgraded design requirements for home stairways; the latest are also being considered for ANSI/ NFPA 501, Standard on Manufactured Housing. The proposed NFPA building code, due out in 2002, will also deal with these issues.

**** This recommendation is included even though there are indications of potential opposing opinions among at least two APHA sections (Injury Control and Gerontological Health). The concern is largely over the relationship of cost and benefit plus the possibility that requirements for sprinklering of some residential facilities will make them unaffordable or infeasible. For this reason, this proposed policy statement includes the words, "that is cost effective." It is hoped that a discussion on this particular issue—and the import of these four words—will occur among APHA sections through 2000 as it is occurring (and has occurred over many years) in other organizations.

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200020: Raising Income to Protect Health

The American Public Health Association,

Recognizing that APHA supports the right of all persons to a freely chosen job paying wages sufficient to support a dignified existence. [APHA Policy Statement 9508]; and

Finding that US has the second highest prevalence of child income poverty (22%) among wealthy countries, and most poor children live in families with at least one working parent;[1] and

Understanding that Healthy People 2010 goals specifically recognize income and educational attainent as determinants of health status; however, the goals do not identify narrowing disparities in these economic and educational determinants;[2] and

Realizing that it is unlikely that increasing access to health care services or targeting public health messages to communities in poverty alone will eliminate health disparities;[3-5] and

Recognizing that data from longitudinal studies in the United States consistently demonstrate that low income predicts premature mortality for all causes across the distribution of income and independent of other socioeconomic correlates of income;[6-11] and

Acknowledging that low income is inversely associated with poor subjective health status and functional limitations;[12-15] and

Recognizing that socioeconomic factors in childhood have been shown to predict health status in adult life, indicating that socioeconomic influences may be cumulative, have latent effects, or set an individual on a particular health trajectory;[16,17] and

Finding that educational attainment is raised and risk of single parenthood lowered due to increased family income;[18] and

Understanding that increased family income may support better utilization of primary care, likely forestalling ambulatory care sensitive hospitalizations.[19-21]

Recognizing existing labor and tax policy tools including the minimum wage and the "Earned Income Tax Credit" could be used to raise income for the working poor; and

Recognizing that the explicit health costs of poverty are not included in the calculus or public discourse regarding minimum wage and tax policy; and

Recognizing that local "living wage" ordinances have passed in more than 30 municipalities that increase wages to a level providing for the minimum average family's needs for housing and utilities, food, transportation, childcare, health care, and taxes; therefore recommends that

1. The prevalence of low income be an explicit health status indicator and reducing the prevalence of low income become a national public health objective;
2. Federal, state, and local governments should consider and evaluate labor and tax policies to increase income to minimum sustenance levels for the working poor as an explicit public health intervention; conversely, costs and benefits to health should be explicitly considered in policy debates regarding the minimum wage and eligibility thresholds for the Earned Income Tax Credit;
3. Epidemiologic studies should be done specifically to evaluate the effectiveness of income-supporting policies on public health; these may include studies that look at the effect of income dynamics on health outcomes[7,18] or studies of "natural experiments" of public policy such as local living wage ordinances or changes in tax or entitlement laws; and
4. APHA members should initiate and inform a public dialogue regarding the effect of income on health; an informed public is particularly important in light of the primary emphasis of media and advertising messages on individual behavior changes, pharmaceutical interventions, and the importance of health care services and institutions.

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