Community Health Centers

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Contention One: Inherency

Community Health Centers first arose decades ago and have recently blossomed under the Bush administration. Millions of people who live in poverty are served each year. However millions of people across the country still lack access to affordable primary care in the status quo. The recent economic decline has only increased the demand and makes government funding vulnerable to belt tightening measures

New York Times, 12-26-08

[By Kevin Sack, "For Bush, a Rise In Health Clinics Shapes a Legacy," *The New York Times*, December 26, 2008, SECTION: Section A; Pg. 1; lexis-nexis]

Although the number of uninsured and the cost of coverage have ballooned under his watch, President Bush leaves office with a health care legacy in bricks and mortar: he has doubled federal financing for community health centers, enabling the creation or expansion of 1,297 clinics in medically underserved areas.

For those in poor urban neighborhoods and isolated rural areas, including Indian reservations, the clinics are often the only dependable providers of basic services like prenatal care, childhood immunizations, asthma treatments, cancer screenings and tests for sexually transmitted diseases.

As a crucial component of the health safety net, they are lauded as a cost-effective alternative to hospital emergency rooms, where the uninsured and underinsured often seek care.

Despite the clinics' unprecedented growth, wide swaths of the country remain without access to affordable primary care. The recession has only magnified the need as hundreds of thousands of Americans have lost their employer-sponsored health insurance along with their jobs.

In response, Democrats on Capitol Hill are proposing even more significant increases, making the centers a likely feature of any health care deal struck by Congress and the Obama administration.

In Nashville, United Neighborhood Health Services, a 32-year-old community health center, has seen its federal financing rise to $4.2 million, from $1.8 million in 2001. That has allowed the organization to add eight clinics to its base of six, and to increase its pool of patients to nearly 25,000 from 10,000.

Still, says Mary Bufwack, the center's chief executive, the clinics satisfy only a third of the demand in Nashville's pockets of urban poverty and immigrant need.

One of the group's recent grants helped open the Southside Family Clinic, which moved last year from a pair of public housing apartments to a gleaming new building on a once derelict corner.

As she completed a breathing treatment one recent afternoon, Willie Mai Ridley, a 68-year-old beautician, said she would have sought care for her bronchitis in a hospital emergency room were it not for the new clinic. Instead, she took a short drive, waited 15 minutes without an appointment and left without paying a dime; the clinic would bill her later for her Medicare co-payment of $18.88.

Ms. Ridley said she appreciated both the dignity and the affordability of her care. "This place is really very, very important to me," she said, "because you can go and feel like you're being treated like a person and get the same medical care you would get somewhere else and have to pay $200 to $300."

As governor of Texas, Mr. Bush came to admire the missionary zeal and cost-efficiency of the not-for-profit community health centers, which qualify for federal operating grants by being located in designated underserved areas and treating patients regardless of their ability to pay. He pledged support for the program while campaigning for president in 2000 on a platform of "compassionate conservatism."

In Mr. Bush's first year in office, he proposed to open or expand 1,200 clinics over five years (mission accomplished) and to double the number of patients served (the increase has ended up closer to 60 percent). With the health centers now serving more than 16 million patients at 7,354 sites, the expansion has been the largest since the program's origins in President Lyndon B. Johnson's war on poverty, federal officials said.

''They're an integral part of a health care system because they provide care for the low-income, for the newly arrived, and they take the pressure off of our hospital emergency rooms,'' Mr. Bush said last year while touring a clinic in Omaha.

With federal encouragement, the centers have made a major push this decade to expand dental and mental health services, open on-site pharmacies, extend hours to nights and weekends and accommodate recent immigrants -- legal and otherwise -- by employing bilingual staff. More than a third of patients are now Hispanic, according to the National Association of Community Health Centers.

↓ New York Times '08 article continues ↓

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↓ New York Times '08 article continues ↓

The centers now serve one of every three people who live in poverty and one of every eight without insurance. But a study released in August by the Government Accountability Office found that 43 percent of the country's medically underserved areas lack a health center site. The National Association of Community Health Centers and the American Academy of Family Physicians estimated last year that 56 million people were ''medically disenfranchised'' because they lived in areas with inadequate primary care.

President-elect Barack Obama has said little about how the centers may fit into his plans to remake American health care. But he was a sponsor of a Senate bill in August that would quadruple federal spending on the program -- to $8 billion from $2.1 billion -- and increase incentives for medical students to choose primary care. His wife, Michelle, worked closely with health centers in Chicago as vice president for community and external relations at the University of Chicago Medical Center.

And Mr. Obama's choice to become secretary of health and human services, former Senator Tom Daschle of South Dakota, argues in his recent book on health care that financing should be increased, describing the health centers as "a godsend."

The federal program, which was first championed in Congress by Senator Edward M. Kennedy, Democrat of Massachusetts, has earned considerable bipartisan support. Leading advocates, like Senator Bernie Sanders, independent of Vermont, and Representative James E. Clyburn, Democrat of South Carolina, the House majority whip, argue that any success Mr. Obama has in reducing the number of uninsured will be meaningless if the newly insured cannot find medical homes. In Massachusetts, health centers have seen increased demand since the state began mandating health coverage two years ago.

At $8 billion, the Senate measure may be considered a relative bargain compared with the more than $100 billion needed for Mr. Obama's proposal to subsidize coverage for the uninsured. If his plan runs into fiscal obstacles, a vast expansion of community health centers may again serve as a stopgap while universal coverage waits for flusher times.

Recent job losses, meanwhile, are stoking demand for the clinics' services, often from first-time users. The United Neighborhood Health Services clinics in Nashville have seen a 35 percent increase in patients this year, with much of the growth from the newly jobless.

''I'm seeing a lot of professionals that no longer have their insurance or they're laid off from their jobs,'' said Dr. Marshelya D. Wilson, a physician at the center's Cayce clinic. "So they come here and get their health care."

Studies have generally shown that the health centers -- which must be governed by patient-dominated boards -- are effective at reducing racial and ethnic disparities in medical treatment and save substantial sums by keeping patients out of hospitals. Their trade association estimates that they save the health care system $17.6 billion a year, and that an equivalent amount could be saved if avoidable emergency room visits were diverted to clinics. Some centers, including here in Nashville, have brokered agreements with hospitals to do exactly that.

Many centers are finding that federal support is not keeping pace with the growing cost of treating the uninsured. Government grants now account for 19 percent of community health center revenues, compared with 22 percent in 2001, according to the Health Resources and Services Administration, which oversees the program. The largest revenue sources are public insurance plans like Medicaid, Medicare and the State Children's Health Insurance Program, making the centers vulnerable to government belt-tightening.

The centers are known for their efficiency. Though United Neighborhood Health Services has more than doubled in size this decade, Ms. Bufwack, its chief executive, manages to run five neighborhood clinics, five school clinics, a homeless clinic, two mobile clinics and a rural clinic, with 24,391 patients, on a budget of $8.1 million. Starting pay for her doctors is $120,000. Patients are charged on an income-based sliding scale, and the uninsured are expected to pay at least $20 for an office visit. One clinic is housed in a double-wide trailer.

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56 million people find themselves without a place to go for basic health care. So problems often go untreated and develop into more serious conditions

Wheeler '07

[By Larry Wheeler, Gannett News Service, HEADLINE: Poor, uninsured depend on community health centers, Great Falls Tribune (Montana), August 23, 2007, SECTION: A SECTION; Pg. 1A, lexis-nexis]

About 56 million people, including many with health insurance, live in places where there are acute shortages of primary care physicians and little prospect for improvement, according to the National Association of Community Health Centers.

Without a community health center, they lack clear options for treating problems such as an infected tooth or high blood pressure that can develop into more serious conditions.

"The toll of unmet health care needs among these health care have-nots is incalculable, and the tragic outcomes they experience are appalling," Joseph Feaster, a board member of the Whittier Street Community Health Center in Boston said at a congressional briefing this spring.

Family practitioners, pediatricians and obstetrician-gynecologists are in short supply, especially in urban neighborhoods and rural towns where the centers are located.

There are more than 2,500 clinical vacancies at community health centers across the country, according to the National Health Service Corps. It offers grants, scholarships and student loan repayments to those who agree to work in medically underserved settings.

The number of doctors, dentists and other medical professionals employed at community health centers through the corps has increased by 74 percent since 2002, but that hasn't been enough.

Some of the reasons have to do with money.

Funding for the National Health Service Corps, a vital source of medical professionals for community health centers, has not kept pace with the growing need.

Because community health centers depend so heavily on federal, state and local government money and to a lesser extent on grants from hospitals and charities doctors at the centers make less than they would in private practice.

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Contention Two: Harms

A huge epidemic of influenza is inevitable. It will be worse than the Spanish flu that killed 100 million and even a "mild" outbreak would be devastating

Osterholm, Professor of Public Health, Minnesota, '05

[Michael T., Director of the Center for Infectious Disease Research and Policy, Associate Director of the Department of Homeland Security's National Center for Food Protection and Defense, and Professor at the University of Minnesota's School of Public Health, Jul/Aug, "Preparing for the Next Pandemic," Foreign Affairs, vol. 84 issue 8, lexis-nexis]

DATING BACK to antiquity, influenza pandemics have posed the greatest threat of a worldwide calamity caused by infectious disease. Over the past 300 years, ten influenza pandemics have occurred among humans. The most recent came in 1957-58 and 1968-69, and although several tens of thousands of Americans died in each one, these were considered mild compared to others. The 1918-19 pandemic was not. According to recent analysis, it killed 50 to 100 million people globally. Today, with a world population of 6.5 billion, more than three times that of 1918, even a "mild" pandemic could kill many millions of people.
A number of recent events and factors have significantly heightened concern that a specific near-term pandemic may be imminent. It could be caused by H5N1, the avian influenza strain currently circulating in Asia. At this juncture scientists cannot be certain. Nor can they know exactly when a pandemic will hit, or whether it will rival the experience of 1918-19 or be more muted like 1957-58 and 1968-69. The reality of a coming pandemic, however, cannot be avoided. Only its impact can be lessened. Some important preparatory efforts are under way, but much more needs to be done by institutions at many levels of society.

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The epidemic that emerges from the inevitable mutation would be capable of killing 40 percent of the world population while disrupting trade, the economy and worldwide security

Garrett, Senior Fellow for Global Health, Council on Foreign Relations, '05
[Laurie, "The Next Pandemic," Foreign Affairs, Jul/Aug., vol. 84 issue 4, lexis-nexis]

SCIENTISTS HAVE long forecast the appearance of an influenza virus capable of infecting 40 percent of the world's human population and killing unimaginable numbers. Recently, a new strain, H5N1 avian influenza, has shown all the earmarks of becoming that disease. Until now, it has largely been confined to certain bird species, but that may be changing.
The havoc such a disease could wreak is commonly compared to the devastation of the 1918-19 Spanish flu, which killed 50 million people in 18 months. But avian flu is far more dangerous. It kills 100 percent of the domesticated chickens it infects, and among humans the disease is also lethal: as of May 1, about 109 people were known to have contracted it, and it killed 54 percent (although this statistic does not include any milder cases that may have gone unreported). Since it first appeared in southern China in 1997, the virus has mutated, becoming heartier and deadlier and killing a wider range of species. According to the March 2005 National Academy of Science's Institute of Medicine flu report, the "current ongoing epidemic of H5N1 avian influenza in Asia is unprecedented in its scale, in its spread, and in the economic losses it has caused." In short, doom may loom. But note the "may." If the relentlessly evolving virus becomes capable of human-to-human transmission, develops a power of contagion typical of human influenzas, and maintains its extraordinary virulence, humanity could well face a pandemic unlike any ever witnessed. Or nothing at all could happen. Scientists cannot predict with certainty what this H5N1 influenza will do. Evolution does not function on a knowable timetable, and influenza is one of the sloppiest, most mutation-prone pathogens in nature's storehouse. Such absolute uncertainty, coupled with the profound potential danger, is disturbing for those whose job it is to ensure the health of their community, their nation, and broader humanity. According to the Centers for Disease Control and Prevention (CDC), in a normal flu season about 200,000 Americans are hospitalized, 38,000 of whom die from the disease, with an overall mortality rate of .008 percent for those infected. Most of those deaths occur among people older than 65; on average, 98 of every 100,000 seniors with the flu die. Influenza costs the U.S. economy about $12 billion annually in direct medical costs and loss of productivity.
Yet this level of damage hardly approaches the catastrophe that the United States would face in a severe flu pandemic. The CDC predicts that a "medium-level epidemic" could kill up to 207,000 Americans, hospitalize 734,000, and sicken about a third of the U.S. population. Direct medical costs would top $166 billion, not including the costs of vaccination. An H5N1 avian influenza that is transmittable from human to human could be even more devastating: assuming a mortality rate of 20 percent and 80 million illnesses, the United States could be looking at 16 million deaths and unimaginable economic costs. This extreme outcome is a worst-case scenario; it assumes failure to produce an effective vaccine rapidly enough to make a difference and a virus that remains impervious to some antiflu drugs. But the 207,000 reckoning is clearly a conservative guess.
The entire world would experience similar levels of viral carnage, and those areas ravaged by HIV and home to millions of immunocompromised individuals might witness even greater death tolls. In response, some countries might impose useless but highly disruptive quarantines or close borders and airports, perhaps for months. Such closures would disrupt trade, travel, and productivity. No doubt the world's stock markets would teeter and perhaps fall precipitously. Aside from economics, the disease would likely directly affect global security, reducing troop strength and capacity for all armed forces, UN peacekeeping operations, and police worldwide.

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New disease mutations or a deliberate bio-weapon attack could threaten world survival. And such an outbreak would be more deadly than nuclear weapons

Steinbruner, Professor of Public Policy, University of Maryland, '98

[John D., Winter, "Biological Weapons: A Plague Upon All Houses," Foreign Policy, no. 109, http://foreignpolicy.com/Ning/archive/archive/109/bioweaapons.pdf?PHPSESSID=69349c202f36a15067fc6fd6ef26df77 download date: 9-5-05]

Although human pathogens are often lumped with nuclear explosives and lethal chemicals as potential weapons of mass destruction, there is an obvious, fundamentally important difference: Pathogens are alive, weapons are not. Nuclear and chemical weapons do not reproduce themselves and do not independently engage in adaptive behavior; pathogens do both of these things.

That deceptively simple observation has immense implications. The use of a manufactured weapon is a singular event. Most of the damage occurs immediately. The aftereffects, whatever they may be, decay rapidly over time and distance in a reasonably predictable manner. Even before a nuclear warhead is detonated, for instance, it is possible to estimate the extent of the subsequent damage and the likely level of radioactive fallout. Such predictability is an essential component for tactical military planning. The use of a pathogen, by contrast, is an extended process whose scope and timing cannot be precisely controlled. For most potential biological agents, the predominant drawback is that they would not act swiftly or decisively enough to be an effective weapon. But for a few pathogens---ones most likely to have a decisive effect and therefore the ones most likely to be contemplated for deliberately hostile use--the risk runs in the other direction. A lethal pathogen that could efficiently spread from one victim to another would be capable of initiating an intensifying cascade of disease that might ultimately threaten the entire world population. The 1918 influenza epidemic demonstrated the potential for a global contagion of this sort but not necessarily its outer limit.

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What happens in the U.S. is key – the level of animal concentration makes the U.S. the most important vector for bird flu, swine flu, and completely new mixed, mutated forms of flu

Greger '6

[Michael, Director of Public Health and Animal Agriculture at The Humane Society of the United States, graduate of the Cornell University School of Agriculture and the Tufts University School of Medicine, Bird Flu: A Virus of Our Hatching, http://birdflubook.com/a.php?id=58 download date: 9-5-08]

Within months, the virus showed up in Texas, Minnesota, and Iowa.1293 Within a year, it had spread across the United States.Pigs did not begin to fly. The rapid dissemination across the country was blamed on long-distance live animal transport.1295 **In the United States, pigs travel coast to coast.** They can be bred in North Carolina, fattened in the corn belt of Iowa, and slaughtered in California.1296 While this may reduce short-term costs for the pork industry, **the highly contagious nature of diseases like influenza** (perhaps made further infectious by the stresses of transport) **needs to be considered when calculating the true cost of long-distance live animal transport. What led to the emergence of this strain in the first place? What changed** in the years leading up to 1998 **that facilitated the surfacing of such a unique strain? It is** likely **no coincidence that the virus emerged in** boss hog **North Carolina, the home of the nation's largest pig farm**.1298 **North Carolina has the densest pig population in North America and boasts more than twice as many corporate swine mega-factories as any other state.**1299 The year of emergence, 1998, was the year North Carolina's pig population hit ten million, up from two million just six years before.1300 At the same time, the number of hog farms was decreasing, from 15,000 in 1986 to 3,600 in 2000. How do five times more animals fit on almost five times fewer farms? By cramming about 25 times more pigs into each operation. In the 1980s, more than 85% of all North Carolina pig farms had fewer than 100 animals. By the end of the 1990s, operations confining more than 1,000 animals controlled about 99% of the state's inventory. Given that the primary route of swine flu transmission is thought to be the same as human flu—via droplets or aerosols of infected nasal secretions —it's no wonder experts blame overcrowding for the emergence of new flu virus mutants. Starting in the early 1990s, the U.S. pig industry restructured itself after Tyson's profitable poultry model of massive industrial-sized units.1304 As a headline in the trade journal National Hog Farmer announced, "Overcrowding Pigs Pays—If It's Managed Properly."1305 The majority of U.S. pig farms now confine more than 5,000 animals each. A veterinary pathologist from the University of Minnesota stated the obvious in Science: "With a group of 5,000 animals, if a novel virus shows up it will have more opportunity to replicate and potentially spread than in a group of 100 pigs on a small farm."1306 Europe is facing a similar situation.1307 **Virginia-based Smithfield is the largest pork producer in the world, raking in more than $10 billion in annual revenue and posting record profits in 2005,** in part because of its expansion of factory-sized pig farms in Europe.1308 This trend is raising a stink among both environmentalists1309 and public health officials.1310 By 1993, a bird flu virus had adapted to pigs, grabbed a few human flu virus genes, and infected two young Dutch children, even displaying evidence of limited human-to-human transmission.1311 Denmark is the North Carolina of Europe. In 1970, the number of pig farms with more than 500 animals was zero. Between 1980 and 1994, 70% of the pig farms went out of business at the same time the pig population climbed to more than ten million.1312 Today, this tiny country is the largest exporter of pork in the world.1313 The world's bans on Asian poultry because of bird flu, combined with bans on U.S. beef because of mad cow disease, are, according to the chairman of Denmark's Bacon and Meat Council, "beginning to favourably affect demand."1314 "Influenza [in pigs] is closely correlated with pig density," said a European Commission-funded researcher studying the situation in Europe.1315 As such, Europe's rapidly intensifying pig industry has been described in Science as "a recipe for disaster."1316 Some researchers have speculated that the next pandemic could arise out of "Europe's crowded pig barns."1317 The European Commission's agricultural directorate warns that the "concentration of production is giving rise to an increasing risk of disease epidemics."1318 Concern over epidemic disease is so great that Danish laws have capped the number of pigs per farm and put a ceiling on the total number of pigs allowed to be raised in the country.1319 **No such limit exists in the United States. Complicating the U.S. picture,** the new swine viruses appear to be crossing back to commercial poultry, as reported in the CDC journal Emerging Infectious Diseases. **The investigators warn: "Repeated introductions of swine influenza viruses to turkeys, which may be co-infected with avian influenza viruses, provide opportunities for the emergence of novel reassortments with genes adapted for replication in** pigs or even **humans."**1320 **North Carolina is also a top poultry producer. Webster blames the triple assortment of the 1998 virus on the "recently evolving intensive farming practice in the USA, of raising pigs and poultry in adjacent sheds** with the same staff," **a practice he calls "unsound**."1321 **With massive concentrations of farm animals within which to mutate, these new swine flu viruses in north America seem to be on an evolutionary fast track, jumping and reassorting between species at an unprecedented rate.**1322 In 2006, the pig/bird/human triple reassortment strain was isolated from a farm worker in Canada.3175 **This reassorting, Webster's team concludes, makes the 60 million strong**1323 **U.S. pig population an "increasingly important reservoir of viruses with human pandemic potential."**1324 "**We used to think that the only important source of genetic change in swine influenza was in Southeast Asia,"** says a molecular virologist at the University of Wisconsin. Now, after H5N1, "**we need to look in our own backyard for where the next pandemic may appear**."1325

1AC

Pandemics can circle the globe in 24 hours – one billion people would die in the first six months – humanity is a half-step away from worldwide pandemic catastrophe

Greger '6

[Michael, Director of Public Health and Animal Agriculture at The Humane Society of the United States; Graduate of the Cornell University School of Agriculture and the Tufts University School of Medicine. Also an internationally recognized lecturer, he has presented at the Conference on World Affairs, the National Institutes of Health, and the International Bird Flu Summit, among countless other symposia and institutions. "Population Bust" http://www.Birdflubook.com download date: 2-2-09]

A pandemic today could be **many times worse** than the pandemic of 1918, the world's greatest medical catastrophe. In 1918 we were, as a nation and as a people, much more self-sufficient.565 With the corporate triumph of free trade, just-in-time inventory management and global supply chains now characterize all major economies and business sectors.566 Economic analysts predict the pandemic would cause a **global economic collapse** unprecedented in modern history.567 With the global population at an historical high, this could lead to unprecedented human suffering. A short 100,000 years ago, all members of the human race lived in eastern Africa.568 The 6.5 billion people alive today represent roughly one out of every nine people who have ever inhabited the Earth.569 In 1918, cities like London were smaller, with just over than one million residents. Today there are 26 megacities in the world, each with more than ten million people.570 With this kind of tinder, experts like the WHO's Klaus Stöhr predict the pandemic will **"explosively" hit world populations "like a flash flood."**571
"The rapidity of the spread of influenza throughout a country is only limited by the rapidity of the means of transportation," explained the 1918 New York State Health Commissioner.572 Back then, the fastest way to cross the world was by steamship.573 In the past, a trip around the world took a year; **today we and our viruses can circle the globe in 24 hours.**574 The number of human globe-trotters now exceeds one billion people a year.575 AIDS left Africa on an aircraft. So too may H5N1 leave Asia, only a plane ride away. Between record population levels and the unprecedented current speed, volume, and reach of global air travel, any pandemic virus could wreak unparalleled havoc.576 H5N1, though, promises to be more than just any pandemic virus. In all of his more than 40 years working with influenza viruses, Robert Webster can state unequivocally, "This is the worst flu virus I have ever seen or worked with or read about."577 At a congressional briefing, Gregory A. Poland of the Mayo Clinic and the Infectious Diseases Society of America tried to get members of Congress to imagine the unimaginable—an H5N1 pandemic. "I want to emphasize **the certainty that a pandemic will occur**," he began. "When this happens, time will be described, for those left living, as before and after the pandemic."578 The top virologist in Russia attempted to tally the worst-case scenario potential human death count: "Up to one billion people could die around the whole world in six months…. **We are half a step away from a worldwide pandemic catastrophe**."579

1AC

We must act quickly – new strains in 2009 could produce major outbreaks
Engel '9

[Mary Engel, "New bird flu outbreaks revive concern; Despite a two-year decline, the virus has continued to 'smolder,' underscoring warnings of a possible pandemic," Los Angeles Times, 1-4, Lexis-Nexis]

Just when you thought you could scratch bird flu off your list of things to worry about in 2009, the deadly H5N1 virus has resurfaced in poultry in Hong Kong **for the first time in six years**, reinforcing warnings that **the threat of a human pandemic isn't over.** India, Bangladesh, Vietnam and mainland China also experienced new outbreaks in December. During the same period, four new human cases -- in Egypt, Cambodia and Indonesia -- were reported to the World Health Organization. A 16-year-old girl in Egypt and a 2-year-old girl in Indonesia have died. The new cases come after a two-year decline in the number of confirmed human deaths from H5N1 bird flu and as fewer countries are reporting outbreaks among poultry. A United Nations report released in October credits improved surveillance and the rapid culling of potentially infected poultry for helping to contain and even prevent outbreaks in many countries. Yet H5N1 has continued to "at the very least smolder, and many times flare up" since the chain of outbreaks began in 2003, said Michael T. Osterholm, director of the Center for Infectious Disease Research and Policy at the University of Minnesota in Minneapolis. The year-end uptick is a reminder of how quickly the situation can turn as long as the H5N1 virus is still out there, Osterholm and other scientists said. "What alarms me is that **we have developed a sense of pandemic-preparedness fatigue**," he said. H5N1 already has been a disaster for poultry farmers in Asia. Public health officials estimate that as many as half a billion fowl have been killed by the virus or culled to contain its spread, causing enormous economic strain and food shortages. But the bigger fear has always been that H5N1 would give rise to a human pandemic like the so-called Spanish flu of 1918, which killed an estimated 50 million people worldwide. It was in Hong Kong in 1997 that the H5N1 virus was first observed to jump from chickens to humans, infecting 18 people and killing six of them, raising fears of a worldwide catastrophe. Hong Kong ordered its entire poultry population, estimated at 1.6 million birds, destroyed within three days. A more recent chain of poultry outbreaks began in South Korea in 2003 and spread over the years to 61 countries in Asia, Africa and Europe. To fuel a pandemic, a virus must be able to both infect humans and spread readily from person to person. The currently circulating H5N1 strain does neither well. The total number of verified human cases since the 2003 outbreak began is 391, of whom 247 died. After peaking in 2006 at 115 human cases with 79 deaths, human infections dropped to 40 in 2008, with 30 deaths, according to a World Health Organization update in mid-December. Most of the human cases were traced to direct contact with poultry, especially in Southeast Asia where many people have backyard flocks and few wear gloves or masks while handling them. The few suspected human-to-human transmissions occurred in those who were closely involved in caring for an infected relative. But as long as the virus continues to circulate, the threat that it could mutate to pass more easily among humans remains, according to the U.N. report. The Hong Kong poultry outbreak last month is significant because the government thought it had stamped out H5N1 in the Chinese territory after an outbreak in 2003. Since then, Hong Kong has vaccinated poultry against the virus and strictly regulated farm sanitation. The government ordered the slaughter of 80,000 fowl at two large farms after the latest outbreak killed 60 chickens at one of the farms. Investigators are looking for the source of the infection and testing the effectiveness of the vaccine used since 2003 to inoculate chickens, geese and ducks against H5N1. Hong Kong uses a vaccine that protects poultry against several flu subtypes. But some scientists believe that the **H5N1** virus **may have mutated to break through the vaccine**. Flu viruses change constantly, which is why human vaccines for seasonal flu are modified every year, said Scott P. Layne, a professor of epidemiology and environmental health sciences at UCLA. Mainland China is using a newer poultry vaccine developed specifically for H5N1. But vaccination programs there and in Vietnam have not eliminated outbreaks. The vaccine itself could be the problem, said Robert Webster, a virologist and avian flu expert at St. Jude Children's Research Hospital in Memphis, Tenn. Vaccines should be used only in areas where the virus is out of control, and then only temporarily, he said. That is because routinely administering the vaccine encourages the evolution to resistant strains. Some countries have managed to stop the virus by culling infected poultry flocks. Japan, South Korea and Malaysia are considered to be free of H5N1, according to the World Health Organization. But the virus appears to be entrenched in Indonesia, parts of China, Vietnam, Egypt and other countries where backyard flocks are more difficult to regulate than commercial chicken farms, according to the United Nations' Food and Agriculture Organization. Though bird flu viruses are common, highly pathological ones such as the 1918 virus and H5N1 -- which has been lethal to 100% of chickens infected and 63% of humans known to be infected -- are rare. Scientists have little experience with which to gauge how H5N1 will evolve. But, Webster said, **"We** still **have to treat this as a** potentially very, **very dangerous virus**."

1AC

PLAN:

[Create your plan in accordance with the judge preferences of your circuit]

1AC

Contention Three: Solvency

Only sustained funding of operation revenue to community health centers can ensure that primary health care is available for those people in poverty seeking help. Supplementary funding is needed.

Roby, Senior Research Associate, George Washington Center for Health Services Research and Policy, '2

[Dylan H. Roby, PhD, Senior research associate at The George Washington University Center for Health Services Research and Policy and an instructor an instructor in the Department of Health Policy. Doctoral degree in public policy from The George Washington University. "A Profile of Federally Funded Health Centers Serving a Higher Proportion of Uninsured Patients," by Anne Markus, Dylan H. Roby (lead author), Sara Rosenbaum,; Published by the UCLA Center for Health Policy Research, June 2002, http://www.healthpolicy.ucla.edu/pubs/publication.asp?pubID=353 download date: 6-19-09]

The findings presented in this report confirm the association between the overall geographic patterns of uninsured, nonelderly persons and the responsiveness of the health centers program. The results of this analysis confirm that health centers function as would be expected given their mission. As the rate of uninsured persons increases, the number and proportion of health centers with high uninsured levels also increases. Although health centers have care to the uninsured as a central part of their missions, they are particularly sensitive to uninsured patterns in the general population and highly sensitive to the existence of state insurance programs aimed at low income persons. Indeed, centers where uninsured patients make up a smaller percentage of their total patient population have been able to rely on Medicaid revenues to support their mission.

Second, in the South and West, where poverty is the highest and insurance rates the lowest, the survival of health centers along with other safety net providers is critical because of the need for subsidized primary health care. Yet, the findings from this study suggest that the very regions of the nation that exhibit the greatest need for such support are also the regions where the greatest concentration of centers with high levels of uninsured patients and limited revenue bases are located. The link between location in high uninsured regions of the country and the presence of high level uninsured centers raises questions regarding how best to support the safety net in these regions. With so many uninsured patients, these centers have a greater than average need for operating revenues to enable them to furnish subsidized health care. Yet these are the centers least likely to be able to generate the Medicaid revenues needed to help offset the cost of overall operations (because eligibility levels often fall below national averages in these regions). Furthermore, high-level uninsured centers are more likely to have special missions related to the care of patients disproportionately at risk for a lack of coverage, such as migrant farm workers and homeless families.

Given the use of health centers by Medicaid beneficiaries, efforts to expand coverage in these states could be expected not only to directly aid more uninsured persons but also to indirectly aid support of health care to uninsured patients. As the proportion of patients insured through Medicaid rises, the infusion of revenues can be expected to strengthen the overall operating capacity of health centers. Despite the fact that virtually all children who use health centers have low incomes and should qualify for some public coverage, 35 percent of all pediatric patients served at health centers were uninsured in 1999.

Indeed, better enrollment outreach and outstationing efforts for Medicaid and CHIP could be expected to have a major impact on the long-term economic health of these health centers. A 1998 study of outstationed enrollment at health centers found that less than half reported any outstationing activities and that the overwhelming cause of limited to no outstationing efforts was a lack of revenues to support such activities. The impact on health centers of high levels of uninsured patients underscores the need for additional revenues aimed at finding and enrolling insured patients.

Finally, the findings from this study underscore that even were coverage rates to increase and payments per covered person to rise, these health centers that have been assigned special care missions, such as services to migrant and homeless families, can be expected to generate very little in the way of third party revenues. Along with their role in the provision of care to low income non-citizens, health centers are singular in their statutorily-based involvement with such high risk populations. Even the most efficiently operated health centers need significant supplemental revenues to carry out this mission. Thus, the continued increase in funding for the operation of health centers remains essential to their success. Programs that offer merely startup capitalization cannot succeed in light of the large number of patients whose care will require ongoing subsidization.

1AC

Continued expanded support for Community Health Centers will help the clinics continue their efforts, help more people and contain any spread of communicable disease. CHC's are crucial to the early identification and reporting of disease outbreaks. CHC's help to prevent, detect, and treat people in order to block an epidemic from spreading. And they help to reduce panic during outbreaks too.

Gayle, Institute for Family Health, '07

[Eric Gayle, M.D., Bronx Regional Medical Director, Institute for Family Health, Testimony before the House Committee on Oversight and Government Reform, Hearing on Drug Resistant Infections, CQ Transcriptions, LLC, Political Transcript Wire, lexis-nexis]

Thank you for the opportunity to address the critical subject of methicillin-resistant Staph. aureus, or MRSA as it's commonly called, specifically in the context of how this affects vulnerable communities like the Bronx, and the role that community health centers can play in this regard.
I am a family physician who has practiced primary care in the Bronx, New York, for the past nine years, and the Bronx regional medical director for the Institute for Family Health, an organization that provides over 75,000 people in New York state, most of them ethnic minorities, and the majority on Medicaid or uninsured.
I am here today to provide testimony that speaks to the specific needs of my community in respect to MRSA and the critical role that community health centers play in the management of contagious diseases such as this.
My most recent contact with community-acquired MRSA was June 2007. Let me reassure you, as I reassure my patients, that MRSA has been in the community for many years, and has been successfully treated well by community health center physicians, for the most part without much fanfare.
MRSA is significant to the health of the individual and to the community mainly if it goes unrecognized and thus is improperly treated.
The problem for community health center physicians is that oftentimes we are called upon to evaluate the patient only after the infection has significantly progressed and the patient is already ill, and possibly toxic.
This is because community health centers are known as places where people can seek care, even if they are uninsured or if they need care in their own language, or even if they become ill in a crisis. We are truly a major part of what has been termed the community's health care safety net.
Community health centers do their best work when they are involved in the prevention of illnesses. One can never do enough in the education of our patients and the public, so that once there is a question about any illness or malady, that they know that they need to contact their primary care provider immediately.
This is the role that community health centers play, and play so well. We are often the first contact for our patients for whatever their health concerns are.
But tragically, many families do not have a medical home, do not have a community health center such as ours to go to. We need to continue to grow and develop these vital community resources so that they are available everywhere.
Where else will patients be educated to take care in their personal health, particularly as it relates to communicable diseases? We advice them that, if they have open sores or rashes, that they ought not to participate in contact sports activities, advise the kids not to share towels in gym, and not to go to school or to work with any contagious illness.
With MRSA now seemingly more prevalent, community health centers with electronic health record capabilities can closely monitor the patients they are seeing for possible outbreaks within a particular community, and similarly alert community providers of any clusters of infections being seen.
With the dramatic media coverage of this infection, MRSA, there is no better place for the community and for patients to receive important information about this disease, and the necessary precautions that one must take, than their local community health center.
Emergency rooms and hospitals have neither the time nor the opportunity to spend in the education of the patients about proper hygiene techniques, most of which we have heard already today.
I would caution all that we need to remember that we are living in times where our communities are constantly being reminded of the many other serious and contagious illnesses that are out there. In communities where there are immigrants from multiple nations and where international travel is common, these include West Nile virus, avian flu, tuberculosis and the risk for both epidemics and pandemics.
Community health centers are the medical home for millions of patients nationally, and our patients are provided not only high-quality, accessible and affordable health care, but extensive health education. In the case of MRSA, a major role has been the dispersal of large quantities of reassurance.

↓ Gayle '07 article continues ↓

↓ Gayle '07 article continues ↓

I want to mention one other point in closing. The Institute for Family Health, where I work, has installed a state-of-the-art electronic medical records system, which is integrated into the Syndromic surveillance system of the New York City Health Department. Every night, all the patient encounter information from the day's visits -- stripped of any identifying information -- is downloaded to the health department for analysis. The health department looks for any symptoms like rash or boils that might be appearing at a higher than normal frequency that day. This kind of sentinel network gives the health department -- and thus, all physicians in the community -- a jumpstart on containing an outbreak of infection illness.

My patients -- your constituents -- deserve this type of investment in their health. This can only occur if there is funding provided for electronic medical records in the community health centers, allowing for integration of health center systems with public health departments, to get more accurate and more timely information out to the public.

Thank you for listening and for the opportunity to address the committee. Continued support to provide a community health center home for all vulnerable people, and to provide information technology in support of the providers who work there, will ultimately work to contain any spread of communicable disease in the community and any spread of the panic that may accompany it.

Thank you.

FYI & BACKGROUND

All purpose FYI card from a director of a community health center in Lincoln, Nebraska

Mahmoodian, Medical Director, People's Health Center, '09

[By Maryam Mahmoodian, medical director of the People's Health Center in Lincoln, Nebraska, "Local View: People's Health Center thrives with support," June 20, 2009, The Journal Star (newspaper in Lincoln, Nebraska), http://journalstar.com/articles/2009/06/20/opinion/columns/doc4a3beeb223965050565213.txt download date: 6-20-09]

A few weeks ago, I had to sit down with a patient and do something no physician ever wants to do. I had to tell a young mother she had breast cancer. As if that's not difficult enough to deal with, she was also uninsured. So as my patient had to digest this horrible new diagnosis, she also could not help thinking, "How much is this going to cost me and my family?"

Unfortunately, stories like these occur more often than any of us would care to admit, and the number of uninsured just keeps getting higher. As we hear more and more bad news about the economy, those of us who work in places like People's Health Center live with the effects of this downturn every day. Every day, we get telephone calls from uninsured and underserved patients who need medical care or a doctor willing to see them, and every day our waiting list for patients gets longer and longer.

There are a lot of myths about the uninsured. Some people choose to go without health insurance rather than have to pay for it, right? I mean, if these people would just get a job, then they would have insurance; it's that simple.

The truth is that NOT everyone can get insurance. And even if they can, a plan that might be affordable most likely also has very limited coverage. I have patients who have been denied insurance because they have too many health problems. I have other patients who only qualify for insurance that does not cover pre-existing conditions or has a huge deductible. So, they have to make the choice between not having coverage at all or paying out of pocket for their insurance and then also paying out of pocket to see the doctor.

Most of my uninsured patients work at least part time, and many work at more than one job. But if you only make $10 an hour, who can afford to buy their own plan? And what do you do if you get laid off? Some people are too disabled to work but are still awaiting actual disability. Many others just get lost in the system.

People's Health Center is a federally qualified health center, which means we charge uninsured patients a fee that is based on their income. Despite their reputations as "clinics for poor people," FQHCs are actually the true model of a patient-oriented medical home. Our providers and staff members advocate strongly for our patients to ensure that they receive the best and most cost-effective care possible, both inside and outside the clinic. Because of where we work, we know as much about costs and community resources as we do about medical and dental care.

It's expected that we are able to tell our patients which pharmacies are the cheapest, where they can get affordable counseling and what programs they can apply for to get recommended health-screening services. At PHC, our patients can see their health care provider and then walk down the hallway to see the diabetes educator. They can then make an appointment with a counselor and with the dentist, all without even leaving the building.

In the same neighborhood as the clinic, they can obtain a reduced-rate eye exam and get their prescriptions filled at an affordable price. All of that is what makes us a community health center. And all of that is what saves money in the long run.

However, being an FQHC does not mean all of our funding comes from the federal government. Actually, less than 20 percent does. This means that more than 80 percent does not, and that large percentage comes from revenue generated by patient fees (including patients who do have insurance), grants and donations. But because of the small percentage that does come from the government, we have very specific guidelines we must follow that translate into excellent care for our patients.

Our patients come from every area of Lincoln (and even outside the city) and from all walks of life. They range from undergraduate and graduate students to professionals to recent immigrants and refugees to the homeless.

Lincoln is also unique in that the medical community is very supportive of PHC. Many specialists actually donate their time by volunteering at the clinic. Many others agree to see our uninsured patients in their offices and charge them fees that are based on our sliding scale. These aren't just physicians. They include physical therapists, optometrists and imaging centers.

Despite the health care safety nets like PHC that do exist here, a large number of uninsured individuals still use the emergency rooms as their primary health care source. Or they just go without.

Six years ago, there was no People's Health Center in Lincoln, but we are still just putting a Band-Aid on the bigger problem of how to deal with the medically underserved. With continued community support, our services hopefully can expand to reach more people and to further improve the overall health care of Lincoln.

FYI & BACKGROUND

Here's the basic idea of the entire Affirmative case in a nutshell

The Tennessean'07

[*The Tennessean* (Nashville), Editorial: Community health centers are bright lights of service, August 6, lexis-nexis]

Our View
In the midst of all the tragic flaws of the nation's health-care system, allow us to sing the praises of what may be one of the least appreciated examples of quality health care community health centers.
Community health centers are local nonprofit, community-owned centers that provide some of the most basic health services for some of the many people who lack ways to get primary health care otherwise. The centers are subsidized with federal funds and are serving an ever-increasing number of patients. Middle Tennessee is blessed to have several of the sites, and there are 23 in the state, but they are in constant need of funding in order to do their jobs, which by the way happens to save money in the long run.
Community health centers provide primary care, including vital prenatal care, cancer screenings and many other basic health services, but they have some basic problems, foremost being a shortage of physicians and the inability to provide more advanced medical procedures such as surgery or cancer treatment. But the care they provide is the type that keeps people out of emergency rooms, where costs are extremely high.
Community health centers in Middle Tennessee include the Matthew Walker Comprehensive Health Center on 14th Avenue North in Nashville, the United Neighborhood Health Service on South Eighth Street in Nashville, the Stewart County Community Medical Center in Dover, the Upper Cumberland Primary Care Health Initiative in Cookeville and the Perry County Medical Center in Linden.
Ceremonies are scheduled Thursday to open the United Neighborhood Health Services Southside Family Clinic at 107 Charles E. Davis Blvd., south of Lafayette Street, which will serve residents of the J.C. Napier and Tony Sudekum public housing developments as well as other neighborhoods.
The health centers serve more than 14 million patients nationally. They are literally the only option available to many of those patients, who are frequently Medicaid or Medicare patients but include the uninsured, although some have some kind of private insurance.
While the centers have difficulty in finding doctors, they can provide a continuity of care and can even outperform some private medical providers in terms of price and quality. Perhaps the most redeeming aspect of the centers is that people who choose to work there are there for the reason of simply trying to provide care to people in need.
Doctors make less at the centers than they would at private facilities, and primary care is not one of the best paying disciplines from the beginning.
So the providers at the community health centers are some of the bright lights in an overall health-care system where decisions are frequently driven by profit motives and the potential for high salaries. The centers are dedicated to providing service to anyone who needs it. What's more honorable than that?
Government funding for community health centers has increased significantly since 2000, but the number of people using the services is rising rapidly, too. The nation needs more attention to health care overall, and it should recognize extraordinarily valuable services where they exist and build upon those foundations. Community health centers are a godsend in a turbulent sea. Congress should see to it that they get the resources they need.

INHERENCY: LACK OF CARE AND SCREENING

Over half of all adults are foregoing medical care and screenings in Status Quo because of cost. However, community health centers can fill the gap

Los Angeles Times '9

[Byline: Francesca Lunzer Kritz, "Free options put wellness within reach," May 25, 2009, SECTION: HEALTH; Part E; Pg. 1, Lexis-Nexis]

Many people are forgoing medical care because of costs these days. In a telephone survey of more than 1,200 adults, released last month by the Kaiser Family Foundation, 59% said they were going without medical care because of costs. Such care includes tests and screenings that can diagnose health problems before they become more serious. That percentage climbed from 53% in a similar survey conducted in February.

But free or low-cost tests and healthcare can be found. Community health centers are the obvious place to start, but national screening days can also offer unexpected opportunities. Organizations such as the American Diabetes Assn. offer these periodically as part of their outreach and awareness efforts.

Below are some resources to help you find low-cost or free screenings and care.

* Community health centers offer care on a sliding-scale basis, determined by income. You should be able to find one at www.findahealthcenter.hrsa.gov.

INHERENCY: NATIONAL HEALTH CARE NOT SOLVE

National Health Care will not be sufficient – Community health centers and public health efforts still will be necessary and need funding

Waxman, Chair of the House Committee on Energy and Commerce, '09

[Henry, U.S. Congress, Democrat-California, "MAKING HEALTH CARE WORK FOR AMERICAN FAMILIES," Opening Statement of Henry A. Waxman Chairman Committee on House Energy and Commerce, *Congressional Quarterly, Congressional Testimony*, March 31, 2009, SECTION: CAPITOL HILL HEARING TESTIMONY COMMITTEE: HOUSE ENERGY AND COMMERCE; SUBCOMMITTEE: HEALTH, lexis-nexis]

Over the past month, we have had several hearings on health insurance and how to get it to all Americans. But as valuable as it is, health insurance can't do everything necessary to make our nation healthy. Even if we make it possible for everyone to be insured, there will still be a major role for public health. Moreover, there will be an ongoing need for funding for these public health activities.

I should begin by clarifying some basics. "Public health" includes many different things:

-- It is working with groups and whole communities to improve health, often more effectively than could be done between a provider and a patient.

* Fluoridation of water for a town is, for instance, vastly better than simply filling every citizen's cavities.

* Exercise programs to prevent obesity are better than having to treat diabetes among people who become obese.

-- It is tailoring health insurance and health care to prevent and diagnose disease early rather than simply treating it in its later stages.

* Immunizations are always better than outbreaks.

* Screening for hypertension is better than simply waiting for strokes.

-- It is providing for safety-net services where the insurance market alone fails to do so.

* Community health centers, HIV-service providers, and family planning clinics provide care to people who might not otherwise be able to find a provider.

* Health professions education programs can add to the primary care workforce when the market might produce only specialists.

-- And, least glamorous but crucial, it is the infrastructure of daily disease control and health promotion.

* Closing down unsanitary restaurants is better than treating food poisoning.

* Compiling and studying epidemic trends can prevent major waves of disease.

"Public health" is all these things and more.

It might be clearer if I use an analogy: No community would be well-served if all its homeowners had fire insurance but there were no fire departments, firefighters, fire hydrants, or smoke detectors. That very well-insured town would still burn to the ground. Insurance is necessary, but it is not sufficient.

As we approach health reform, we must consider what aspects of the nation's health are based on public health and make those investments at the same time as we invest in coverage. We need to provide as firm a funding and organizational base for these services as we do for insurance - because they are essential in making insurance efficient and productive and in making the nation healthier.

We will continue to debate insurance plans, Medicare Advantage, Health Savings Accounts, and acute care on other days. But today's hearing is about these public health activities that we seldom think about and we even more rarely provide for. I hope health reform will make us change that.

HARMS: AVIAN FLU – CAN SPREAD IN HUMANS

Avian flu is transmissible in humans – a variety of experts conclude

Greger '6

[Michael, Director of Public Health and Animal Agriculture at The Humane Society of the United States, graduate of the Cornell University School of Agriculture and the Tufts University School of Medicine. Also an internationally recognized lecturer, he has presented at the Conference on World Affairs, the National Institutes of Health, and the International Bird Flu Summit, among countless other symposia and institutions. "What Happens to a Pandemic Deferred?" http://www.Birdflubook.com download date: 9-5-08]

First, her chickens died. Then, her niece died, coughing blood as she expired in her mother's arms.472 In 2005, the New England Journal of Medicine reported the first documented case of deadly human-to-human transmission. Until that point, nearly all of the human deaths had "involved people who lived or worked with poultry, poultry meat or eggs in Southeast Asia."473 While the 11-year-old niece was exposed to sick chickens while living in a village with her aunt, her mother arrived from the Bangkok suburbs to care for her and had no known exposure to chickens, sick or otherwise. The day after the funeral, the mother started to feel sick too, and after severe illness, died. The aunt also fell sick, but recovered.474 Both she and her sister tested positive for the same virus that had killed the child.475 The report **sent shivers down the spine** of the scientific and medical community.476 In the week following the report, the European science publication New Scientist ran an editorial titled, "Bird Flu Outbreak Could Kill 1.5 Billion People."477 The top UN animal health official spoke of an "enormous sword of Damocles" hanging over the world.478 The director of the U.S. Centers for Disease Control and Prevention described it as the number-one health threat in the world and called it a "very ominous situation for the globe."479 Upon hearing the news, a Johns Hopkins University infectious disease specialist said, "I think people were **delusionally hoping** that it would never be transmitted from person to person and that would save us."480 The head of the World Health Organization in Asia held a press conference. He said: "We at WHO believe that the world is now in the gravest possible danger of a pandemic."481

HARM: SWINE FLU

Swine Flu is not over. The next wave of the flu pandemic will hit this Fall. We must act now in order to be prepared for the next outbreak of the disease

Canadian Press 6-20-09

[By Tamsyn Burgmann, "Avoid potential second-wave crisis by planning for H1N1 now,"
http://www.google.com/hostednews/canadianpress/article/ALeqM5jK5Mv4URZZkr4GkR6PdwrIoKZD-g download date: 6-20-09]

The pandemic that hit like a cyclone but mellowed to a cool breeze could still take the world by storm.
That's why it's crucial, in the relatively present calm, to soak up lessons from the on-going swine flu situation, say speakers at a disaster management conference taking place in Toronto this week.
"There's a belief we missed the bullet, which is a little unnerving," said Regina Phelps, founder of San Francisco-based consulting company Emergency Management and Safety Solutions.
"That says to me people are thinking 'Gee, we're done, we missed it, we lucked out, it wasn't bad and life is going to continue on as it is.' Which could be a huge mistake."
If seasonal flu strikes this fall as expected, there's also potential for a more vicious second wave of illness and deaths related to the new H1N1 virus. It's something everyone should prepare for, Phelps said.
"We're in a situation that is evolving and that is highly fluid and if anyone tells you they know what is going to happen they're totally fooling themselves, because no one actually does."
Dr. Allison McGeer, a Toronto-based flu expert, agrees that more planning is necessary.
"I'm really happy to see all the work that's been done has paid off, but we're still a long way from what would have been an ideal response," she said.
In Canada that would include improved co-ordination of a national response that specifically fills the biggest gap, she said, which is co-ordinating primary care.
The virus first reached public view in mid-March, sweeping from Mexico through the U.S. and Canada, and then to Europe, Asia, the Middle East, Australia and South America.
It was declared a global pandemic, the first since 1968, by the World Health Organization in early June.
Yet after initial panic, the cancellation of Mexico's Cinco de Mayo celebrations, quarantine of travellers in China and shuttered schools across the world, the announcement was anti-climactic - especially as the WHO stressed pandemic rankings refer to geographic spread and not severity of the illness.
By last week, infections had been confirmed in nearly 45,000 people in more than 90 countries and 180 deaths had been attributed to the virus. With the majority of cases mild and far fewer deaths than are caused by seasonal flu, public attention in North America has waned.
Phelps believes this pattern parallels the Spanish flu epidemic of 1918. A bug, unknown to anyone at the time and seemingly lenient, suddenly emerged and spread across the globe. It too attacked young people with greater frequency than the rest of the population.
Yet so far it stands in contrast to swine flu because, by its end, it had killed millions.
As North Americans release the grip on the backs of their seats, they could easily return to complacency and that's the wrong attitude to take, Phelps warned.
"The first lesson we have learned is that we haven't learned," she said.
"I don't want people to be scared, I want people to be worried and concerned to a significant enough level that they do something."
She recommends all people, from CEOs to parents, create a pandemic plan because "the planning we've done has paid off, but we're not done."
She also suggests the strengthening of health-care systems, the continuation of steady information flow, that school boards probe the impact of closures and create better responses to a crisis and that HR departments write policy for workers who become ill.
McGeer added that ongoing education is paramount, without which people may view swine flu with the same indifference as seasonal flu - a killer of 4,000 Canadians every year that people "completely ignore," she said.
"Influenza is very difficult for all of us to get our heads around ... (because) even in a catastrophic situation, most illness is mild," she said.
"It's hard to respond to disease in which risk is relatively low for each individual patient, but risk to the community is high."
Whether swine flu takes a nasty turn and explodes into something much worse, or even if the next flu season is just rougher than usual, the impact will be much worse without plans in place, she said.
"It's not often we have the potential and that much advance notice to get prepared for something that could be significant."

HARMS: PANDEMIC → EXTINCTION

Unchecked new diseases threaten human survival

Lederberg, Professor of Genetics, Stanford Medical School, '99

[Joshua Lederberg, professor of genetics at Stanford U. School of Medicine, 1999, *Epidemic The World of Infectious Disease*, p. 13

The sheer number of microbes, the rapidity with which they can reproduce. and their tendency to change their genetic makeup gives them an enormous potential when it comes to acquiring advantageous adaptations. The bugs have the potential to make toxins, to vary, to find defense mechanisms against our antibiotics, and to alter their proteins such that they escape detection by our immune system. In pondering all this – and I have spent all my life looking at microbial variability and diversity – I am left with the question, why are we still here? It's perfectly easy to imagine the microbe that could wipe us out. We have had some close calls with real microbes. For example, the Spanish influenza pandemic of 1918 killed twenty to twenty-five million people. about 0.5 percent of the world's population. The toll of the fourteenth-century plague, the "Black Death," was closer to one third. If the bugs' potential to develop adaptations that could kill us off were the whole story, we would not be here. However, with very rare exceptions. our microbial adversaries have a shared interest in our survival. Almost any pathogen comes to a dead end when we die; it first has to communicate itself to another host in order to survive. So historically_ the really severe host-pathogen interactions have resulted in a wipeout of both host and pathogen. We humans are still here because, so far, the pathogens that have attacked us have willy-nilly had an interest in our survival. This is a very delicate balance, and it is easily disturbed, often in the wake of large-scale ecological upsets.

HARMS: PANDEMIC → EXTINCTION

Rabies virus proves uniformly lethal viruses can exist

Ryan, M.D., '97
[Frank Ryan, M.D.. 1997, *Virus X*, p. 367-8]

To cause our extinction, Virus X would need to take two steps. First it would have to kill everybody, or almost everybody, it infected. The qualifier is needed because the end of human civilization might not re-quire the death of all of its members. Has any virus, or any other infectious agent. ever caused such a lethality? The answer, unfortunately, is yes — though the emergence of such catastrophic lethality is rare. Rabies was uniformly lethal in humans for at least four thousand years of history until Louis Pasteur discovered the first vaccine treatment. A member of the genus Lyssa viruses, from the Greek lyssa, which means "frenzy-." rabies is one of over one hundred members of the family of Rbabdoviridae, which infect an incredible range of life, from plants to reptiles, fish, crustaceans, and mammals. In the opinion of Herve Bourhy, an expert at the Pasteur Institute, the human rabies virus lives in a symbiotic cycle with bats, from which it is capable of infecting a wide variety of mammals, particularly foxes, coyotes, jackals, and rodents.5 Could anybody conceive a more sinister expression of aggressive symbiosis? The virus is programmed to infect the centers in the animal brain that induce uncontrollable rage, while also replicating in the salivary glands to best spread the contagion through the provoked frenzy of biting.

HARMS: PANDEMIC → EXTINCTION

New disease could virtually eradicate humanity if not detected and stopped

Ryan, M.D., '97

[Frank Ryan, M.D., 1997, *Virus X*, p. 375-377]

That same self-deluding complacency_ lies behind our present refusal to come to terms with such a threat. It goes like this: since no such extinction event has ever wiped out humanity in the past. it is impossible that it will happen in the future. But extrapolating future trends from past history can only be deceivir_g. In humbling contradiction is the statistic that 99 percent of all of the species that have ever evolved on earth have suffered extinction. The mean survival of a mammalian species is put at about a million years. While suspected causes vary, in fact the fossil record is insufficient to attribute a cause to most of these with any accuracy,"' But plague infections have been suspected as a possible contributor, possibly a major one, and caused the extinction of at least one species during recent history. Swaynes hartebeest was wiped out by an epidemic of rinderpest, introduced into Africa in the nineteenth century by Indian bullocks used by Kitcheners army to pull gun carriages. Past history cannot be a template for the future, for we have altered the earth's ecoloacy on such a scale that a host of unknown major variables have entered the scenario. And, shocking as it might seem, the extinction scenario has actually been tested by the deliberate hand of man. The myxomatosis pandemic in rabbits is now regarded as the classic experiment. In 1859 rabbits, a totally alien species, were introduced into Australia as a source of food. Lacking natural predators, their population un- derwent an explosive expansion, with consequent destruction of grass- land and farmland. In 1950, in an attempt to reduce their numbers, wild rabbits in the Murray Valley in southeast Australia were infected with the myxoma virus. This virus, of the genus, Leporipoxvirus, lived in a symbiotic relationship with the Brazilian rabbit, Sylvillagus brasiliensis, which is a denizen of the tropical forest. The consequences for the Australian rabbits were altogether predictable. The myxoma virus is not spread by aerosol, but as an arbovirus by biting mosquitoes. Nevertheless the prevalence of the vector was so high it became as efficient as a true aerosol spread. Viral "traffic" between the two species began slowly, from May to November, in the rabbits burrows. Suddenly, in December, the Australian summer, augmented perhaps by a proliferation of the insect vector during a wet spring, the epidemic exploded. Over the course of just three summer months, 99.8 percent of the rabbit population of the entire southeast, a land area equivalent to the whole of Western Europe, became infected and died. Is J. Following this initial annihilation, the tiny surviving population of rabbits began to coevolve with the virus. So, year by year, the mortality fell until, seven years after the introduction of myxomatosis, the lethality was now just 2$ percent. Selective changes took place both for more resistant rabbits and for less lethal strains of virus. At present the AIDS epidemic, which moves much more slowly be- cause of its mode of transmission, maybe showing the earliest signs of a similar evolution, as a handful of survivors are being reported. In time, if left to its natural course, even the lethal HIV-I will evolve, as more and more people survive, until eventually the new human strains of virus coevolve with their human symbiont. After many centuries, the future progeny of HIV-I may cause no more illness than it currently causes chimpanzees or the sivs their host monkeys. How likely is it that, given the enormous diaspora of viruses in nature, there might already reside one or many species that could, with minimal accommodation, assume the Virus X of our worst nightmares? The human species is essentially a monoculture — comparable in many respects to the rabbits that overpopulated southeastern Australia. The myxomatosis experience, together with the evidence from many past human pandemics, suggests that a percentage of people will be resistant even to the most virulent extinction strain. That resistance de- rives from the genetic differences that exist between all except identical twins, spread over all of the races and differing populations of people throughout the world and the widely varying ecologies they inhabit. Total human extinction is therefore unlikely as a result of a viral pandemic, but a near miss, such as the rabbits experienced with myxomatosis, or even a lesser global lethality, would prove so catastrophic socially and psychologically that we can derive only limited comfort from this.

HARMS: FLU PANDEMIC OUTWEIGHS

Defer AFF on basic risk assessment – the probability of flu pandemic and the enormous loss of life outweigh the negative's scenario for WMD use

Zakaria, '5.

[Fareed, Ph.D. in Political Science from Harvard, and contributing editor at Newsweek, "A Threat Worse than Terror," 10-31-2005, *Newsweek*, http://www.fareedzakaria.com/ARTICLES/newsweek/103105.html download date: 3-10-09]

A flu pandemic is the most dangerous threat the United States faces today," says Richard Falkenrath, who until recently served in the Bush administration as deputy Homeland Security adviser. "It's a bigger threat than terrorism. In fact it's bigger than anything I dealt with when I was in government." **One makes a threat assessment on the basis of two factors: the probability of the event, and the loss of life if it happened. On both counts, a pandemic ranks higher than** a major terror **attack**, even one **involving weapons of mass destruction**. A crude nuclear device would probably kill hundreds of thousands. A flu pandemic could easily kill millions. Whether this particular virus makes the final, fatal mutation that allows it to move from human to human, one day some virus will. The basic factor that is fueling this surge of viruses is China's growth. (China is the natural habitat of the influenza virus.) As China develops, it urbanizes, and its forests and wetlands shrink. That forces migratory birds to gather closer together-and closer to human habitation--which increases the chances of a virus spreading from one species to the next. Also, growth means a huge rise in chicken consumption. Across thousands of homes in China every day, chickens are slaughtered in highly unhygienic ways. "Every day the chances that this virus or another such virus will move from one species to another grow," says Laurie Garrett, author of "The Coming Plague," who has been writing brilliantly on this topic for years. Nobody really disputes that we are badly unprepared for this threat. "If something like this pandemic were to happen today," says Falkenrath, "the government would be mostly an observer, not a manager." The government can't even give intelligent advice to its citizens because it doesn't actually know what to say. We don't know whether people should stay put, leave cities, stay home or go to the nearest hospital. During the cold war, hundreds of people in government participated in dozens of crisis simulations of nuclear wars, accidents and incidents. These "tabletop exercises" were conducted so that if and when a real crisis hit, policymakers would not be confronting critical decisions for the first time. No such expertise exists for today's deadliest threat.

HARMS: FLU PANDEMIC OUTWEIGHS

We control probability – avian outbreak is inevitable – the only hope is to manage the scope

Greger, '6

[Michael, Director of Public Health and Animal Agriculture at The Humane Society of the United States, graduate of the Cornell University School of Agriculture and the Tufts University School of Medicine. Also an internationally recognized lecturer, he has presented at the Conference on World Affairs, the National Institutes of Health, and the International Bird Flu Summit, among countless other symposia and institutions. "What Happens to a Pandemic Deferred?" http://www.Birdflubook.com download date: 9-5-08]

Similar fears reportedly keep U.S. Secretary of Health and Human Services Mike Leavitt awake at night. "It's a world-changing event when it occurs," Leavitt said in an interview. "It reaches beyond health. It affects economies, cultures, politics and prosperity—not to mention human life, counted by the millions."585 Yes, but what are the odds of it actually happening? What are the odds that a killer flu virus will spread across the world like a tidal wave, killing millions? "The burning question is, will there be a human influenza pandemic," Secretary Leavitt told reporters. "On behalf of the WHO, I can tell you that **there will be. The only question is the virulence and rapidity of transmission from human to human.**"586 The Director-General of the World Health Organization concurred: "[T]here is **no disagreement** that this is **just a matter of time**."587 "The world just has no idea what it's going to see if this thing comes," the head of the CDC's International Emerging Infections Program in Thailand said, but then stopped. "When, really. It's when. **I don't think we can afford the luxury of the word 'if' anymore. We are past 'if's**."588 The Chief Medical Officer of Great Britain,589 the Director-General of Health of Germany,590 the director of the U.S. [CDC] Centers for Disease Control,591 the Senior [UN] United Nations Coordinator for Avian and Human Influenza,592 and the director of the U.S. National Security Health Policy Center593 **all agree that another influenza pandemic is only a matter of time.** As the director of Trust for America's Health put it, "This is not a drill. This is not a planning exercise. This is for real."594

HARMS: FLU PANDEMIC OUTWEIGHS

We control timeframe – the clock is ticking for a pandemic – we're overdue and it could come any day

Greger, '6

[Michael, Director of Public Health and Animal Agriculture at The Humane Society of the United States, graduate of the Cornell University School of Agriculture and the Tufts University School of Medicine. Also an internationally recognized lecturer, he has presented at the Conference on World Affairs, the National Institutes of Health, and the International Bird Flu Summit, among countless other symposia and institutions. "What Happens to a Pandemic Deferred?" http://www.Birdflubook.com download date: 9-5-08]

The National Academy of Science's Institute of Medicine now describes a pandemic as "**not only inevitable, but overdue.**"596 This is based in part on the understanding that there have been ten pandemics recorded since global travelers embarked approximately three centuries ago.597 Pandemics average every 27.5 years,598 with 39 years presented as the longest known interval between pandemics.599 2006 places us at year 37 since the pandemic of 1968. According to the director of the CDC, "It doesn't take a scientist to appreciate that **the clock is ticking**, and that another pandemic is due."600 Said a WHO spokesperson, "All the indications are that we are living on borrowed time…."601 A senior associate at the Center for Biosecurity lists the indications: "The lethality of the virus is unprecedented for influenza, the scope of the bird outbreak is completely unprecedented and the change that needs to happen to create a pandemic is such a small change—**it could literally happen any day**."602 **Never before has bird flu spread so far, so fast**,603 and **the longer the virus circulates** in poultry production systems, **the higher the likelihood of additional human exposure**.604

HARMS: FLU PANDEMIC OUTWEIGHS

Avian outbreak would kill 1.5 billion immediately and mutate to extinction levels

Greger, '6

[Michael, Director of Public Health and Animal Agriculture at The Humane Society of the United States, graduate of the Cornell University School of Agriculture and the Tufts University School of Medicine. Also an internationally recognized lecturer, he has presented at the Conference on World Affairs, the National Institutes of Health, and the International Bird Flu Summit, among countless other symposia and institutions. "What Happens to a Pandemic Deferred?" http://www.Birdflubook.com download date: 9-5-08]

First, her chickens died. Then, her niece died, coughing blood as she expired in her mother's arms.472 In 2005, the New England Journal of Medicine reported the first documented case of deadly human-to-human transmission. Until that point, nearly all of the human deaths had "involved people who lived or worked with poultry, poultry meat or eggs in Southeast Asia."473 While the 11-year-old niece was exposed to sick chickens while living in a village with her aunt, her mother arrived from the Bangkok suburbs to care for her and had no known exposure to chickens, sick or otherwise. The day after the funeral, the mother started to feel sick too, and after severe illness, died. The aunt also fell sick, but recovered.474 Both she and her sister tested positive for the same virus that had killed the child.475 The report sent shivers down the spine of the scientific and medical community.476 In the week following the report, the European science publication New Scientist ran an editorial titled, "Bird Flu Outbreak Could Kill 1.5 Billion People."477 The top UN animal health official spoke of an "enormous sword of Damocles" hanging over the world.478 The director of the U.S. [CDC] Centers for Disease Control and Prevention described it as the **number-one health threat** in the world and called it a "very ominous situation for the globe."479 Upon hearing the news, a Johns Hopkins University infectious disease specialist said, "I think people were delusionally hoping that it would never be transmitted from person to person and that would save us."480 The head of the [WHO] World Health Organization in Asia held a press conference. He said: "We at WHO believe that **the world is now in the gravest possible danger of a pandemic**."481 The case compelled Thailand to launch a massive search for other cases of human spread, involving as many as one million volunteers going door-to-door. Thankfully, no further clusters of cases were found.482 The virus still has some learning to do. Currently infection requires more than just a sneeze, a handshake, or a breath. So far, all officially suspected human-to-human transmissions have involved "close physical contact that included hugging, kissing, or cuddling the infected individuals to whom they were exposed."483 H5N1 is a gifted learner. Grasping the mutant swarm concept is critical to understanding how the virus got from strain A to Z+, and how it may get from Z+ to the pandemic strain. One individual may theoretically only be infected by a single virus particle, but one infected cell can start sloppily churning out millions of mutant progeny. H5N1 has a large graduating class. This dynamic mutant swarm breaks out and tries to reinfect other cells. The ones that are best at infecting further human cells are naturally selected to live long and prosper, passing on their genes. Only the strong survive; it's a mammoth campaign of trial and error. Out of millions of competing viruses, the ones whose N spikes best worm their way through human mucus, the ones whose H spikes are best at unlocking human cells, the ones with NS1 proteins that best block human interferon—those are the ones that may best survive to make millions more in the next cell. By death, their hosts' lungs are saturated with more than a billion infectious viral doses per ounce of tissue.84 "The clock keeps ticking," Webster frets. "Every time this virus replicates, it makes mistakes. Sooner or later it will make the mistakes that will allow it to go human-to-human."485 Michael Osterholm, the director of the University of Minnesota's Center for Infectious Disease Research and Policy, compares H5N1 to a computer hacker. "We're providing that virus every opportunity. I mean every day, every second, is an evolutionary experiment going on in Asia. You know, it's like a computer hacker that has a program that will figure out what a nine-digit security code is. If they have enough time and there's nothing to stop them, they can just run the program until all nine numbers work."486 Senate Majority Leader Bill Frist, M.D., compares H5N1 to a gambler. From the floor of the Senate, Frist explained: "Billions of mutations of the virus are occurring every day. With each mutation, the virus multiplies its odds of becoming transmissible from human to human. It's like pulling the lever on a Vegas slot machine over and over again. If you pull enough times, the reels will align and hit the jackpot."487 In the end, the virus that wins, the virus that succeeds in making the most copies of itself, is the virus that outperforms the others, passaging through thousands of individual cells to learn how best to infect the human species. It is that virus which gets breathed into the next person's lungs and the process starts all over so the virus can get even smarter. Within a single individual, the virus is evolving, adapting, learning. It hits dead ends and tries something new, slowly notching up mutations that may lock into place the ability to effectively survive in, and transmit between, people. **Every single person** who gets infected presents a risk of spawning the pandemic virus. Describes one virologist, "**You're playing Russian roulette every time you have a human infection**."488 One day soon, experts fear, with more and more people becoming infected, the virus will finally figure out the combination—the right combination of mutations to spread not just in one elevator or building, but **every building, everywhere, around the globe.** One superflu virus. It's happened before, and experts predict it may soon happen again.

HARMS: FLU PANDEMIC OUTWEIGHS

Avian could end all life – top experts agree

Greger, '6

[Michael, Director of Public Health and Animal Agriculture at The Humane Society of the United States, graduate of the Cornell University School of Agriculture and the Tufts University School of Medicine. Also an internationally recognized lecturer, he has presented at the Conference on World Affairs, the National Institutes of Health, and the International Bird Flu Summit, among countless other symposia and institutions. "Get rid of the 'if.'This is going to occur." http://www.Birdflubook.com download date: 9-5-09]

Other public health authorities have expressed similar sentiments on a global scale. World Health Organization executive director David Nabarro was recently appointed the bird flu czar of the United Nations. At a press conference at UN headquarters in New York, Nabarro tried to impress upon journalists that "we're dealing here with world survival issues—or the **survival of the world as we know it**."583 "The reality is that if a pandemic hits," explained the executive director of Trust for America's Health, a public health policy group, "it's **not just a health emergency. It's the big one."**584

HARMS: FLU PANDEMIC OUTWEIGHS

Avian flu is the greatest catastrophe in history, spreads quickly, and is almost certain to occur

Greger, '6

[Michael, Director of Public Health and Animal Agriculture at The Humane Society of the United States, graduate of the Cornell University School of Agriculture and the Tufts University School of Medicine. Also an internationally recognized lecturer, he has presented at the Conference on World Affairs, the National Institutes of Health, and the International Bird Flu Summit, among countless other symposia and institutions. "Get rid of the 'if.'This is going to occur." http://www.Birdflubook.com download date: 9-5-09]

A pandemic today could be many times worse than the pandemic of 1918, the world's greatest medical catastrophe. In 1918 we were, as a nation and as a people, much more self-sufficient.565 With the corporate triumph of free trade, just-in-time inventory management and global supply chains now characterize all major economies and business sectors.566 Economic analysts predict the pandemic would cause a **global economic collapse** unprecedented in modern history.567 With the global population at an historical high, this could lead to unprecedented human suffering. A short 100,000 years ago, all members of the human race lived in eastern Africa.568 The 6.5 billion people alive today represent roughly one out of every nine people who have ever inhabited the Earth.569 In 1918, cities like London were smaller, with just over than one million residents. Today there are 26 megacities in the world, each with more than ten million people.570 With this kind of tinder, experts like the WHO's Klaus Stöhr predict the pandemic will "explosively" hit world populations "like a flash flood."571 "The rapidity of the spread of influenza throughout a country is only limited by the rapidity of the means of transportation," explained the 1918 New York State Health Commissioner.572 Back then, the fastest way to cross the world was by steamship.573 In the past, a trip around the world took a year; **today we and our viruses can circle the globe in 24 hours.**574 The number of human globe-trotters now exceeds one billion people a year.575 AIDS left Africa on an aircraft. So too may H5N1 leave Asia, only a plane ride away. Between record population levels and the unprecedented current speed, volume, and reach of global air travel, any pandemic virus could wreak unparalleled havoc.576 H5N1, though, promises to be more than just any pandemic virus. In all of his more than 40 years working with influenza viruses, Robert Webster can state unequivocally, "This is the worst flu virus I have ever seen or worked with or read about."577 At a congressional briefing, Gregory A. Poland of the Mayo Clinic and the Infectious Diseases Society of America tried to get members of Congress to imagine the unimaginable—an H5N1 pandemic. "I want to emphasize **the certainty that a pandemic will occur**," he began. "When this happens, time will be described, for those left living, as before and after the pandemic."578 The top virologist in Russia attempted to tally the worst-case scenario potential human death count: "Up to one billion people could die around the whole world in six months…. We are half a step away from a worldwide pandemic catastrophe."579

HARMS: FLU PANDEMIC OUTWEIGHS

Avian flu outbreak is certain – the only question is magnitude

Greger, '6

[Michael, Director of Public Health and Animal Agriculture at The Humane Society of the United States, graduate of the Cornell University School of Agriculture and the Tufts University School of Medicine. Also an internationally recognized lecturer, he has presented at the Conference on World Affairs, the National Institutes of Health, and the International Bird Flu Summit, among countless other symposia and institutions. "Get rid of the 'if.'This is going to occur." http://www.Birdflubook.com download date: 9-5-09]

The National Academy of Science's Institute of Medicine now describes a pandemic as "**not only inevitable, but overdue."**596 This is based in part on the understanding that there have been ten pandemics recorded since global travelers embarked approximately three centuries ago.597 Pandemics average every 27.5 years,598 with 39 years presented as the longest known interval between pandemics.599 2006 places us at year 37 since the pandemic of 1968. According to the director of the CDC, "It doesn't take a scientist to appreciate that **the clock is ticking**, and that another pandemic is due."600 Said a WHO spokesperson, "All the indications are that we are living on borrowed time…."601 A senior associate at the Center for Biosecurity lists the indications: "The lethality of the virus is unprecedented for influenza, the scope of the bird outbreak is completely unprecedented and the change that needs to happen to create a pandemic is such a small change—**it could literally happen any day**."602 **Never before has bird flu spread so far, so fast**,603 and **the longer the virus circulates** in poultry production systems, **the higher the likelihood of additional human exposure**.604 Virology professor John Oxford explains: The problem is one chicken can contain hundreds of thousands of strains of H5N1. Let's say there are a billion chickens in Asia and 10% are infected—that's a vast population of viruses, more than the entire human population of the planet. Now let's further suppose some of these strains have mutated so they can latch not only onto a chicken but onto you or me, but they cannot do it very efficiently. That's the position we appear to be in. If a child catches the virus from a chicken they may transmit it to their mother, but the mother won't be able to go out and infect the grocer. At the moment it's a slow greyhound of a virus. It's when it develops into a normal greyhound that we're in for it.605 But there are more than a billion chickens in Asia. In 1968, the year of the last pandemic, there were 13 million chickens in China. Now, there are more than 13 billion in mainland China alone. And since the time from hatching to slaughter is only a matter of weeks or months, depending on whether the chicken is raised for meat or eggs, there are multiple cycles of these billions passing through the system in the course of the year. Back then, there were 5 million pigs in China; now there are 500 million.606 "High concentrations of animals," concluded the International Food Policy Research Institute, "can become breeding grounds for disease."607 H5N1 may be here to stay. "This virus cannot now be eradicated from the planet," said Center for Biosecurity director O'Toole. "It is in too many birds in too many places."608 On the contrary, the virus seems to be getting more entrenched. "If you described it as a war, we've been losing more battles than we've won," a WHO spokesman told the Financial Times. "From a public health point of view, and an animal health point of view, this virus is just getting a stronger and stronger grip on the region."609 "That's why every virologist in the world is flying around with his hair on fire," says O'Toole.610 In a tone uncharacteristic of international policy institutions, the UN's Food and Agriculture Organization writes: "Over this bleak landscape sits a black cloud of fear that the virus might become adapted to enable human-to-human transmission and then spread around the globe."611 The urgency and alarm among those tracking H5N1's building momentum is palpable.612 "I feel it every day, and my staff feels it every day," describes NIH's Fauci.613 "It's like watching a volcano getting ready to erupt," described a spokesperson of the World Organization for Animal Health (known as OIE, for Office Internationale des Epizooties).614 Helen Branswell of the Canadian Press, considered to be the world's leading journalist on bird flu,615 has spent years researching pandemic influenza and has likely interviewed nearly everyone in the field. "A number, including leading influenza experts," she reported, "told me they all suffer sleepless nights."616 "We're all holding our breath," said Julie Gerberding, head of the CDC.617

HARMS: MRSA

Unchecked MRSA outbreak guarantees extinction

Collins '98

[Sharon Collins, *Sunday Mirror*, Mirror Group newspapers health editor, formerly trained as a specialized medical correspondent, 4-12-1998, "'Doomsday' fear as we over-use antibiotics," lexis-nexis]

THE golden age of antibiotics, the 20th Century's wonder drug, is over. Scientists now fear a **Doomsday scenario**, where infection spreads rapidly across the globe. One in six prescriptions written out by GPs is for antibiotics, yet they no longer work on many extremely dangerous bacteria - or are only effective when used in amounts so high that they can cause serious side-effects. Some bugs like salmonella and TB have become resistant to the antibiotics used to destroy them because of over-use. And other bacteria, such as the deadly hospital superbug MRSA (right) which kills 5,000 patients a year, are actually the product of the microscopic war against germs. The more doctors have bombarded the bugs with antibiotics the faster they have mutated to produce resistant strains, **like MRSA**. Richard Young, head of The Soil Association's Antibiotics Group which is investigating the crisis, said: "**The problem of antibiotic resistance** is very worrying and **could potentially lead to** a public health problem of **apocalyptic proportions**. The misuse of antibiotics is threatening us all." Now drug companies are desperately working to find alternatives which can hit back at the bugs. MRSA was present in 177 hospitals which reported almost 20,000 patients affected in 1996. This was up from just 2,286 cases in 1992. In the latest outbreak, at Ninewells Hospital, Dundee, in February, six patients were struck down by the bug. Last night former Belfast MP Lord Fitt told how he lost his wife Ann to the deadly superbug in 1996. Lady Fitt, 74, had an asthma attack and was treated at London's Chelsea and Hammersmith Hospital. But within days the grandmother was in the grip of MRSA. "We survived murderous attacks on our home while I was a Westminster MP, so to lose her that way was extremely distressing," said Lord Fitt. Lady Fitt's asthma was aggravated by hot weather, and she went into hospital for two or three days to review her medication. Four days later she became infected with MRSA, which she had picked up from another patient. "From that moment her health went downhill at an alarming rate," said Lord Fitt. "The infection caught hold and attacked her respiratory system. I was told that unless she was put on a ventilator in intensive care she would be dead in a matter of hours. "Together with my five daughters - two of whom are nurses - we kept a round the clock vigil for 21 days while she fought for her life." There was just one hope - an antibiotic called vancomycin, one of the few that is successful against MRSA. Lady Fitt was given the antibiotic but it had little effect. She eventually returned home, but was left very weak and died from a bout of flu. "Needless to say hospitals don't advertise the fact they have outbreaks of MRSA on their wards," said Lord Fitt. "Maybe we would have thought twice about Ann going in if we'd known." Former miner Allan Brown, 83, was also a victim of MRSA. He was one of 19 people struck by the superbug in his ward in St. John's hospital, West Lothian, in November last year. And Joe McGuiness, 67, caught the bug following a gallstone operation at Monklands General Hospital, in Lanarkshire in 1995. MRSA is a mutant strain of skin bacteria which usually invades thebody through open wounds and can cause blood poisoning, urinary tract infections, pneumonia and death. It attacks its victims' immune system and fights off all known antibiotics. The old and young are particularly vulnerable. Patients are allowed to have visitors, who are told to wear gloves and an apron, but must not touch them and every item they come into contact with has to be destroyed. Scientists believe it is only a matter of time before a strain of MRSA appears that is also resistant to vancomycin, the drug used to treat Lady Fitt. It already has no effect on another bacteria called enterococcus and there have been cases of VRE (vancomycin resistant enterococcus) in humans. Research has shown that drug- resistance genes can hop to other bugs and so scientists fear that VRE could be just the start of a **worldwide outbreak** of drug resistant bacteria. At present there is no replacement for the antibiotic vancomycin and, says Richard Young: "It's no good waiting for drug companies to develop new antibiotics. "There are no new ones in the pipeline to replace the life-saving ones to which resistance is developing."

HARMS: TUBERCULOSIS

Transients and Immigrants contract Tuberculosis most frequently. Screening and treatment among these specific groups is key to eradication of the worst types of TB

Journal of the American Academy of Physicians Assistants '8

[Journal of the American Academy of Physicians Assistants (JAAPA), HEADLINE: Testing and treatment in special populations; TUBERCULOSIS; Disease/Disorder overview; BYLINE: Hendrikson, Edward C.; January 1, 2008, Page 23(2) Vol. 21 No. 1 ; lexis-nexis]

Changing patterns of migration and increased ease of international travel have caused growing concerns about screening and treatment of tuberculosis (TB) in special populations. These are defined as new immigrants to the United States and transient populations, including the homeless and imprisoned. The number of cases of TB in the United States has been steadily decreasing since 1992. In 2006, however, the TB incidence rate in foreign-born persons living in the United States was nearly 10 times greater than that in US-born persons)

Transient populations are at increased risk of contracting TB because of overcrowded living conditions, lower socioeconomic status, poor nutritional state, and reduced access to health care. Left untreated, these populations have increased mortality rates from TB with a survival rate of only 50%, and they can pose a significant public health risk. (1) Persons with immunodeficiency diseases, such as HIV infection and AIDS, also deserve special consideration. Compounding factors have significantly increased the morbidity caused by TB among HIV-infected persons. (2)

The majority of people infected with TB are able to contain the bacterium, a condition known as latent tuberculosis infection (LTBI). (3) Someone with LTBI is not considered infectious and will not spread the disease. However, up to 10% percent of persons exposed to the bacterium will not be able to mount an immune response and will develop active TB (termed TB disease) if they are not given preventive therapy. Those with TB disease are considered infectious to others.

> WHAT'S NEW IN TARGETED TUBERCULIN TESTING?

Initial screening for TB is performed with the tuberculin skin test using purified protein derivative (PPD). Because of the variable prevalence of TB in special populations, the newest recommendations ford efining a positive reaction are divided into three groups (4) (see Table 1, page 25). Previous vaccination with bacille Calmette-Guerin (BCG) is not a contraindication to administering a tuberculin skin test. Evaluation of reactions in persons vaccinated with BCG should be interpreted using the same criteria used for those not BCG-vaccinated. (4,5)

In 2005, the FDA approved the QuantiFERON-TB Gold test for use as an aid in diagnosing TB. It has advantages over the PPD test, including the benefit that results can be available within 24 hours; it requires only one patient visit; it is not subject to reader bias; and itis not affected by prior BCG vaccination. Disadvantages include limited data on its use in special populations and in children younger than 17 years, the need for processing within 12 hours, and potential errors in collecting or transporting blood specimens. (6)

> WHAT ARE THE CURRENT RECOMMENDATIONS FOR LTBI THERAPY IN SPECIALPOPULATIONS?

Once TB disease has been ruled out by history, physical examination, chest film, and, if warranted, sputum or other clinical samples, treatment for LTBI can be initiated. Four regimens are currently recommended, but the preferred one is isoniazid (INH) for 9 months. (4,7) Local disease prevalence, health department policies, patient adherence to a long regimen, and potential side effects all need to be considered when deciding which regimen to follow. In persons at risk of developing peripheral neuropathy, pyridoxine should be added to the therapy. (5) Patients should receive periodic follow-up evaluations while on therapy to assess for side effects or signs of hepatitis. Routine baseline and follow up laboratory testing are not recommended, unless the initial assessment has suggested the need.

PAs providing care to special populations should be aware of the potential barriers to successfully treating LTBI. In order to achieve a high rate of patient adherence, proper patient education on the need for therapy is paramount. Some patients may have a difficult time understanding the need for therapy when they are asymptomatic. In addition, patients may have health beliefs that differ from those accustomed to Western medicine, they may have difficulty communicating their understanding of the situation because of language barriers, or they may be unable pay for the necessary health services.

Treatment decisions can be complicated by circumstances that put the success of therapy in doubt. If you suspect the patient may discontinue therapy early for financial reasons, lack of knowledge, or plans to travel, take time to provide careful education on the importance of completing therapy. Some countries, such as Mexico, will not initiate or continue INH therapy for a positive PPD test result. These issues should be raised and discussed with the patient. In cases where patients intend to leave the country, a follow-up chest film should be obtained when the patient returns. (9)

> WHAT ARE THE CURRENT RECOMMENDATIONS FOR TREATMENT OF TB DISEASE?

In patients suspected to have TB disease, and because of the relatively high number of organisms showing resistance to INH, a four-dragregimen of INH, rifampin (Rifadin, Rimactane), pyrazinamide, and ethambutol (EMB, Myambutol) is initiated for the first 2 months of therapy. Once drug susceptibility results are known and if there is no resistance, EMB can be discontinued. The therapeutic regimen is continued for another 4 months for most patients. If cultures at completion of the initial phase of treatment remain positive; therapy is continued for 7 additional months. At each follow-up visit, visual changes should be assessed in all patients taking EMB. (10) If cultures remain positive after the first 2 months of treatment, then directly observed therapy should be considered. (1

> WHAT ELSE IS IMPORTANT?

The screening and treatment of LTBI can be very different in special populations, depending on risk factors, the mobility of the population involved, and the availability of follow-up. However, the increased incidence in special populations and the ease of transmission warrants an aggressive approach to the management. All cases of LTBI andTB disease must be reported to local and state health departments. The health department will conduct a contact investigation by screening all family members and close contacts.

Reports of outbreaks of multidrug-resistant TB around the world, sporadic cases of extensively drug-resistant TB, and virulent TB strains seen among persons with HIV/AIDS have reinforced the importance of screening and treatment for this deadly disease. Special populations and immunocompromised persons represent groups particularly at risk for TB and can present challenges to its successful eradication.

HARMS: OUTBREAK INEVITABLE – MUST ACT NOW

Disease outbreak is inevitable – we must act now to avoid a disaster

Osterholm '05

[Michael T., Director of the Center for Infectious Disease Research and Policy, Associate Director of the Department of Homeland Security's National Center for Food Protection and Defense, and Professor at the University of Minnesota's School of Public Health, Jul/Aug, "Preparing for the Next Pandemic," Foreign Affairs, vol. 84 issue 8, lexis-nexis]

THE WORLD must form a better understanding of the potential for the emergence of a pandemic influenza strain. A pandemic is coming. It could be caused by H5N1 or by another novel strain. It could happen tonight, next year, or even ten years from now.
The signs are alarming: the number of human and animal H5N1 infections has been increasing; small clusters of cases have been documented, suggesting that the virus may have come close to sustained human-to-human transmission; and H5N1 continues to evolve in the virtual genetic reassortment laboratory provided by the unprecedented number of people, pigs, and poultry in Asia. The population explosion in China and other Asian countries has created an incredible mixing vessel for the virus. Consider this sobering information: the most recent influenza pandemic, of 1968-69, emerged in China, when its population was 790 million; today it is 1.3 billion. In 1968, the number of pigs in China was 5.2 million; today it is 508 million. The number of poultry in China in 1968 was 12.3 million; today it is 13 billion. Changes in other Asian countries are similar. Given these developments, as well as the exponential growth in foreign travel over the past 50 years, an influenza pandemic could be more devastating than ever before.
Can disaster be avoided? The answer is a qualified yes. Although a coming pandemic cannot be avoided, its impact can be considerably lessened. It depends on how the leaders of the world--from the heads of the G-8 to local officials--decide to respond. They must recognize the economic, security, and health threat that the next influenza pandemic poses and invest accordingly. Each leader must realize that even if a country has enough vaccine to protect its citizens, the economic impact of a worldwide pandemic will inflict substantial pain on everyone. The resources required to prepare adequately will be extensive. But they must be considered in light of the cost of failing to invest: a global economy that remains in a shambles for several years.

HARMS: OUTBREAK INEVITABLE – MUST ACT NOW

A huge epidemic is inevitable. Must act now to lessen the impact.

Osterholm '05

[Michael T., Director of the Center for Infectious Disease Research and Policy, Associate Director of the Department of Homeland Security's National Center for Food Protection and Defense, and Professor at the University of Minnesota's School of Public Health, Jul/Aug, "Preparing for the Next Pandemic," *Foreign Affairs*, vol. 84 issue 8, lexis-nexis]

DATING BACK to antiquity, influenza pandemics have posed the greatest threat of a worldwide calamity caused by infectious disease. Over the past 300 years, ten influenza pandemics have occurred among humans. The most recent came in 1957-58 and 1968-69, and although several tens of thousands of Americans died in each one, these were considered mild compared to others. The 1918-19 pandemic was not. According to recent analysis, it killed 50 to 100 million people globally. Today, with a world population of 6.5 billion, more than three times that of 1918, even a "mild" pandemic could kill many millions of people.

A number of recent events and factors have significantly heightened concern that a specific near-term pandemic may be imminent. It could be caused by H5N1, the avian influenza strain currently circulating in Asia. At this juncture scientists cannot be certain. Nor can they know exactly when a pandemic will hit, or whether it will rival the experience of 1918-19 or be more muted like 1957-58 and 1968-69. The reality of a coming pandemic, however, cannot be avoided. Only its impact can be lessened. Some important preparatory efforts are under way, but much more needs to be done by institutions at many levels of society.

HARMS: DELAY BAD – MUST ACT NOW

Every hours counts. Any delay in Solvency during an infectious disease outbreak makes it uncontrollable

Loh '04

[Christine Loh, Chief Executive Officer of Civic Exchange, an independent public policy think-tank. Masters Degree in Chinese and Comparative Law from City University, Hong Kong. In 1992, she was appointed to the Legislative Council and ran successfully in the 1995 and 1998 elections. "Chapter 14: Lessons Learned," in *At the Epicentre: Hong Kong and the SARS Outbreak*, edited by Christine Loh and Civic Exchange, Hong Kong University Press, page(s) 238]

In an infectious disease outbreak, every hour counts, "as the window of opportunity for preventing deaths and further spread closes quickly." Once the disease has affected healthcare workers in significant numbers and is present in the general community, it becomes much harder to control. Governments and healthcare professionals therefore need to move quickly to contain the spread of the disease. SARS demonstrated that responding to an outbreak requires good communication among key decision-makers so that information can be amassed, analysed and acted upon. An effective response extends beyond providing medical care to patients and may continue long after the disease itself has subsided. SARS not only had a significant impact on medical treatment and practice, it also created a substantial political challenge and possibly even a legal challenge for the authorities.

HARMS: PANDEMIC → ECONOMIC DECLINE

Even a mild pandemic can cause massive global economic decline

McKibbin and Sidorenko, Brookings Institution, '09

[Warwick J. McKibbin, Nonresident Senior Fellow, Global Economy and Development at the Brookings Institution, and Alexandra A. Sidorenko, Adjunct Research Fellow, Australian National University, "What a Flu Pandemic Could Cost the World," April 28, 2009, Brookings Institution, http://www.brookings.edu/opinions/2009/0428_swine_flu_mckibbin.aspx download date: 6-18-09]

Comparing the recent outbreak of swine flu to the influenza epidemic of 1918-19 may seem premature. A century ago, 50 million died -- a mortality rate far, far higher than this current strain has seen so far. Yet while today's modern world is much better prepared to deal with a public health emergency, in one respect, it is in fact more vulnerable to contagion. The integrated nature of the global economy means that international finance offers little resistance to the economic shocks that accompany pandemics.

Even with a relatively small number of cases and deaths, the global cost of a modern epidemic is large and not limited to the countries directly affected. Outbreaks inspire massive drops in the consumption of various goods and services (think tourism and group recreation); they increase businesses' operating costs, and they speed the flight of foreign capital. The SARS epidemic in 2003 offers a telling example. As flights were cancelled, schools shut down, and panic gripped Asian markets, the relatively short-lived outbreak cost the world $40 billion.

In 2006, we estimated the likely global economic consequences of an influenza pandemic using several epidemic scenarios. The study began with a multi-country, multi-sector, dynamic model capable of describing the trade and financial linkages between and within economies. We then fed the model with a series of shocks meant to simulate the effect of pandemic: a decreased labor force, increased business costs, a shift in consumer preferences due to social distancing, and changes to risk premiums. We took into account the geography of each region and the strength of its health system. Labor supply shocks varied depending on the infection rate and mortality in a given country.

Even a mild pandemic, we discovered, would likely make a noticeable dent in global economic output. The mild scenario, estimated to cost the world 1.4 million lives, reduces total output by nearly 1 percent or approximately $330 billion (in constant 2006 prices) during the first year. In our model, as the scale of the pandemic increases, so do the economic costs. A massive global economic slowdown occurs in the next-worst scenario, with more than 142 million people killed and some output in economies in the developing world shrinking by half. The loss in output in this scenario could reach $4.4 trillion, 12.6 percent of global GDP in the first year. Of course, the composition of the slowdown would differ sharply across countries, with a major shift of global capital from the affected economies to the less-affected safe havens of North America and Europe.

In the most severe scenario, cost shocks play a much larger role in the GDP losses. Markets close down entirely. Wealth and income effects are larger in developing countries, and the contraction of demand is therefore much larger than in Europe and North America (Japan is caught in the middle). The destructive cycle feeds itself; Worse epidemiological outcomes in poorer countries perversely send much-needed capital flowing out and into industrialized economies. This exacerbates the current-account positions of the receiving countries and puts downward pressure on developing-country exchange rates. In essence, entire developing markets could become junk assets. World trade would likely contract significantly.

So far, our real-world swine flu pandemic appears to be less severe than the dire scenarios used in our modeling. But even now, the global economy is seeing some troubling signs of capital retreat. The Mexican peso, for example, has taken a hit. And just five days after news of the outbreak, it looked likely that Mexico's government would have to tap its $47 billion credit line with the International Monetary Fund.

Although stocking Tamiflu and developing vaccines might be the most pressing priorities of the day, it will take a much longer, sustained effort to prevent a future financial catastrophe. Investing in poverty reduction and healthcare in developing countries are the keys to managing pandemics in the long term. For now, we will have to live with a world where a relatively minor flu outbreak in Mexico City can send markets reeling in Tokyo.

HARMS: PANDEMIC → ECONOMIC DECLINE

Pandemic would crush productivity, dooming the economy

Garrett, Senior Fellow for Global Health, Council on Foreign Relations, '05

[Laurie, "The Next Pandemic," *Foreign Affairs*, July/August, vol. 84 issue 4, lexis-nexis]

As great as they would be, the economic consequences of travel restrictions, quarantines, and medical care would be well outstripped by productivity losses. In a typical flu season, productivity costs are ten times greater than all other flu-related costs combined. The decline in productivity is usually due directly to worker illness and absenteeism. During a pandemic, productivity losses would be even more disproportionate because entire workplaces--schools, theaters, and public facilities--would be shut down to limit human-to-human spread of the virus. Workers' illnesses also would likely be even more severe and last even longer than normal. Frankly, no models of social response to such a pandemic have managed to factor in fully the potential effect on human productivity. It is therefore impossible to reckon accurately the potential global economic impact.

HARMS: PANDEMIC → END OF INTERNATIONAL TRADE

A major disease outbreak would bring free trade to a halt and damage international relations

Garrett, Senior Fellow for Global Health, Council on Foreign Relations, '05

[Laurie, "The Next Pandemic," Foreign Affairs, Jul/Aug., vol. 84 issue 4, lexis-nexis]

Such a devastating disease would clearly have profound implications for international relations and the global economy. With death tolls rising, vaccines and drugs in short supply, and the potential for the virus to spread further, governments would feel obliged to take drastic measures that could inhibit travel, limit worldwide trade, and alienate their neighbors. In fact, the z+ virus has already demonstrated its disruptive potential on a limited scale. In July 2004, for example, when the z+ strain reemerged in Vietnam after a three-month hiatus, officials in the northern province of Bac Giang charged that Chinese smugglers were selling old and sickly birds in Vietnamese markets where more than ten tons of chickens are smuggled daily. Chinese authorities in charge of policing their side of the porous border, more than 1,000 kilometers long, countered that it was impossible to inspect all the shipments. Such conflicts are now limited to the movement of livestock, but if a pandemic develops they could well escalate to a ban on trade and human movement.

Although there is little evidence that isolation measures have ever slowed the spread of influenza--it is just too contagious--most governments would likely resort to quarantines in a pandemic crisis. Indeed, on April 1, 2005, President George W. Bush issued an executive order authorizing the use of quarantines inside the **U**nited **S**tates and permitting the isolation of international visitors suspected of carrying influenza. If one country implements such orders, others will follow suit, bringing legal international travel to a standstill. The SARS (severe acute respiratory syndrome) virus, which was less dangerous than a pandemic flu by several orders of magnitude, virtually shut down Asian travel for three months.

HARMS: PANDEMIC → END OF INTERNATIONAL TRADE

Epidemic would shut down free trade

Osterholm '05

[Michael T., Director of the Center for Infectious Disease Research and Policy, Associate Director of the Department of Homeland Security's National Center for Food Protection and Defense, and Professor at the University of Minnesota's School of Public Health, Jul/Aug, "Preparing for the Next Pandemic," Foreign Affairs, vol. 84 issue 8, lexis-nexis]

The pandemic-related collapse of worldwide trade and its ripple effect throughout industrialized and developing countries would represent the first real test of the resiliency of the modern global delivery system. Given the extent to which modern commerce relies on the precise and readily available international trade of goods and services, a shutdown of the global economic system would dramatically harm the world's ability to meet the surging demand for essential commodities such as food and medicine during a crisis. The business community can no longer afford to play a minor role in planning the response to a pandemic. For the world to have critical goods and services during a pandemic, industry heads must stockpile raw materials for production and preplan distribution and transportation support. Every company's senior managers need to be ready to respond rapidly to changes in the availability, production, distribution, and inventory management of their products. There is no model for how to revive the current global economy were it to be devastated.

NATIVES: UNIQUENESS & INHERENCY

Obama and Sebelius are committed to boosting health care provided to Native Americans but more funding is still needed

Dallas Morning News '09

[Associate Press story, "Health and Human Services chief to put more focus on health care for American Indians," http://www.dallasnews.com/sharedcontent/dws/news/nation/stories/DN-indianhealth_17nat.ART.State.Edition1.50fb759.html download date: 6-19-09]

Health and Human Services Secretary Kathleen Sebelius acknowledged Tuesday that government health care for American Indians has been a "historic failure" for more than a century and pledged to launch an extended effort to make it better.
Sebelius said she will begin a multiyear effort to improve the troubled Indian Health Service and will challenge Congress to make the back-burner issue a priority. Part of that strategy will be to recruit more providers for reservations and to focus on preventive care, which is often neglected at Indian health clinics as money runs out.
"[We need to] begin to lay the groundwork with Congress right now to say, 'Here's where we need to be,' " she said. "I think often the tribal issues just fade away."
She said her department also is increasing the size of the U.S. Public Health Service Commissioned Corps, which dispatches doctors to reservations as part of its mission.
President Barack Obama campaigned on Indian reservations last year and promised better health care there. His budget for 2010 includes an increase of $454 million, or about 13 percent, and the stimulus bill he signed earlier this year provided for construction and improvements to clinics.
Sebelius said that generous increase would still be far from what the agency needs.

GENERAL N/U: STIMULUS BILL

Non-Unique: February's Stimulus Bill doubled Federal support for community health centers and other similar programs

States News Service '09

[HEADLINE: HEALTH CARE GETS BIG BOOST IN ECONOMIC RECOVERY BILL, February 17, 2009; BODY: The following information was released by Vermont Senator Bernie Sanders; lexis-nexis]

Millions more Americans will have access to primary health care as support for community health centers will double and funds for training doctors, nurses and other health care professionals will nearly triple under economic recovery legislation President Barack Obama will sign today.

This is one of the most significant steps forward that we have seen in decades in addressing the primary health care crisis in our country, said Senator Bernie Sanders (I-Vt.).

At Sanders urging, the plan invests an extra $2 billion in Federally Qualified Health Centers to expand the program that provides affordable primary care, dental care, mental health services and low-cost prescription drugs. A cost-effective alternative to hospital emergency rooms, community health centers offer basic services like prenatal care, childhood immunizations and cancer screenings. Open to everyone, the centers care for patients covered by Medicaid, Medicare and private insurance as well as those who have no insurance.

The added funds in the stimulus bill are on top of a $2 billion annual budget for the 1,100 community health centers that now serve 18 million people nationwide. Another 56 million Americans, however, live in areas with inadequate access to a doctor or dentist. Applications by hundreds of additional centers have not been funded because of budget shortfalls.

The bill Obama signed includes $1.5 billion for health center construction, renovation and equipment purchases. Another $500 million is allotted for health center operations, including new sites, increased services and supplemental payments to accommodate growing numbers of uninsured patients.

At a time when the United States faces a major crisis in terms of an inadequate number of primary health care physicians and dentists, the bill also sets aside $300 million for the National Health Service Corps to provide incentives for physicians and dentists to practice in medically underserved communities. The corps provides debt forgiveness and grants for medical and dental students in exchange for practicing in underserved areas. The bill also provides an additional $200 million for other health care professionals, including nurses, to become involved in primary health care.

Sanders late last year joined Senate Appropriations Committee Chairman Daniel K. Inouye (D-Hawaii) in pushing for adding funds to the stimulus bill for health centers and the National Health Service Corps. In a December 16 letter to Senate Majority Leader Harry Reid (D-Nev.), Inouye and Sanders wrote that funding the programs would create thousands of jobs in construction and health care while laying the groundwork for broader health care reform in the future. Reid supported their proposal. Senator Tom Harkin (D-Iowa), chairman of the Senate panel that funds medical research, health care and education initiatives, also championed the provisions in the stimulus package. Leading House supporters were Majority Whip James Clyburn (D-S.C.) and the chairmen of two key committees, David Obey (D-Wis.) and Henry Waxman (D-Calif.).

Other health care provisions in the bill that Obama signed include about $19 billion to develop a system of electronic health records. Another $1.1 billion is set aside for research comparing which treatments work best for a particular disease. The measure also allots about $1 billion for a "prevention and wellness fund." About $300 million of that would provide additional immunizations. Most of the rest of that money will go to programs on smoking, obesity and various preventable health problems.

A/T: SPENDING DA

No link – Plan will be revenue neutral. Normal means for Obama administration health proposals is strict adherence to revenue neutrality

The Atlantic '09

[by Chris Good, "Sebelius Reiterates: No Deficit Spending," June 17 2009, 3:45 pm, http://politics.theatlantic.com/2009/06/sebelius_reiterates_no_deficit_spending.php download date: 6-20-09]

Health and Human Services Secretary Kathleen Sebelius took the Obama administration's health care platform to the Democratic Leadership Council's policy forum today, reiterating the administration's plan to make its health reform efforts deficit neutral.

"In the days ahead, we will work with Congress and address other proposals for funding health reform. We are open to good ideas. But we are not open to deficit spending," Sebelius said.

"Health reform will be paid for and it will be deficit neutral over ten years."

Whether this is possible is a big debate right now, and it depends to some degree on possible cost savings in Medicare, health cost savings across the board, Congress's ability to stick to proposed budget rules, and finding money to pay for early deficits within ten years.

The realism of deficit-neutral health reform is something that's doubted by many, but the administration is sticking to it, and Sebelius laid it out in black-and-white terms today.

A/T: SPENDING DA

TURN: CHC's provide efficient care, decreasing use of expensive emergency rooms and thus decreasing overall costs

Wheeler '07

[By Larry Wheeler, Gannett News Service, HEADLINE: Poor, uninsured depend on community health centers, Great Falls Tribune (Montana), August 23, 2007, SECTION: A SECTION; Pg. 1A, lexis-nexis]

Despite their problems finding doctors, community health centers deliver better continuity of care than private physicians or hospital outpatient facilities, according to a 2000 study published in the Journal of the American Medical Association.
Other studies show community health centers can outperform private physicians, hospitals and emergency rooms in price, quality of care and efficiency.
The centers give expectant mothers greater access to prenatal care, increase childhood vaccinations, lower infant mortality rates and improve the prognosis of patients living with chronic conditions such as diabetes and high blood pressure.
Health centers also reduce the disease gap between whites and minority populations.
African-American women who receive care at community health centers, for example, deliver significantly fewer low-birth-weight babies than the national average, according to a 2004 analysis published in the Journal of Public Health Policy.
Patients at community health centers also are less likely to use a hospital emergency room for non-emergency treatment, saving money for hospitals and patients.
A 2001 study of 50,000 Medicaid beneficiaries concluded that patients who got most of their care at community health centers were significantly less likely than other patients to be hospitalized or seek emergency room care.
"Emergency rooms all over the country are providing too much primary care," said David Sjoberg, vice president of strategic services for the Baptist Health Care hospital system in Pensacola, Fla. "You have people coming in sick because they have not taken their insulin, people with the flu. Instead of going to a $40 primary care visit at a health care center, they're spending $1,500 to $3,000 to get treated in an emergency room."

A/T: SPENDING DA

TURN: More CHC's would reduce expensive visits to Emergency Rooms, saving money overall

Lang '07

[By Tony Lang, "Health Clinics Bring Hope To The Indigent," *The Cincinnati Enquirer* (Ohio), July 22, 2007, lexis-nexis]

Neighborhood Health Care CEO Angela McLemore says 41 percent of patients pay at least some of their costs. But those sliding-scale payments account for only 6 percent of total revenues. Medicaid pays 42 percent, and Medicare pays 7 percent, mostly for the elderly. Another 45 percent comes from government and foundation grants, plus private donors.

Federally qualified health centers don't try to compete with hospital trauma centers. Their niche is primary care and prevention services for the medically underserved, including homeless people and migrant workers. The centers aim to treat ailments before they become a crisis.

The goal is to have fewer people flooding hospital emergency rooms later.

"We are not like the old Medicaid mills of the 1970s," McLemore says. "People think care for the poor is poor care. That's not true. All our doctors are board-certified. All graduated from the best schools."

Serbian-born Jovicic did his residency at University Hospital. To qualify for his visa, he signed on for three years to doctor to the uninsured or underinsured, but after three years at East End Health Center, he felt no need to move on. He's been there seven years, treating mostly neighborhood people, but also some from Kentucky and Cincinnati's West Side. The East End clinic, like the others, sees lots of patients with type 2 diabetes and hypertension.

"Many patients are depressed," Jovicic says. "At least seven out of 10. Very often they ask for help." The wait for an outside psychiatrist can run five to six months, so Jovicic either prescribes antidepressants or refers patients to on-staff mental health counselors. He hails the recent addition of mental health services as a great improvement.

Many East End patients had been "frequent fliers" to local hospital emergency rooms, Jovicic says. But after connecting with the clinic, patients don't head for the ER as often as before. Jovicic is proud of the health center's added role as a teaching facility: University of Cincinnati med students serve on one-month rotations there.

A/T: POLITICS DA

Universal support for more funding for CHC's – Bush Republicans, Obama Administration, and Democrats in Congress all support the plan

New York Times '08

[By Kevin Sack, "For Bush, a Rise In Health Clinics Shapes a Legacy," *The New York Times*, December 26, 2008, SECTION: Section A; Pg. 1; lexis-nexis]

Although the number of uninsured and the cost of coverage have ballooned under his watch, President Bush leaves office with a health care legacy in bricks and mortar: he has doubled federal financing for community health centers, enabling the creation or expansion of 1,297 clinics in medically underserved areas.

For those in poor urban neighborhoods and isolated rural areas, including Indian reservations, the clinics are often the only dependable providers of basic services like prenatal care, childhood immunizations, asthma treatments, cancer screenings and tests for sexually transmitted diseases.

As a crucial component of the health safety net, they are lauded as a cost-effective alternative to hospital emergency rooms, where the uninsured and underinsured often seek care.

Despite the clinics' unprecedented growth, wide swaths of the country remain without access to affordable primary care. The recession has only magnified the need as hundreds of thousands of Americans have lost their employer-sponsored health insurance along with their jobs.

In response, Democrats on Capitol Hill are proposing even more significant increases, making the centers a likely feature of any health care deal struck by Congress and the Obama administration.

In Nashville, United Neighborhood Health Services, a 32-year-old community health center, has seen its federal financing rise to $4.2 million, from $1.8 million in 2001. That has allowed the organization to add eight clinics to its base of six, and to increase its pool of patients to nearly 25,000 from 10,000.

Still, says Mary Bufwack, the center's chief executive, the clinics satisfy only a third of the demand in Nashville's pockets of urban poverty and immigrant need.

One of the group's recent grants helped open the Southside Family Clinic, which moved last year from a pair of public housing apartments to a gleaming new building on a once derelict corner.

As she completed a breathing treatment one recent afternoon, Willie Mai Ridley, a 68-year-old beautician, said she would have sought care for her bronchitis in a hospital emergency room were it not for the new clinic. Instead, she took a short drive, waited 15 minutes without an appointment and left without paying a dime; the clinic would bill her later for her Medicare co-payment of $18.88.

Ms. Ridley said she appreciated both the dignity and the affordability of her care. "This place is really very, very important to me," she said, "because you can go and feel like you're being treated like a person and get the same medical care you would get somewhere else and have to pay $200 to $300."

As governor of Texas, Mr. Bush came to admire the missionary zeal and cost-efficiency of the not-for-profit community health centers, which qualify for federal operating grants by being located in designated underserved areas and treating patients regardless of their ability to pay. He pledged support for the program while campaigning for president in 2000 on a platform of ''compassionate conservatism.''

In Mr. Bush's first year in office, he proposed to open or expand 1,200 clinics over five years (mission accomplished) and to double the number of patients served (the increase has ended up closer to 60 percent). With the health centers now serving more than 16 million patients at 7,354 sites, the expansion has been the largest since the program's origins in President Lyndon B. Johnson's war on poverty, federal officials said.

"They're an integral part of a health care system because they provide care for the low-income, for the newly arrived, and they take the pressure off of our hospital emergency rooms," Mr. Bush said last year while touring a clinic in Omaha.

With federal encouragement, the centers have made a major push this decade to expand dental and mental health services, open on-site pharmacies, extend hours to nights and weekends and accommodate recent immigrants -- legal and otherwise -- by employing bilingual staff. More than a third of patients are now Hispanic, according to the National Association of Community Health Centers.

The centers now serve one of every three people who live in poverty and one of every eight without insurance. But a study released in August by the Government Accountability Office found that 43 percent of the country's medically underserved areas lack a health center site. The National Association of Community Health Centers and the American Academy of Family Physicians estimated last year that 56 million people were "medically disenfranchised" because they lived in areas with inadequate primary care.

President-elect Barack Obama has said little about how the centers may fit into his plans to remake American health care. But he was a sponsor of a Senate bill in August that would quadruple federal spending on the program -- to $8 billion from $2.1 billion -- and increase incentives for medical students to choose primary care. His wife, Michelle, worked closely with health centers in Chicago as vice president for community and external relations at the University of Chicago Medical Center.

And Mr. Obama's choice to become secretary of health and human services, former Senator Tom Daschle of South Dakota, argues in his recent book on health care that financing should be increased, describing the health centers as "a godsend."

The federal program, which was first championed in Congress by Senator Edward M. Kennedy, Democrat of Massachusetts, has earned considerable bipartisan support. Leading advocates, like Senator Bernie Sanders, independent of Vermont, and Representative James E. Clyburn, Democrat of South Carolina, the House majority whip, argue that any success Mr. Obama has in reducing the number of uninsured will be meaningless if the newly insured cannot find medical homes. In Massachusetts, health centers have seen increased demand since the state began mandating health coverage two years ago.

TOPICALITY: PEOPLE IN POVERTY

Community Health Centers are targeted to those living in poverty

Park '08

[By Carolyne Park, "Centers finding no end to health-needy in state Rising costs, demand besetting caregivers," *Arkansas Democrat-Gazette* (Little Rock), December 28, 2008, lexis-nexis]

Dr. Shirley Price-Barnes is the first doctor many of her patients have seen in years, sometimes decades.
Many are poor or have little or no health insurance coverage. Some are superstitious and think it's bad luck to go to the doctor.
The toughest cases, she said, are those that come too late. In one case, a 60-year-old woman came in with a lump under her arm that turned out to be latestage breast cancer. She died within a year.
"She hadn't been to a doctor in over 20 years," Price-Barnes said.
In eight years at Jefferson Comprehensive Care Center in Pine Bluff, Price-Barnes has learned to take the bad with the good. Many patients wouldn't get care without the center, she said.
Jefferson Comprehensive Care System Inc. is one of 12 member systems covering 59 clinics that are part of Community Health Centers of Arkansas Inc., Arkansas Primary Care Association.
During the legislative session starting next month, Community Health Centers of Arkansas will ask for $20 million in annual state funding to offset high costs of providing care to 120,000 Arkansans, and to help recruit and retain providers, said Sip Mouden, the group's chief executive officer.
Rising costs and growing demand for services have made it harder to provide care, she said.
"It is to help us with serving the uninsured, the underinsured and underserved," Mouden said. "It's all about access." It won't be the first time Community Health Centers of Arkansas has sought state help. While they've gotten one-time payments, efforts to get annual funding in 2005 and 2007 were unsuccessful.
This legislative session they'll be competing with other agencies and initiatives for state dollars at a time of tight budget constraints.
Gov. Mike Beebe presented what he called a "conservative" $4.47 billion general revenue budget in November. He has asked state agencies to scale back spending and said he anticipates a "pretty bleak period" with the economic downturn. Matt De-Cample, Beebe's spokesman, said community health centers will be among several healthcare topics addressed during the session, along with development of a trauma system to coordinate emergency care statewide.
"The [community health centers] have an important role, and we're all about giving Arkansas the accessibility to as many options for health care as we can," DeCample said.
The Step Up Coalition, a coalition of more than 20 groups that's pushing to raise Arkansas' cigarette tax, has identified the trauma system and community health centers as its two top priorities for funding from the proposed tax increase. Beebe has said he's considering whether to support such an increase.
Nationwide, community health centers serve an estimated 18 million people a year at more than 7,000 sites, according to the National Association of Community Health Centers.
The association has set a goal of expanding care to 30 million people by 2015.
Increased federal funding for community health centers allowed the creation of nearly 1,300 clinics under President Bush.
While President-elect Barack Obama has not said how the centers will play into future healthcare plans, he and his choice for health and human services secretary, U.S. Sen. Tom Daschle, have supported increased funding for community health centers in the past. Community health centers are private, nonprofit businesses, different from public health units run by the Arkansas Department of Health. The Health Department has 93 health units in every county in the state, said department spokesman Ed Barham. The units provide services, including primary and preventive care, immunizations, in-home health services and hospice care. They serve anyone, regardless of income level or whether the patient has insurance.
"We would never want anyone to stay away because they felt like they couldn't afford care," Barham said.
PROVIDING CARE In Arkansas, community health centers are an essential part of the state's health system, serving many people who have limited options for care, like those living in rural areas, said Kevin Ryan, executive associate director of the Arkansas Center for Health Improvement.
Ninety-three percent of patients at community health centers in Arkansas were at or below 200 percent of the poverty level in 2007, which was equal to $41,300 for a family of four.
"They serve as a safety-net provider for Arkansans," Ryan said.

TOPICALITY: SERVICES & PEOPLE IN POVERTY

Contextual evidence proves that CHC's provide basic health SERVICES to People in Poverty

New York Times '08

[By Kevin Sack, "For Bush, a Rise In Health Clinics Shapes a Legacy," *The New York Times*, December 26, 2008, SECTION: Section A; Pg. 1; lexis-nexis]

Although the number of uninsured and the cost of coverage have ballooned under his watch, President Bush leaves office with a health care legacy in bricks and mortar: he has doubled federal financing for community health centers, enabling the creation or expansion of 1,297 clinics in medically underserved areas.

For those in poor urban neighborhoods and isolated rural areas, including Indian reservations, the clinics are often the only dependable providers of basic services like prenatal care, childhood immunizations, asthma treatments, cancer screenings and tests for sexually transmitted diseases.

As a crucial component of the health safety net, they are lauded as a cost-effective alternative to hospital emergency rooms, where the uninsured and underinsured often seek care.

TOPICALITY: SERVICES & PEOPLE IN POVERTY

CHC's provide services to poor people, originated with War on Poverty

Wheeler '07

[By Larry Wheeler, Gannett News Service, HEADLINE: Poor, uninsured depend on community health centers, Great Falls Tribune (Montana), August 23, 2007, SECTION: A SECTION; Pg. 1A, lexis-nexis]

Americans are used to hearing bad news about their health care system that millions of people lack health insurance and medical costs are spinning out of control. But amid those trends is evidence that a vital and often overlooked health care safety net is performing effectively and efficiently.

That national network of 952 federally approved community health centers serves more than 14 million **poor** and uninsured patients who otherwise might go without prenatal care, cancer screenings, diabetes treatment and a long list of other **services**.

"I have no idea where else I would go for health care," said Shirley Dorsey, 51, a patient at Baltimore Medical System's health center. "It's important to have someplace where **poor people** who don't have insurance can come and not be afraid of being turned away."

Since 2000, the Bush administration and Congress have nearly doubled annual spending on community health centers, to almost $2 billion. That's the largest increase in the history of the public health program, born during the 1960s War on **Poverty**.

Over the same period, the number of centers has increased by more than 200 and the number of patients they treat has risen by 4.5 million, or 53 percent.

The centers, located in areas deemed medically underserved, rely heavily on Medicaid payments and federal grants and must meet a number of requirements to qualify for federal funding. Most of their patients are minorities, with Hispanics far outpacing other racial and ethnic groups in growth.

TOPICALITY: SERVICES

CHC's provide many services under one roof

The Times of Shreveport '07

[BYLINE: Mary Jimenez, July 23, , Page 1A, HEADLINE: Community health centers a lifeline to many, lexis-nexis]

It's a typical day at David Raines Community Health Center in north Shreveport.
Expectant mom Ashley Wilson, 18, waits to enroll in a government nutrition program for herself and her baby. Joy Harris has brought in son Justin Harris, 4, who has a fever and aching head. Christy Williams has her three children in for their annual Kid-Med visits, a preventative screening program.
Community health centers like the four sites operated by David Raines Community Health Centers are a lifeline to primary and preventative health care for many people; offering medical, dental, optometry, pharmacy, immunizations and many other programs under one roof.
They are part of the national network of 952 federally approved centers on the front line of a challenge to provide access to health care for 46 million uninsured Americans.
"It's the best way to put money where it will do the most good," said Willie White III, chief executive officer of the David Raines centers in Shreveport, Gilliam, Haynesville and Minden. "We try to offer comprehensive **services** under one roof so people don't have to go multiple places. That's a very unique model that community health centers have been promoting."
Without a close watch on blood sugar levels, blood pressure, cholesterol and dental hygiene, an individual can end up in the hospital with an acute illness.
Community centers in a sense save everyone money, White said. It keeps people out of the charity system of care that someone eventually has to pay for.
"Those costs show up in increased doctors fees or insurance costs," White said. "I think that President Bush has realized that, and the money he's put into the program is well-placed dollars."

A/T: STATES CP

No Solvency: State health programs and budgets are overstretched now. They lack the money and staff necessary to solve. Pandemics would spread.

Associated Press '09

[By RITA BEAMISH and FRANK BASS, "Flu scare reveals strapped local health agencies," May 26, 2009, http://www.google.com/hostednews/ap/article/ALeqM5iXxwlXbCCk1pvBiGkFlY0e2eyeAAD98E3T0G0 download date: 6-20-09]

Facing Michigan's latest budget cuts, Kent County health director Cathy Raevsky sized up the local impact: no more nursing visits to new moms, fewer restaurant inspections and reduced communicable disease control. There was a familiarity to the cuts. "I've been doing it for seven years," she said ruefully.

Already down more than one quarter of her staff, Raevsky managed the recent, limited swine flu outbreak by stretching her team. But a major, sustained outbreak would overwhelm the county, she said, echoing the concern of many local health departments that are the community bulwarks against disease and health emergencies in the United States.

Swine flu fell short of a full-blown international crisis, but revealed the precarious state of local health departments struggling with cutbacks as well as increased demand from people who have lost jobs and medical insurance.

Stung by the lean economy, 13 states and U.S. territories had smaller health budgets in 2008 than in 2007, and eight more made midyear cuts, according to a survey by an advocacy group, the Association of State and Territorial Health Officials. With local budgets also in trouble, and new cutbacks anticipated this summer, many health officials fear a serious outbreak.

"We won't be able to do it," Raevsky said. She said getting vaccine to everyone would require shutting down all other services, plus pulling workers from other departments.

A review by the U.S. Health and Human Services Department in January noted great strides in preparedness but said many shortfalls remain. They include the ability to maintain public health functions such as food safety and daily needs during a pandemic, and the capacity to meet surges in health care demand and to strategically close schools.

State capabilities vary. But among some local departments that rely on a combination of federal, state and local revenues, an Associated Press review found troubling signs:

_Twenty-nine public health workers in Sacramento County, Calif., learned just before being called to work on swine flu that they probably will lose their jobs this summer. Senior nurse Carol Tucker, contacting potential flu victims, thought about future epidemics.

"Who will be around to do these things?" she said.

_Nationwide, officials have reported more than more than 6,700 swine flu cases, and 12 deaths.

"We have good plans and we're exercising them," said Matthew A. Stefanak, health commissioner of Mahoning County, Ohio, whose work force dropped 20 percent in two years. "But for the nuts and bolts of an outbreak — contact investigations, probable cases of H1N1 flu — we don't have the manpower, the trained disease investigators the public health nurses who would do it. That's where we're weakest right now."

_Federal investment in local emergency planning since the attacks of Sept. 11, 2001, has paid off in a smooth response to the limited swine flu outbreak. But the money has dwindled.

Last year at least 10,000 local and state health department jobs were lost to attrition and layoffs, including at laboratories that identify disease strains, according to surveys by the state and territorial group and the National Association of County and City Health Officials.

An annual flu-shot clinic no longer comes to town hall in Berlin Center, Ohio. "The real danger is how many just won't get shots," said Ivan Hoyle, 78.

_People calling for routine immunizations now reach a recording saying the Worcester, Mass., clinic is closed. With just two of its six public health nurses surviving layoffs, the city is re-evaluating its responsibilities and says it can meet emergencies by working with the University of Massachusetts and local hospitals.

Ann Cappabianca, one of the remaining nurses, scrambles to track communicable disease and tuberculosis cases. "We just can't get it all done. You try to focus on the most important thing at the moment," she said.

Worst is having to make cuts without "enough ability to assess the needs of my community," said Bob England, the health director of Arizona's sprawling Maricopa County, which closed its family planning clinic.

Public health departments will get some help from this year's stimulus spending of $1 billion for prevention and wellness efforts.

But it will take years to bring local health agencies to the point where they can fight a sustained, widespread pandemic, said Richard Hamburg, a lobbyist at the nonprofit Trust for America's Health, an advocacy group supported by private and government grants.

A report from the group in December found emergency planning gaps in areas such as rapid disease detection, food safety and "surge capacity" to quickly scale up equipment, staff and supplies to meet a major outbreak.

↓ AP '09 article continues ↓

↓ AP '09 article continues ↓

Dan Sosin, head of emergency response at the Centers for Disease Control and Preparedness, praised the federal swine flu response, but acknowledged that public health officials face "capacity issues in terms of ongoing resources and funding."
"We could spend more money," he said. "We could use more than we have."
The CDC's acting director, Richard Besser, told Congress last month the government is concerned about states being too short-staffed to conduct required emergency exercises.
The main fund for local health emergency planning after the Sept. 11 attacks, the federal Public Health Emergency Preparedness program, has dropped nearly one-third since a 2006 peak of almost $1 billion, according to CDC figures. The money had included a special three-year congressional allocation for pandemic flu preparation that ran out last year.
President Barack Obama now is asking Congress for $1.5 billion to fight swine flu.
A second fund to help local agencies plan for public health emergencies, the Hospital Preparedness Program, has fallen nearly a quarter from $457 million in the 2006 budget year.
Decreases in the Public Health Emergency Preparedness program were most significant in Iowa, Mississippi, Colorado, Missouri, Michigan, Ohio, Pennsylvania and Louisiana. After a pair of killer hurricanes hit Louisiana in 2005, Washington sent nearly $15 million in 2006 health emergency help. This year, it's down to $9.8 million.

A/T: STATES CP

No Solvency: California is broke. Budget deficit there means huge cuts in health programs. Cali just could not enact the policy.

Coast News 6-18-09

[by Gideon Marcus, "Community clinics rally against funding cuts," June 18, 2009, Coast News (California), http://www.thecoastnews.com/pages/full_story?page_label=home_coast&id=2753713-Community+clinics+rally+against+funding+cuts&widget=push&article-Community%20clinics%20rally%20against%20funding%20cuts%20=&instance=coast_more_news&open=& download date: 6-19-09]

With California's budget deficit now above $24 billion, Sacramento is looking at cutting public health. Four of San Diego County's community health centers, representing more than 200,000 patients annually, banded together for a joint press conference at North County Health Services, or NCHS, June 11, to protest a proposal by Gov. Arnold Schwarzenegger to eliminate several programs which subsidize health costs for the poor and uninsured.

Community health centers provide care and education, particularly for those who would not otherwise have access to it. The governor presented plans in May to reduce Medi-CAL as well as cut SCHIP Healthy Families program, the Expanded Access to Primary Care program and state-funded HIV/AIDS screening, testing and prevention. This would leave thousands uninsured in San Diego County alone, and drain vital monies from health center coffers, conference speakers said.

"We will see these families suffering," Vista Community Clinic CEO Barbara Mannino said. "They will have to make a choice between having a roof over their children's heads, putting food on the table, or providing health care cover for their children."

"We have a fragile safety net right now that will become even more fragile if the cuts go through," CEO of Neighborhood Healthcare Tracy Reams said. "What it comes down to is the only way to keep the doors open is to reduce services."

Several speakers made the point that although cutting health coverage might save money in the short run, costs would ultimately run much higher. Patients who no longer could afford preventative clinic visits would find themselves accumulating tremendous emergency room bills later on.

Dr. Kevin Ellis, medical director for NCHS, said that this would not only lead to financial hardships for uninsured patients, but many would not be able to pay for the treatment they received which would cause hospitals to raise rates. This would drive up insurance costs for the already insured.

"What would have cost $150 for three visits at a clinic could end up costing the system tens of thousands of dollars," NCHS President and CEO Irma Cota said. "It's prudent to retain these programs not just from the financial sense but also the ... quality of life."

Another concern brought up was N1H1 Swine Flu, which the World Health Organization had classified as a pandemic on the day of the conference. NCHS was swamped with thousands of patients in May during the last outbreak, and Cota warned that community health centers would be ill-equipped to deal with another should the cuts go through.

A/T: EXCLUDE ILLEGAL IMMIGRANTS

TURN: Excluding immigrants drives a key population away from seeking care, increasing the risk of flu pandemic for everyone

A.P. '09

[Associated Press, By RICARDO ALONSO-ZALDIVAR, Associated Press Writer, HEADLINE: Swine flu could shine glaring light on uninsured, May 5, 2009, lexis-nexis]

Swine flu could shine a glaring light on the best and worst about American-style health care.

At top labs, scientists are optimistic they can make a vaccine that's effective against the new virus. But in a country where one in seven people lack medical insurance, doctors worry that some individuals won't get needed protection because of cost.

It could leave the rest of society more vulnerable.

In a flu epidemic, the uninsured face the worst options: flooding the emergency rooms or self-medicating with cold preparations and hoping for the best. Many might not be aware they can also go to a federally-funded community health center and see a doctor or nurse for little or no cost.

Helping the estimated 50 million uninsured will mean more than just paying for their health care. For example, if they're here as illegal immigrants, should taxpayers still cover the costs?

Public health experts say obstacles to getting medical attention are counterproductive if you're trying to stop an infectious disease in a highly mobile society like the United States.

"The person I'm most worried about is the one who decides to delay getting care, and does it in such a way that they infect others or put themselves at greater risk," said Dr. Georges Benjamin, executive director of the American Public Health Association.

"To have an epidemic with millions of people who may not go to the doctor because they can't afford to pay remains one of the unique challenges of our system."

Lawmakers are already proposing fixes. The big health care overhaul Congress is working on probably won't be ready if a bad flu strikes later this year.

Sen. Dick Durbin, D-Ill., and Rep. Lois Capps, D-Calif., have introduced legislation to pay for temporary medical treatment for uninsured people during a public health emergency. It could be a natural disaster such as an earthquake or hurricane, a bioterror attack, or a medical emergency such as a flu pandemic.

"We can't afford to have barriers that keep people from getting care when an epidemic is sweeping the community," Capps said.

Separately, Sen. Tom Harkin, D-Iowa, has proposed to offer all individuals a free flu shot each year.

The Obama administration has not taken a position on either bill. But it has started shipping anti-flu medicines to community health centers, which provide basic medical care to the uninsured.

Trust for America's Health, a public health group that has focused on pandemic flu preparedness, is supporting the Durbin-Capps bill.

"During a public health emergency, the federal government would step in and take care of the needs of the people who are affected by that emergency," said Jeff Levi, executive director of the group. "Health care providers would not be left holding the bag for people who are uninsured. It will be a 'win' for individuals because they'll be able to get the care they need."

Many details of the legislation are still being worked out. Government coverage would be limited to treatment for problems that are related to the public emergency.

Dealing with immigrants could be one of the most difficult issues.

The uninsured are mostly native born. But immigrants are more than twice as likely to be uninsured as people born here.

When Congress was under Republican control it sharply restricted safety net benefits for immigrants, even legal ones. The Democratic-controlled Congress reversed that trend for legal immigrants when it expanded health insurance earlier this year for children in low-income families.

It would be another issue to cover illegal immigrants, even if only for a short time. But since Mexico is the epicenter of the outbreak, some experts say that may be prudent.

"We don't want to have a policy that drives people underground," Benjamin said. "It's better to have them present for care so that they don't put anybody else at risk."

COMMUNITY HEALTH CENTERS - NEG

NO HARM: SWINE FLU

Don't believe the hype. Swine Flu is no big deal – very few actual deaths

Manila Times '09

[Isabel Ongpin, Don't panic, it's only a kind of flu," June 19, 2009, http://www.manilatimes.net/national/2009/june/19/yehey/opinion/20090619opi5.html download date: 6-20-09]

We need a bit of sobriety in this time of flu. There is a flu pandemic as we have all been told which means the flu has reached the required number of countries to be considered present worldwide.

It originated in Mexico and traveled to the US and then did more traveling from the American continent to Europe, Asia and Australia. It has reached the Philippines and we have evolved from the occasional number of cases, usually in schools or offices, to a community outbreak in Nueva Ecija.

While this flu has been initially termed swine flu, it does not come from pigs at this stage and eating pork will not make one vulnerable to it. The term has been pointedly excluded from the official language of health organizations, notably the World Health Organization itself. It behooves us therefore to acknowledge the point and not panic regarding pigs or pork as panicking adversely affects the producers of pork and the rural economy.

It is worth noting that the flu in its present form is not a killer disease. The majority of the small number that have died in the pandemic are people who had underlying health issues which made them vulnerable to morbidity.

The Department of Health has come out with guidelines that should help avoid catching the flu, as well as steps to take if one manifests flu symptoms like a fever, sore throat, cough, etc. It has also strongly suggested that travelers upon arrival here should do some form of self-quarantine by sticking to their abodes for a term of days so as to be certain they have not come back with the flu.

The government through the Department of Health has been managing the flu situation in its various locations with tests, drugs and medical supervision. The public should cooperate and follow the Health department's advice.

With the above circumstances, those who do get the flu need not panic, go into hysterics or retreat into self-pity. With the attention available that will take care of them, they will be cured and come back to health.

It would be ideal if in this period there was only one spokesperson to inform the public of the latest A(H1N1) flu news as well as the guidelines to avoid it or to cope with it. This source would thus become the one authority to inform and instruct the public regarding this flu. Needless interviews with others in the medical field asking repetitive questions and getting routine answers or requests for personal opinions on the pandemic are useless rather than helpful. They go out of focus. The Secretary of Health has already said his piece and so with the Infectious Diseases Medical Chief at San Lazaro Hospital. The media should now let them be to attend to their tasks of monitoring, treating and managing the pandemic in the Philippines.

Another suggestion to the media is to report the facts at lower decibels avoiding dire prognostications that can panic the public. Panic leads to irrational and uncivil behavior, which some Nueva Ecija barangays have complained about regarding outsiders' behavior towards them as a result of hyperbolic reporting.

The fact is we are in the midst of a pandemic and we should cope with it in a rational and effective fashion. It would be good to be unaffected and carry on normally. But there is a possibility that one or some of us will not escape it. If this happens, there is a way back to health keeping the individual and community's sanity and equilibrium intact

NO HARM: AVIAN FLU

Avian Flu risk is a FALSE ALARM. It's not genetically similar to prior epidemics, it does not spread among humans, and it won't spread rapidly even if it mutates. Our source is qualified.

Siegel, Associate Professor of Medicine, New York University,' 05

[Marc, "Don't Worry, Be Healthy: Fear is more likely to get you than avian flu," Slate.com, download date: 9-14-05, http://slate.msn.com/id/2126233/]

This hardly seems the time to be arguing against apocalyptic public health warnings, as the aftermath of Hurricane Katrina continues to unfold. But Katrina should not be a basis for heeding every dire prophecy. Given that we have limited resources to predict and protect ourselves, the hurricane instead is a reminder of the importance of distinguishing health warnings that are grounded in impending danger from warnings that are not.

Fear works best as a warning system when it is a response to dangers that directly threaten those who are afraid. In New Orleans, fear of the weak levees could have mobilized the public to put more pressure on the local and federal governments to fix them. But that didn't happen. One reason is that Americans tend to pour their fears into dangers that, however real, pose a relatively low risk for any individual—like terrorism, anthrax, smallpox, and now the avian flu.

The avian flu virus, or H5N1, has killed millions of birds in China and Russia, either directly or because they've been destroyed to prevent its spread. The virus has infected 112 humans, 57 of whom have died. Despite the small numbers, public health officials in Russia, Germany, and the United States—along with articles like this one and this one in Foreign Affairs—have loudly sounded the alarm: Avian influenza is about to transform into a massive human killer that could kill 50 million to 100 million people. In preparation, the Department of Health and Human Services has contracted for the production of 2 million doses of vaccine, with several million more on the way, as well as millions of doses of the anti-viral drug Tamiflu. This week, Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases, called bird flu "a time bomb waiting to go off."

Yet the science behind all the worry is questionable. It rests on the unproven claim that the avian flu will develop exactly like the strain that caused the flu pandemic of 1918. A March 2004 article in Science showed that the 1918 flu—which infected close to a billion people and killed 50 million or more—made the jump from birds to humans through a slight change in the structure of its hemagglutinins, the molecules by which the virus attaches itself to body cells. This mutation allowed the virus to kill more World War I soldiers than weapons did, effectively ending the war when forces on both sides became too sick to fight.

The current bird flu, however, has a different molecular structure than the 1918 bug. And though it has infected millions of birds, there is no direct evidence that it is about to mutate into a form that would transmit from human to human. In isolated cases, food handlers in Asia have gotten sick, but that doesn't mean that a wildly lethal mutation is about to occur. As Wendy Orent points out in the New Republic, diseases that come from animals are often hard for humans to transmit. They lack the "essential characteristics" of virulent human infections—they're not durable, or waterborne, or carried by hospital workers, or transmitted sexually.

Even if the worst-case scenario does occur and the virus mutates, there is no current indication that it will spread the way the Spanish flu did in 1918. That disease incubated in the World War I trenches before it spread across the world, infecting soldiers who were exhausted, packed together in trenches, and lacked access to hygiene. These conditions were an essential breeding ground for the virus. Today, there is no way a huge number of people would be packed together in WWI-like conditions. Also, technology allows doctors to diagnose and isolate flu patients far more effectively.

Despite the lack of evidence about a huge avian flu pandemic, still we worry. That's a problem because fear causes stress, and stress is bad for your health. Numerous studies have shown the familiar link. The American Heart Association has emphasized a correlation between stress and overeating and stress and smoking, both of which lead to heart disease. A 2000 study in the journal Stroke of more than 2,000 men showed that those suffering from anxiety or depression were three times as likely to suffer a fatal stroke. A study in Psychosomatic Medicine showed that Israeli women with an expressed fear of terrorism had twice the level of an enzyme that correlates with heart disease.

NO HARM: AVIAN FLU

No risk of a huge avian flu epidemic

Stipp '05

[David, staff writer for Fortune Magazine, March 7, vol. 151, "The Coming War Against Bird Flu," *Fortune*, EBSCO]

Today's global jet travel does enable flu viruses to get from A to B fast. But when they get to B, they don't usually land in jam-packed wartime hospitals where within hours they can jump from one person to hundreds or thousands, as they did in 1918. The population mixing favored by modern world travel may also have hurt flu viruses' cause: It means that most of us have been exposed to more flu strains than people had been in 1918, says Walter Dowdle, former deputy director of the Centers for Disease Control and Prevention. "There's a huge amount of generic flu resistance out there," says Dowdle, now at the nonprofit Task Force for Child Survival and Development in Atlanta. Such resistance may partly explain why the flu pandemic of 1957 was much less lethal than 1918's, and the one of 1968 was milder yet.

The fact that the H5N1 virus has spread widely in birds is worrisome, for by mixing with other flu viruses present in avian cells, H5N1 may acquire genes for readily spreading in people--a talent it now lacks. But experts who assert that H5N1 is steadily progressing toward pandemic form are going too far, says Richard Schabas, former chief medical officer of Ontario, who's now at York Central Hospital in Richmond Hill, Ontario. "We have no idea why some avian flu strains leap the species boundary to spread in humans," he explains. "For all we know, there may be hundreds of viruses that have gone down this route [of infecting birds as H5N1 has] and didn't make the grade" as human strains. If so, the odds that H5N1 will mutate into a Spanish flu look-alike may be much smaller than has been suggested by all the alarming headlines about it.

NO HARM: NO SARS SPREAD

SARS Spread is small – transmission is low

Chan-Yeung, Professor of Medicine, University of Hong Kong and Loh, CEO of Civic Exchange, '04

[Moira, on leave as Professor of Medicine, University of British Columbia, She has headed the Occupational and Environmental Lung Diseases Unit at UBC since 1989. She has also served as the Chairperson of the Assembly of Environmental and Occupational Health for the American Thoracic Society; as a member of the Pulmonary Disease Advisory Committee, National Heart, Lung, and Blood Institute, part of the US National Institutes of Health; and as Chairperson of the Respiratory Diseases Section for the International Union Against Tuberculosis and Lung Disease; Christine Loh, is Chief Executive Officer of Civic Exchange, an independent public policy think-tank. Masters Degree in Chinese and Comparative Law from City University, Hong Kong. In 1992, she was appointed to the Legislative Council and ran successfully in the 1995 and 1998 elections. Loh writes extensively for local and international publications. "Chapter 4: The New Coronavirus: In the Search of the Culprit," in *At the Epicentre: Hong Kong and the SARS Outbreak*, edited by Christine Loh and Civic Exchange, Hong Kong University Press, page(s) 49]

However, despite fears about transmission of SARS, the SARS-coronavirus has a relatively low infectivity. It does not transmit from person to person efficiently and a fairly large dose of virus appears to be needed for transmission to occur. SARS is much less infectious than the typical flu. The concern is the virulence of the SARS-coronavirus, which can cause rapid and serious damage to human organs. A high number of patients require intensive care. At the height of the outbreak in Hong Kong, 14 percent of SARS patients were in intensive care units (ICUs). This put considerable pressure on the healthcare system

NO HARM: NO SARS SPREAD

Dire predictions on SARS are wrong. It spreads slowly and natural immunity checks it

Lau '04

[Alexis, Associate Director of the Center for Coastal and Atmospheric Research pf the Hong Kong University of Science and Technology, He received Ph.D. in Atmospheric and Oceanic Sciences from Princeton in 1991, "Chapter 6: The Numbers Trail: what the Data Tells Us," in *At the Epicentre: Hong Kong and the SARS Outbreak*, edited by Christine Loh and Civic Exchange, Hong Kong University Press, page(s) 85-86]

During the outbreak, another important issue in which the public was interested was whether Hong Kong's healthcare system could cope as the number of SARS cases rose. From the initial growth rates of the disease, it appeared that, had transmission been more effective, hospitals would have come under much greater stress and may well not have been able to manage.

Early on, it was not clear how the disease would progress. One German newspaper went so far as to predict that everyone in Hong Kongwould be infected!' In fact, SARS spread relatively slowly. Dire predictions based on initial data were inaccurate because nobody knew how effective transmission of the virus would be. There were also other factors that affected the spread of the disease, including the community's response and the build-up of immunity among the population.

NO SOLVENCY: AVIAN FLU

Can't contain Avian flu outbreak

Garrett, Senior Fellow for Global Health, Council on Foreign Relations, '05

[Laurie, "The Next Pandemic," Foreign Affairs, Jul/Aug., vol. 84 issue 4, lexis-nexis]

OVER THE COURSE of this brief but rapid evolution, the H5N1 virus developed in ways unprecedented in influenza research. It is not only incredibly deadly but also incredibly difficult to contain. The virus apparently now has the ability to survive in chicken feces and the meat of dead animals, despite the lack of blood flow and living cells; raw chicken meat fed to tigers in Thailand zoos resulted in the deaths of 147 out of a total of 418. The virus has also found ways to vastly increase the range of species it can infect and kill. Most strains of influenza are not lethal in lab mice, but z+ is lethal in 100 percent of them. It even kills the very types of wild migratory birds that normally host influenza strains harmlessly. Yet domestic ducks, for unknown reasons, carry the virus without a problem, which may explain where z+ hides between outbreaks among chickens.

NO SOLVENCY: DOCTOR SHORTAGE

Shortage of primary care doctors blocks any increase

Washington Post '9

[By Ashley Halsey III, Washington Post Staff Writer, "Primary-Care Doctor Shortage May Undermine Reform Efforts, No Quick Fix as Demand Already Exceeds Supply," Saturday, June 20, 2009, http://www.washingtonpost.com/wp-dyn/content/article/2009/06/19/AR2009061903583.html download date: 6-20-09]

As the debate on overhauling the nation's health-care system exploded into partisan squabbling this week, virtually everyone still agreed on one point: There are not enough primary-care doctors to meet current needs, and providing health insurance to 46 million more people would threaten to overwhelm the system.

Fixing the problem will require fundamental changes in medical education and compensation to lure more doctors into primary-care offices, which already receive 215 million visits each year.

The American Academy of Family Physicians predicts that, if current trends continue, the shortage of family doctors will reach 40,000 in a little more than 10 years, as medical schools send about half the needed number of graduates into primary medicine.

The overall shortage of doctors may grow to 124,400 by 2025, according to a study by the Association of American Medical Colleges. And, the report warns, "if the nation moves rapidly towards universal health coverage" -- which would be likely to increase demand for primary care and reduce immediate access to specialists -- the shortages "may be even more severe."

Many of the measures needed to compensate for shortages -- such as easing the debt incurred by medical students and expanding the role of community health centers -- are included in the provisions being put forth by lawmakers, but there is no quick or easy fix within the grasp of Congress or the Obama administration.

"You're talking about an eight-to-12-year period to fix the problem," said Robert L. Phillips Jr., director of the Robert Graham Center for Policy Studies in Family Medicine and Primary Care, part of the American Academy of Family Physicians.

Evidence that demand already exceeds the supply of primary-care doctors ripples through the system as patients increasingly have trouble finding a new doctor, then wait weeks or months for an appointment, spend more time in the waiting room than in the examining room, encounter physicians who refuse to take any form of insurance, and discover emergency rooms packed with sick people who cannot find a doctor anywhere else.

With 248 primary-care physicians per 100,000 residents, Washington fares far better than the national average of 88 doctors per 100,000 people (Maryland has 113; Virginia, 88). Nonetheless, with an average wait of 30 days to see a family doctor, Washington ranks third among cities with the longest wait times.

Fifty years ago, half of the nation's doctors practiced what has come to be known as primary care. Today, almost 70 percent of doctors work in higher-paid specialties, driven in part by medical school debts that can reach $200,000.

NO SOLVENCY: DOCTOR SHORTAGE

Education & Training takes years - solving Doctor and Nurse shortage would be long term

Washington Post '9

[By Ashley Halsey III, Washington Post Staff Writer, "Primary-Care Doctor Shortage May Undermine Reform Efforts, No Quick Fix as Demand Already Exceeds Supply," Saturday, June 20, 2009, http://www.washingtonpost.com/wp-dyn/content/article/2009/06/19/AR2009061903583.html download date: 6-20-09]

Community health centers would be expanded under all of the major proposals. And the measures envision far greater use of nurse practitioners and physician assistants, who would be teamed with doctors in larger groups.

A study by the Robert Graham Center and the National Association of Community Health Centers concluded that 15,585 more primary-care providers would be needed in order for health centers to serve 30 million new patients.

It takes six years to educate a nurse practitioner and a dozen years to produce a doctor. Even if Medicare funding for residency programs is increased, if medical schools increase their enrollments by the 30 percent recommended by the Association of American Medical Colleges and if financial incentives to enter primary care are put in place, it will take years to build the health-care system into the new model.

STATES CP – SOLVENCY

States can fund community health centers and programs to recruit more doctors

The Times of Shreveport '07

[BYLINE: Mary Jimenez, July 23, , Page 1A, HEADLINE: Community health centers a lifeline to many, lexis-nexis]

It's a typical day at David Raines Community Health Center in north Shreveport.
Expectant mom Ashley Wilson, 18, waits to enroll in a government nutrition program for herself and her baby. Joy Harris has brought in son Justin Harris, 4, who has a fever and aching head. Christy Williams has her three children in for their annual Kid-Med visits, a preventative screening program.
Community health centers like the four sites operated by David Raines Community Health Centers are a lifeline to primary and preventative health care for many people; offering medical, dental, optometry, pharmacy, immunizations and many other programs under one roof.
They are part of the national network of 952 federally approved centers on the front line of a challenge to provide access to health care for 46 million uninsured Americans.
"It's the best way to put money where it will do the most good," said Willie White III, chief executive officer of the David Raines centers in Shreveport, Gilliam, Haynesville and Minden. "We try to offer comprehensive services under one roof so people don't have to go multiple places. That's a very unique model that community health centers have been promoting."
Without a close watch on blood sugar levels, blood pressure, cholesterol and dental hygiene, an individual can end up in the hospital with an acute illness.
Community centers in a sense save everyone money, White said. It keeps people out of the charity system of care that someone eventually has to pay for.
"Those costs show up in increased doctors fees or insurance costs," White said. "I think that President Bush has realized that, and the money he's put into the program is well-placed dollars."
An additional 120 health centers nationwide will get federal start-up grants by fall, and Bossier Parish could be among them. That center will be operated by David Raines.
"We should hear about that in September," White said. "It will be somewhere in the vicinity of Shed Road between Airline and Benton."
State officials have also promised more funds for community health and rural care clinics.
According to the state Department of Health and Hospitals, Louisiana has more than 657,000 uninsured residents and even more living in areas without adequate access to health care.
"The state considers community health centers a vital component for the state," said Gerrelda Davis, acting director of the department's chronic disease prevention and control unit.
The unit is part of the Bureau of Primary Care and Rural Health, which administers the community health centers program.
Davis points to the last session of the Louisiana Legislature, which approved a surplus spending bill that included $41.5 million toward primary health clinics.
Fifty-eight expansion projects "" some community health centers and others kinds of projects "" are in the capital outlay budget of the Bureau of Primary Care, Davis said.
Reports and research back up the push for more health centers.
The National Association of Community Health Centers and the Association of Community Affiliated Plans recently released a report on the impact community health centers and community-affiliated health plans have on emergency department use.
"Louisiana alone wastes about $355 million annually on avoidable ED visits," said Davis, stating figures from the report. "And it has been shown our community centers save Medicaid about 30 percent annually by seeing people at the clinic."
But what is keeping health centers from being all they can be is adequate funding and staffing.
"There's a misconception that because it's federally subsidized, it pays for everything, but we have to rely on patient payments," said White, whose budget includes only about 20 percent revenue from federal grant money. "We're not free, but we're at a significant discount. We work with families based on income and we won't turn anyone away."
Another 5 percent of the revenue comes from the state and the remainder is a combination of self-pay, private insurance and Medicaid and Medicare payments.
"We're very prudent," said White, answering how the centers make ends meet. "We run the centers like any other business "" trying to keep cost low and overhead down."
Then there's the problem of finding and keeping medical staff on the limited budget.
National and state programs, which offer medical students loan repayment plans or give physicians incentives to take their practice to a community health center, help the recruitment dilemma but doesn't solve it, said White.

TOPICALITY: CHC ≠ SOCIAL SERVICES

Testimony at Congressional hearing proves community health program and social service are distinct. This is contextual evidence specific to the provision of government benefits

King, Altarum Institute,'09

[John King, Director, Veterans Community Action Teams Mission Project, Altarum Institute, Ann Arbor, Michigan, "U.S. Department of Veterans Affairs Medical Care: The Crown Jewel and Best Kept Secret," Testimony by John King to U.S. House Veterans' Affairs Subcommittee on Health Hearing; Congressional Documents and Publications, May 19, 2009, lexis-nexis]

Good afternoon, Chairman Michaud, Ranking Member Brown, and Members of the Subcommittee.

Thank you for inviting Altarum Institute to testify before this oversight hearing of the Subcommittee on Health. We appreciate the opportunity to offer our views on VA Medical Care: The Crown Jewel and Best Kept Secret. In our testimony today, we will address the methods and activities through which we have observed the Veterans Health Administration (VHA) communicating the availability of services to veterans. We also will share our observations regarding the differences in outreach strategies for the current generation of new veterans versus those used for older veteran populations.

Altarum Institute (Altarum) is a nonprofit health systems research and consulting organization serving government and private-sector clients. We provide objective research and tailored consulting services that assist our clients in understanding and solving the complex systems problems that impact health and health care. Our unique model combines the analytical rigor of a research institution with the business acumen of a traditional consultancy to deliver comprehensive, systems-based solutions that meet unique needs.

In 2008, Altarum launched its Mission Projects Initiative, committing more than $8 million in internal resources to three critical areas of societal need. The purpose of the initiative is to solve pressing health care issues using our systems methods at the institutional, organizational, and community levels in partnership with the public and private sectors, with the goal of improving the quality of life for millions of Americans.

Our Mission Projects are focused on three areas: developing systems changes to prevent childhood obesity, fostering innovation in community health centers, and facilitating integration and coordination of community health and social services for veterans and their families. Today's testimony will focus on the last area.