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# THE CLEAN AIR ACT AND PUBLIC HEALTH

## HEARING

BEFORE THE

## COMMITTEE ON ENVIRONMENT AND PUBLIC WORKS UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

JUNE 15, 2011

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COMMITTEE ON ENVIRONMENT AND PUBLIC WORKS

ONE HUNDRED TWELFTH CONGRESS
FIRST SESSION

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# OVERSIGHT HEARING ON THE CLEAN AIR ACT AND PUBLIC HEALTH

**WEDNESDAY, JUNE 15, 2011**

U.S. SENATE,
COMMITTEE ON ENVIRONMENT AND PUBLIC WORKS,
*Washington, DC.*

The full committee met, pursuant to notice, at 10 a.m. in room 406, Dirksen Senate Office Building, Hon. Barbara Boxer (chairman of the full committee) presiding.

Present: Senators Boxer, Inhofe, Carper, Lautenberg, Whitehouse, Merkley, Vitter, Barrasso, Alexander.

## OPENING STATEMENT OF HON. BARBARA BOXER, U.S. SENATOR FROM THE STATE OF CALIFORNIA

Senator BOXER. Good morning, everybody. The Committee will come to order.

I call this hearing to conduct oversight on one of the most successful and significant public health statutes in our Nation's history, the Clean Air Act. Before President Richard Nixon signed the Clean Air Act into law in 1970, the Nation's air was heavily polluted in many places in our great Nation. For example, a fog of pollution covered Donora, Pennsylvania, for 5 days in 1948. Records indicate that 20 people died, 6,000 people were sickened and hundreds were evacuated as a result of the pollution.

In another tragic case, the eastern United States was blanketed by harmful smog in 1966. Scientists and researchers eventually concluded the smog caused the death of 24 people per day over a period of 6 days.

The Clean Air Act, which has deep bipartisan roots, changed that. President Richard Nixon said, "I think that 1970 will be known as the year of the beginning, in which we really began to move on the problems of clean air for the future generations of America."

When President George Bush signed the Clean Air Act amendments in 1990, he said "I take great pleasure in signing the legislation as demonstration to the American people of my determination that each and every American shall breathe clean air."

Now, 40 years after the Clean Air Act was created, many of the benefits to public health are clear and measurable. Let me show you how successful this landmark environmental law has been in protecting children and families in my State of California. In 1976, and that's the peak of the line, the red line, there were 166 days when health advisories were issued in Southern California to urge

people with asthma and other people with lung sensitivities to stay indoors.

In 35 years, the number of smog-related health advisories issued in southern California dropped from 166 days in 1976 to zero days in 2010. And I think that chart, if a picture is 1,000 words, this chart says it about the Clean Air Act. Thank you.

While the Clean Air Act has dramatically improved health safeguards, more work remains to be done. A 2011 report by the American Lung Association shows that 154 million people live in areas with levels of toxic soot and smog pollution that current science demonstrates is dangerous. Last year the Pittsburgh Post Gazette reported on the oily black rain of pollution from an electric utility company that coated a local community in 2006. Because of the potential impact of the pollution on public health, local farmers were told that livestock should not graze in their fields and families were told not to eat fruits and vegetables from their own gardens.

In 2008, USA Today ran a series on toxic air pollution near our Nation's schools. I remember, it was the first time I really met formally with Lisa Jackson here, as she was coming up for her confirmation hearing. I asked EPA to help monitor for such threats, and she said she pledged she would do so. And now the agency is focused on addressing sources of toxic air pollution near schools. We all know that children are much more sensitive to these dangerous pollutants than adults, given their size.

The EPA is also helping my constituents in Mecca, California. Yes, there is a Mecca, California. There is a horrible odor emanating from a soil recycling plant. It made people very sick. And Senator Inhofe, as you know, sometimes we see these issues in the local press, well, I saw it in the local press and I looked at it. Everyone was just shrugging their shoulders, what was it? What was causing it? These kids were dizzy, they were practically fainting. Teachers were being hospitalized. It was just a nightmare.

And the kids were told they couldn't go out and play. And you tell a little child they can't go out and play, it is a prison sentence.

So we got EPA activated, they got involved with the State, with the local people. And now they have identified the source of the pollution. The point I am making is, we need to enforce this law. Under the Clean Air Act, EPA is required to strengthen protections if the science indicates that pollution adversely impacts public health, again, including children's health. And recently, EPA proposed much-needed Federal safeguards to reduce toxic air pollution from old power plants, by requiring the use of modern pollution controls. These proposed safeguards would reduce mercury, lead, chromium, which are known to cause cancer and birth defects.

The point is, this is the Clean Air Act at work. And Administrator Jackson has to do her job. Unless we repeal the Clean Air Act or portions thereto, which there are some attempts to do, which have failed, Lisa Jackson has to do her job, or there will be lawsuits and she will have to defend why she is doing nothing. So I hope colleagues will understand that this is her responsibility.

When EPA reduces toxic air pollution, it helps families and children. EPA recently conducted a congressionally required peer-reviewed analysis of the Clean Air Act showing overwhelming health benefits now and into the future. The annual benefits by 2020, and

I will show you this, it is a little small printing, but I think colleagues can read it, will include preventing more than 230,000 premature deaths, 200,000 cases of heart attacks, 2.4 million cases of asthma attacks, 120,000 emergency room visits and 5.4 million lost days at school.

So in contrast to the unsupported claims by some polluters who argue health threats from mercury are exaggerated and other air pollutants are exaggerated, we will hear today from Administrator Jackson and representatives of the American Academy of Pediatrics, the nurses, the Thoracic Society, who are experts on this issue . And these witnesses will describe the critical steps that have been taken to reduce dangerous air pollution.

Again, before I turn to the Ranking Member, to whom I will give an extra 2 minutes, I want to thank you personally for your involvement in this Mecca situation. Because I went there, and we had a meeting. Everyone was around the table. It was so uplifting for the community. It is a poor community. And they really feel that their voices have been heard. I know we won't stop until we get this all resolved. I wanted to thank you.

Now I will turn to my colleague, and I will give you 7 minutes.

**OPENING STATEMENT OF HON. JAMES M. INHOFE, U.S. SENATOR FROM THE STATE OF OKLAHOMA**

Senator INHOFE. Thank you, Madam Chair. I think a lot of people don't realize that what you said about the merits and successes of the Clean Air Act, I have said many times, and I agree. In fact, one of the things I was going to talk about today, both the EIA and the EPA data indicates that since 1970, coal use has increased by over 200 percent while SOX and NOX emissions have dropped by 65 and 85 percent, respectively. It is a success story.

This is the first time that we have had Administrator Jackson here to discuss the Environmental Protection Agency's air quality regulations, so I am very glad you are here and look forward to this hearing.

I would also like to thank the witnesses on our second panel, Cathy Woollums. It will be nice to hear how the regulations are affecting the ratepayers. And Dr. Brenner, I think reference was made to you last week by Margo Thorning. You have a real interesting testimony. So we can be learning more about how energy price increases and unemployment affect public health. There is a relationship there that nobody every talks about. So I look forward to that.

There is always the propensity of people who want to over-regulate our lives to try to use such things as health and deaths and all that. But we don't hear the other side of it. So we will hear some of it today.

Over the past 2 years, the Obama EPA has moved forward in an unprecedented number of rules that will have enormous consequences on families and businesses and the Nation's fiscal well-being. Take for example the EPA's new greenhouse gas cap and trade regulations. I appreciated your honesty, Administrator Jackson, gosh, it has been months ago, I guess, when I was saying, if we were to do something like that, either through regulations or through any of the legislation, like the Markey Bill and some of the

rest of them, would that decrease concentrations. And of course, you had stated it would not have an impact on greenhouse gas concentrations, obviously, since we are looking at where the problem is is not the United States, but it is countries like China and like India and elsewhere.

I would take it one step further, and I have several times, these were not your words, but they were mine, that it could have just the opposite effect. Because as we lose our jobs, as hey are out seeking power and energy, they have to go to places where the regulations are not nearly as stringent as ours, it could have an increased effect.

The agency's voluntary reconsideration of the National Ambient Air Quality Standards for ground level ozone, a decision based on outdated data, could lead to significant economic constrains in the Country. It is another agency action of dubious merit. EPA projects costs of this rule to be somewhere around $90 billion. Meanwhile, the agency is planning to tighten the standards again in just 2 years.

The Obama EPA is aggressively moving forward to regulate nearly all aspects of American life. It is now regulating, has regulations to cover dust on farms, in puddles of water along the side of the road, and it is businesses and working families who have to pay for all this.

Today we have a witness from the electric power industry with us. So let's focus on the regulations affecting her business for a minute. Just last week, in response to EPA's rules, American Electric Power announced that they would be forced to close nearly 6,000 megawatts of low cost coal-powered energy. Now, when you do the math on that, that works out to about 12 plants.

As a consequence, the AEP, that is American Electric Power, estimates nearly 600 power plant workers will lose their jobs, totaling nearly $40 million in annual wages. These are good-paying jobs in rural areas in Virginia, West Virginia, Ohio, Indiana, and Texas. They won't be easily replaced.

Of course, the effects to the communities will be far greater than these direct job losses alone, as electricity prices increase in nearby businesses suffer in the wake of plant closures. A recent report by the National Economic Research Association anticipates this will be replicated across the Country, with an estimated 48 gigawatts in plant closures. This is just from two of the EPA rules. That is the AEP tragedy eight times over.

Before this analysis is criticized, let me say that it is consistent with multiple projections, including that of the Obama Department of Energy, which estimates that plant closures could be as high as 70 gigawatts. NERA, that is the National Economic Recovery Associates, goes on to predict that these two rules, Utility MACT and the Transport Rule, will cause electricity prices to increase by as much as 23 percent. And by 2020, 1.4 million jobs could be lost. Now, that comes from the Obama administration, not from some other association.

As I said in last week's hearing, we all have an interest in dealing with real pollution concerns and protecting public health. We also know that President Obama has a cap and trade agenda that is specifically designed to raise the prices of energy by forcing coal

and oil out of the market. That is coal, oil and gas. He couldn't get it passed through the Senate, so now he is trying to do it with the EPA doing it for him.

It is kind of interesting that everyone up here on this panel is always talking about great all this stuff is, and global warming is coming, we have to do cap and trade. And yet there probably are not, at the very most, 30 votes in the U.S. Senate that would support that when it comes down to a vote. So it makes for good conversation, but the votes aren't there. It is something that no more than one-third of this Senate would vote for.

Today, the Clean Air Act is being implemented in a way that bears no resemblance to what Congress intended. I have already said that I was a great supporter of the successes of the Clean Air Act in the past. Congress didn't give the EPA the authority to set mandates that can't be achieved. Congress didn't give the EPA authority to pursue an agenda that hurts the very people that it is supposed to be trying to protect. And we all know that Congress didn't give the EPA authority to regulate greenhouse gases. But here we are.

So we hear a lot about the Clean Air Act these days, and I will be the first to admit that industry and States have done a great job of cleaning up air over the past 40 years. But the Clean Air Act is in dire need of modernization. It needs to be updated to undo years of bureaucratic over-reach and messy court rulings, updated to meet the pollution challenges of today, and yes, updated to stop politicians from using it to pursue a reckless political agenda.

I have to say to our first witness, Lisa Jackson, it is nice to have you back. I always really sincerely appreciate the fact that you do give direct answers, even when it is not popular to give them. So I thank you very much for being here.

And also, I heard from one of the green publications yesterday, I was doing an interview. They had gone to your office and said you still have a beautiful picture hanging on your wall. I was glad to hear that.

[The prepared statement of Senator Inhofe follows:]

STATEMENT OF HON. JAMES M. INHOFE, U.S. SENATOR
FROM THE STATE OF OKLAHOMA

Madam Chairwoman, I appreciate your having today's hearing. This is the first time this session we've had Administrator Jackson here to discuss the Environmental Protection Agency's (EPA) air quality regulations. I'm glad you're here. I'd also like to thank the witnesses on our second panel. Cathy Woollums, I'm anxious to hear how EPA's regulations are affecting your rate payers. Dr. Brenner, I look forward to learning more about how energy price increases and unemployment affect public health. I think your testimony will be particularly insightful in light of the sweeping job losses we expect from EPA's rules.

Over the past 2 years, the Obama EPA has moved forward with an unprecedented number of rules that will have enormous consequences for families, businesses, and the nation's fiscal well-being. Take for example, EPA's new greenhouse gas (GHG) cap and trade regulations. Administrator Jackson, you have admitted that regulating GHGs in the U.S. will have no impact on global GHG concentrations, yet your rules will come at an estimated cost of $300 to $400 billion annually. The Agency's voluntary reconsideration of the national ambient air quality standards for ground-level ozone—a decision based on outdated data that could lead to significant economic constraints on the country—is an another Agency action of dubious merit. EPA projects the cost of this rule in the order of $90 billion. Meanwhile, the Agency is planning to tighten the standards again in just 2 years.

The Obama EPA is aggressively moving forward to regulate nearly all aspects of American life—it now has regulations covering dust on farms and puddles of water along the side of road. And it is businesses and working families who will pay the price.

Today we have a witness from the electric power industry with us, so let's focus on the regulations affecting her business for a minute. Just last week, in response to EPA's rules, American Electric Power (AEP) announced they would be forced to close nearly 6,000 Megawatts of low cost (coal) power generation. As a consequence, AEP estimates nearly 600 power plant workers will lose their jobs, totaling nearly $40 million in annual wages. These are good paying jobs in rural areas of Virginia, West Virginia, Kentucky, Ohio, Indiana and Texas. These jobs won't easily be replaced.

Of course, the effects to the communities will be far greater than these direct job losses alone, as electricity prices increase and nearby businesses suffer in the wake of plant closures. A recent report by National Economic Research Associates (NERA) anticipates this will be replicated across the country, with an estimated 48 Gigawatts in plant closures. And this is from just two of EPA's rules. That's the AEP tragedy eight times over. And before this analysis is criticized, let me say that it is consistent with multiple projections, including that of Obama's Department of Energy, which estimates that plant closures could be as high as 70 Gigawatts. NERA goes on to predict that these two rules—the "Utility MACT" and the "Transport Rule"—will cause electricity prices to increase by as much as 23 percent. By 2020, 1.4 million jobs could be lost.

As I said at last week's hearing, we all have an interest in dealing with real pollution concerns and protecting public health. But we also know that President Obama has a cap and trade agenda that's specifically designed to raise energy prices by forcing coal and oil out of the market. He couldn't get it passed the Senate, so now he has the EPA doing it for him. This is something that no more than one-third of the U.S. Senate would vote for.

Today, the Clean Air Act is being implemented in a way that bears no resemblance to what Congress intended. Congress didn't give EPA the authority to set mandates that can't be achieved. Congress didn't give EPA the authority to pursue an agenda that hurts the very people it's supposedly trying to protect. And we all know that Congress didn't give EPA the authority to regulate greenhouse gasses. But here we are.

We hear a lot about the Clean Air Act these days. And I'll be the first to admit that industry and states have done a great job of cleaning up the air over the past 40 years. But the Clean Air Act is in dire need of modernization. It needs to be updated to undo years of bureaucratic overreach and messy court rulings; updated to meet the pollution challenges of today. And yes, updated to stop politicians from using it to pursue a reckless political agenda that hurts working families.

Senator BOXER. Thank you so much to my Ranking Member.

I would say in the order of arrival, on our side, Whitehouse, Merkley, Lautenberg, and Alexander on the Republican side.

## OPENING STATEMENT OF HON. SHELDON WHITEHOUSE, U.S. SENATOR FROM THE STATE OF RHODE ISLAND

Senator WHITEHOUSE. Thank you, Madam Chair. I would respectfully differ with our Ranking Member that we don't hear much from the polluting side. I think we hear relentlessly in this building from the polluting side. I think that is one of the reasons that we don't have the votes yet on trying to do something responsible about carbon pollution.

But I would note that although there is a focus, because the polluting side pays the benefits of cleaner air, pays the costs of getting the cleaner air, the value is more widespread, but it is very real. According to the Office of Management and Budget, the total economic benefits of the Clean Air Act are estimated to exceed compliance costs anywhere from four to one to eight to one.

And the health benefits of the Clean Air Act are even larger. The direct health benefits of just the 1990 Clean Air Act amendments, which included the acid rain program and the program to phaseout

chemicals that deplete the ozone layer, exceeded the cost of industry compliance by 30 to 1. The upcoming Clean Air Act rules have similar benefit to cost ratios.

EPA will soon finalize the Transport Rule, very important to Rhode Island, because we get bombarded with pollution from States that we have no control over, creating one of the highest rates of asthma around. Eleven percent of children in Rhode Island have asthma. And the Transport Rule will help reduce that. In doing so, it will serve our economy by avoiding the significant health costs.

The Transport Rule has a predicted benefit to cost ratio of anywhere from 55 to 1 to 145 to 1. What we hear from more than any place else is the one.

EPA is also finally taking steps to control toxic air pollution from power plants. The agency is moving in response to longstanding peer-reviewed, scientific evidence that establishes the health threats of mercury, dioxin, acid gases and other toxic air pollution. The new Toxic Air Standards have a predicted benefit to cost ratio of anywhere from five to one to 13 to one. Again, we hear a lot from the one.

The arguments against, I think, are very often not particularly well-founded. There was a Wall Street Journal op-ed recently entitled The Myth of Killer Mercury. It was written by a consultant of the George C. Marshall Fund, whose role in fixing the science against the public health is chronicled pretty effectively in a book called Merchants of Doubt. I won't go into it any further, but I think General Marshall is probably horrified that his name has been associated with this fund.

The other author is a senior fellow at an Exxon-funded think tank and a former principal of an energy public relations firm. Up against that, you have the fact that every single one of our 50 States has put out mercury advisories, warning pregnant women and children not to eat certain kinds of fish for fear of causing permanent neurological damage. Every one of our 50 States has that out.

With respect to the AEP shut-downs, I take a bit of an interest in that, because years ago as attorney general of Rhode Island, I participated in a lawsuit that has provoked a lot of these shutdowns for the very health reasons that I have just described. Rhode Island was getting bombarded. Just the other day, when we were here a week ago, it was a bad air day in Rhode Island. Nothing we could do about it. Pollution from Midwestern power plants turns into ozone, and we get notices in drive time radio in Rhode Island saying, if you have infants, elderly, people with respiratory conditions should stay inside today, because the air is not safe to breathe. That is a cost when you have to stay inside because the air is not safe to breathe because of a downwind power plant.

Forty-five hundred out of the 5,500 megawatts that are being taken offline are being taken offline because of that lawsuit. Not because of what it threatened, but because of what they did and the fact that it was wrong and the fact that they settled that case. And in that case, just by the way, on this question of cost benefit, the cleanup costs for AEP and for the defendants involved were $4.6 billion, and the savings in health and other benefits on the

other side were estimated to be $30 billion, not once, but annually thereafter. Four point six billion dollar investment to save $30 billion in health and other costs annually thereafter. I think that is pretty good business for the United States of America to be involved in.

And I thank the Chairman for the hearing and the Administrator for her hard work.

Senator BOXER. Thank you so much, Senator Whitehouse.

Senator Alexander.

**OPENING STATEMENT OF HON. LAMAR ALEXANDER, U.S. SENATOR FROM THE STATE OF TENNESSEE**

Senator ALEXANDER. Thank you, Madam Chairman. Administrator Jackson, welcome. Good to see you.

When the Nissan plant was thinking about locating in the United States 30 years ago, it thought of Tennessee. And the first thing the officials did was to go down to the State air quality board and get an air quality permit for their paint plant. Because the air was clean enough for them to get it, Nissan located there. And today, a State that had almost no auto jobs has about a third of its manufacturing jobs in the auto business. In other words, clean air for us means good jobs.

Across the State of Tennessee, we have a lot of county officials who are struggling to meet the National Ambient Air Standards. They would like to get the next Volkswagen supplier. They want to be able to get their air quality permits. And they won't be able to get it unless we have a strong national Clean Air law, which is why I have joined with Senator Carper for the last 6 years in introducing a law that regulated sulfur, nitrogen and mercury, and saying while we argue about carbon, let's go ahead and do the other three and do it right.

I am also interested in the health effects, which have been talked about. And I am also interested, because we like to see the Great Smoky Mountains, and visitors don't come there to see the smog, they come to see the blue haze that the Cherokees sang about. And it is the most polluted national park in America, because dirty air blows in from all over the Country, not just from TVA.

That is why I support the Tennessee Valley Authority's recent decision on coal, to either close its coal plants or put pollution control equipment on all of its plants by 2020. That is the right thing to do. It will make it easier for us to attract auto jobs. It will help our health and it will attract tourism jobs and give us a chance to see the mountains.

It also means we will be able to use coal. Thirty-five percent of our electricity will be made by coal, more or less, by the year 2020. And if we can figure out a way to deal with carbon from coal plants, more of it will be from coal.

So there are some things I like about the EPA's rules, and there are some things I don't like. The Clean Air Transport Rule is very much like the law that I wish we had passed in the last Congress on SOX and on NOX. It doesn't have enough flexibility, as much as we did. I think you still have authority to grant more flexibility in dealing with sulfur and nitrogen. And I hope you consider that. I will be asking about that during my question time.

As far as mercury and the other pollutants, I believe coal plants should get rid of mercury up to 90 percent. The technology is there to do it. Mercury is dangerous. It comes down near the coal plants, shouldn't be traded, I agree with all of that. But I want to make sure that when we lump all the other pollutants with mercury, I think it suddenly runs the cost up and takes it into an unrealistic range. So my question would be, wouldn't it be better if we gave you the authority only to deal with mercury, which is what Senator Carper's bill and I did.

Finally, on the Boiler MACT provision, I think that rule belongs on another planet somewhere. It is completely unrealistic. It is not based on real world achievability. It may be the most expensive such rule ever proposed. And I don't believe it can be fixed by the Environmental Protection Agency without some congressional action. The EPA admitted, when it petitioned the court 15 months ago, that it was having a hard time with it. You have been forced to come up with a rule faster than you should. So today, I am going to be asking two questions of the Administrator. And if I have time to do it in my question time, I will do it then. And if not, I would appreciate very much a written response to the questions.

One would be, do you have the legal authority to make the necessary changes to the solid waste portion of the rules affecting industrial boilers? That is my first question. My second question would be, do you have the time to fix the rule considering the fact that courts have already forced you to move faster than EPA originally wanted and your administrative stay is already being challenged by a new lawsuit?

And when the time comes, I will ask a third question about your mercury rule. Wouldn't it be better if we gave you the authority only to deal with mercury, as Senator Carper and I proposed in our bill, rather than lump mercury in with other pollutants, which will cause utilities to have to spend too much money to deal with those pollutants. Having low-cost electricity is an important part of making it easier and cheaper to create good new jobs in this Country.

I believe we can do that with rules on sulfur and nitrogen and mercury over a reasonable period of time. But the Boiler MACT and the other pollutants send the cost into the stratosphere.

Thank you very much, Madam Chairman.

Senator BOXER. Thank you, Senator. And hopefully you can stay for questions. But I will make sure, and I know that Administrator Jackson will make sure to answer you in writing, if you can't stay in time to get all those questions.

Senator ALEXANDER. Thank you very much.

Senator BOXER. Senator Merkley.

## OPENING STATEMENT OF HON. JEFF MERKLEY, U.S. SENATOR FROM THE STATE OF OREGON

Senator MERKLEY. Thank you, Madam Chairman. Welcome, Administrator Jackson.

I had a recent experience that reminded me of how important clean air is, in that the Senate had a bipartisan delegation to China. And everywhere we went, we were told it was the best air day they had had in the year, or possibly the previous 2 years. And we couldn't see buildings 100 yards away. We were told by the em-

bassy personnel that they were thinking that they should keep family members no more than 2 years in China because of the moral implications of exposure to family members in regard to health. We heard about the China cough syndrome, and heard it as well, and so on and so forth.

It took me back to when, in my earlier days in Oregon, we used to have bad air quality days much more routinely. Nothing like L.A., we were happy to acknowledge, but certainly still were affected. And so when I look at how the Nation's health, and really its whole quality of life has been impacted by the Clean Air Act, it is a tremendous success. The statistics on 2010 alone, preventing 160,000 cases of premature mortality, reducing heart attacks by more than 100,000, reducing lost work days by 13 million, reducing asthma attacks by nearly 2 million in a single year, and those projections continue.

So I know it is often popular to attack the Clean Air Act on the basis that it will cripple our economy, cripple our industry or bring down our businesses. But the fact is that that has never been the case. It has always been the argument and it has never been the case. And indeed, there are costs of compliance, but those costs are outweighed by about a 30 to 1 factor in terms of reduction in health care expenses. And behind those health care expenses is not just an issue of the wallet, it is an issue of our daily quality of life.

So I look forward to your testimony as we work to sustain and improve our air quality in America.

Senator BOXER. Thank you, Senator.

Senator LAUTENBERG.

## OPENING STATEMENT OF HON. FRANK LAUTENBERG, U.S. SENATOR FROM THE STATE OF NEW JERSEY

Senator LAUTENBERG. Thanks, Madam Chairman. Welcome, Administrator Jackson.

I always feel that the air is made lighter when I see you and know what you are doing for us. I congratulate you and urge you, don't quit. That is what you have to do. Continue to enforce the rules. Continue to care about what the net gain is for America. Because costs are discussed here as if that is the ultimate goal.

But we know darned well, that is not the goal. That is not the goal of those of us who think that we ought to be investing and protecting the health and well-being of our kids at stages of life when clean air is so important, living in a country where Code Orange days say, children, the elderly, stay indoors. Stay indoors? Is that what we want to tell our children? I don't think so.

I don't want to surprise people here, but I am a senior citizen. And I am told, get out here, no matter what the weather is. But that is a political thing.

[Laughter.]

Senator LAUTENBERG. Anyway, this year we have also experienced Code Red, where even healthy adults are advised to limit their outdoor activity. The alarm is ringing and those on the other side just don't see the urgency. They are good people and I know they care about their children and their families. But their priority would result in protecting the polluting companies that are causing

the problems. Not long ago that kind of thinking was the exception, not the rule.

In 1990, both parties came together to strengthen the Clean Air Act, protect our Country from dangerous air toxics. But the big polluters put their lawyers and lobbyists to work, spent millions of dollars to prevent EPA from implementing the law, setting rules that cleaned up the largest sources of deadly emissions. The Obama administration is trying to fix this, by putting limits on the largest sources of air toxics. But the other side attacks these new rules as too costly. How costly is it when life is at risk? We have to be clear. These rules now are more than a decade overdue. While industry and their allies in Congress keep stalling, Americans are paying a price that in many ways is irrecoverable.

We know that dirty air causes asthma attacks, heart attacks, strokes, cancer. And on a personal side, my oldest grandchild, who is only 17, has asthma. And my daughter, when he goes out to play sports, first checks to see where the nearest emergency clinic is, so that if he starts to wheeze, she gets him there in a hurry.

So when we look at things as dreadful and deadly as mercury, essentially brain poison for children, can damage a child's kidneys, liver, nervous system and permanently a lower a child's i.q., what is the cost? What is the cost there? In emotional and human terms, the cost is inconceivable that it would continue to be, that people would continue to be exposed there, as opposed to reducing health care costs and seeing children happy and able to go outside and do what kids normally do.

So Madam Chairman, I ask unanimous that my full statement be included in the record. And I commend you for your pursuit of better health for our families, our children, and we all have to keep that in mind. I want to say this to my colleagues on the other side. I know that you are concerned about the health and well-being of children. But I would ask, if you could only at least consider that the primary cost of what we are trying to do is not the dollars involved, but rather the results that we can get if we implement the rule as they are.

Thank you very much, Madam Chair.

Senator BOXER. Thank you so much.

Senator BARRASSO.

## OPENING STATEMENT OF HON. JOHN BARRASSO, U.S. SENATOR FROM THE STATE OF WYOMING

Senator BARRASSO. Thank you very much, Madam Chair.

For 2 years, Madam Chairman, this Administration has had an economic policy that has not rescued our economy and has not created jobs. In fact, this Administration's policies have done just the opposite. They have made it worse.

I believe in fostering economic growth through innovation, low taxes and less regulation. This will spur the private sector to create the jobs al across this great Country. This Administration has been picking winners and losers. It is attempting to create a green economy where you regulate one sector of the economy out of business and subsidize the other sectors to clean up the mess with taxpayer money.

For the last 2 years, this Administration and this EPA have pursued their green wins while red, white and blue energy loses. That is the economic policy that they have been pursuing, and the result is 9.1 percent unemployment.

Lisa Jackson, who is before us today, was quoted as saying recently that "We want to make environmental protection and environmental technology a central piece of our effort to win the future." Along with some very difficult spending cuts, she says the President is calling for investments in our schools and our teachers, our innovators and small businesses, and the infrastructure that keeps our economy running. She calls this essential ingredients to a robust green economy.

Where can we look, Madam Chairman, to see where these green economy policies have been in effect? Well, in September 2009, at the Second Annual Governors Global Climate Summit, Jackson stated "California has been out front on energy efficiency, greenhouse gas reduction, transportation innovation and so much more." She goes on to say "In many ways the Country is once again catching up with what is happening here." She is referring to California.

Two years since that statement, 2 years since that statement was made, the unemployment rate in California is 11.9 percent, well above the national average. If that is how an only green economy works, the 9.1 percent of the Country looking for jobs aren't interested. Even green American businesses that are receiving Government support are finding it hard to compete. As President Obama touted the success of LED light bulb manufacturers in North Carolina, he failed to mention that one of the companies he toured was having significant financial difficulty, and their stock value was cut in half over the last year. This was despite the company receiving a $39 million tax credit through the Obama so-called stimulus law.

Explaining this phenomenon was Jeffrey Bencik, a green technology analyst for the New York investment banking firm, who stated that U.S. makers of LED products, energy-efficient light emitting diodes, will have a hard time competing unless anyone can get their costs down to compete with the Chinese companies. Wishful thinking and the political ideology of this Administration and this EPA simply fail to account for the economic realities of the global marketplace.

This Administration's steadfast vocal support of green energy initiatives and a green economy doesn't make American companies more innovative at home or more competitive abroad. At some point, I would like to see this Administration's policy dreams of tomorrow actually acknowledge the economic reality of today. The economic reality is millions of Americans still unemployed, looking for work to provide for their families. Many families with children are sliding into poverty as the bills pile up.

This Administration can't continue to pick the winners and losers in America's energy debate. We need it all, green, red, white and blue energy jobs I believe our job is to make sure that things don't get any worse and create an economic environment where things can actually get better.

During the testimony of Dr. Margaret Thorning during last week's Clean Energy Subcommittee hearing, she quoted Professor Brenner of Johns Hopkins University, who is scheduled to testify

today, whose research showed that economic growth leads to actually the lowering of mortality rates, including child mortality. In addition, according to the National Center for Health Statistics, American children in poverty are 3.6 times more likely than non-poor children to have poor health and five times more likely to die from an infectious disease.

That is the concern I have regarding the economy, Madam Chairman. It is our responsibility to make America's air as clean as we can as fast as we can. And let us do it in a way that doesn't hurt American families during this economic crisis. Costly job-crushing regulations, heavy tax burdens, and investment in non-competitive industries does not foster economic growth, does not create jobs, does not promote commerce and does not make the public healthier.

Thank you, Madam Chairman, and I look forward to the testimony.

Senator BOXER. I am sure you do.

Senator VITTER.

## OPENING STATEMENT OF HON. DAVID VITTER, U.S. SENATOR FROM THE STATE OF LOUISIANA

Senator VITTER. Thank you, Madam Chairman, for this hearing. I will submit my full statement for the record, but I did want to make a few comments.

Certainly this hearing is timely, in my opinion, particularly since over the last 6 months or so EPA, I believe, has lost enormous credibility in terms of the core fundamental issue of the soundness of its science and its scientific reviews. We have seen this in a number of instances, I have been particularly involved in one where I was pushing for an independent review and study by the National Academy of Sciences. We finally got that, and quite frankly, it confirmed my concerns about the validity and soundness of the science work going on for EPA.

I think that is a very important backdrop to all of these discussions. And I agree with the call for everything to be based on sound science. I think we have a lot of work to do to ensure that that is happening under this Administration.

So I will submit the rest of my comments for the record. But that is the fundamental backdrop and concern I have. Thank you.

[The prepared statement of Senator Vitter follows:]

STATEMENT OF HON. DAVID VITTER, U.S. SENATOR FROM THE STATE OF LOUISIANA

Thank you Chairman Boxer and Ranking Member Inhofe for holding this hearing today on EPA regulation under the Clean Air Act and public health.

If anything this hearing is timely. Over the last sixth months or so EPA has lost credibility as an agency capable of handling scientific reviews in an unbiased manner. EPA has lost credibility as an agency capable of doing comprehensive economic analysis on the impacts of the suite of new regulations it wants to impose on American businesses. EPA has also lost credibility with the courts as an agency capable of operating within its statutory authority. All of which has led to the EPA being apply nicknamed the "Employment Prevention Agency."

For the several years leading to 2011 this committee was holding regular hearings on why we needed Cap and Trade to create jobs and spur economic growth. As those arguments collapsed under further scrutiny we were told Cap and Trade was needed to protect public health. Fortunately, republicans saw through the disingenuous arguments and were able to thwart that legislative effort. Had we not prevented Cap

and Trade from becoming law it clearly would have exacerbated the 9 percent unemployment rate we see today as well as the soaring energy prices American consumers and businesses are suffering through this summer.

Unfortunately, the Obama administration and the EPA see a litany of new regulations as a consolation prize to Cap and Trade, and are aggressively hoping to implement what is both scientifically dubious and economically unsound.

The National Academies reported about a month ago on the scientific review process being done at EPA at both Administrator Jackson's and my request. Administrator Jackson and I negotiated aggressively to have that work done by the NAS. Their findings in April confirmed what many intuitively knew. The report confirmed that EPA has very serious and chronic flaws in scientific work being conducted, and in particular the methodologies and lack of weighting scientific evidence, which in turn leads to routinely biased conclusions.

Additionally, EPA seems bent on ignoring the economic realities of today and routinely fails to produce even semi-respectable economic analysis on the impacts of the Agency's decisions. As well, EPA routinely ignores requirements under section 321(a) of the Clean Air Act. We see this in particular in EPA's ongoing saga in regulating commercial, institutional and industrial boilers. In fact, EPA's economic analysis was so bad that the Department of Commerce had to get involved with their own analysis, which reportedly showed far worse an impact than EPA had concluded. EPA officials have since been forced to acknowledge their failure to "calculate standards that fully reflected operational reality."

Confounding these problems EPA has aggressively taken steps to exceed its statutory authority. Just last month Judge Richard Leon of the Federal district court for the District of Columbia found that EPA's use of the Environmental Appeals Board to extend review periods for permits under the Clean Air Act was in contradiction to clear statutory authority. Quite similar to the Interior Department, EPA has a permitting problem. And unfortunately for the American worker and businesses, the permits these agencies are mismanaging are the permits companies need to create jobs. In the words of Judge Leon "how absurd."

In opposition to a free market economy crony capitalism has been given new life in the Obama administration. It's become this simple: If you are not a favored industry you are going to have trouble getting your permits. If you are a favored industry and endorse the Administration's agenda you will not only be more likely to get your permits, but you may even get Federal financing and there is a good chance you will be appointed as an economic advisor to the President. Jeff Immelt and John Bryson can attest to this fact.

Finally, there exist two very serious public health problems ongoing in the U.S. today. They are unemployment and poverty, both of which are being exacerbated by a dysfunctional Environmental Protection Agency. Unfortunately, the prescription this administration is prescribing is a combination of crony capitalism, agency overreach, biased science, poor economic analysis and selective permitting. That is not an elixir that will cure what ails our economy. And the unemployment perpetuated by this strategy will continue to be the single greatest public health issue facing the United States.

Senator BOXER. Thanks. I am just going to address a couple of comments.

Senator Barrasso's comments, and it will go off my time, don't worry about it, Senator Barrasso's comments lead me to believe he lives in an alternate universe. Red, white and blue, he says, about the energy supports, like oil that we import from countries who want to do us in. Really, that is not red, white and blue. It is the opposite. We have to get off of that. And harness the energies here in our Country and do it in a smart way, which, I think with the Clean Air Act help, we have shown we can do it.

Senator Inhofe proved that when he talked about how we have had an expansion, for example, in coal. But because of the Clean Air Act and its work, we have managed not to lose control of the quality of the air.

Then, and this is supposed to be a hearing on the Clean Air Act, he attacks the President on job creation. Again, an alternate universe. When President Obama took the oath of office, we were bleeding 800,000 jobs a month. The auto industry was on the brink.

So let's talk about the facts. Let's not get so emotional about our political wishes for the next election that we lose site of what we are doing.

Senator INHOFE. OK, let me respond also.

Senator BOXER. You can respond on your time, just like I have responded.

Senator INHOFE. Well, let me go ahead and respond to this, because I think——

Senator BOXER. No. No. You are out of order.

Senator INHOFE. We are not going to have enough time as it is.

Senator BOXER. You are out of order. I am going to get to my questions.

Senator INHOFE. With 9.1 percent unemployment, that is not what I call successful.

Senator BOXER. When somebody stands here in this Committee and attacks the President of the United States for not doing enough on jobs when he took over and there was a bleeding loss of 800,000 a month, I am going to respond. Now there is free speech around here, and everybody has it, everybody can say what you want. But that doesn't mean it isn't responded to, and my friend can respond to me in his time.

Senator INHOFE. In all respect, Madam Chairman——

Senator BOXER. You can respond to me on your time. The Committee will come to order. I will add time to your opportunity to respond to me.

Now, another myth around here is that greenhouse gas emissions are not covered in the Clean Air ct. It was repeated by my friend, the Ranking Member. I would tell him to look at te Supreme Court decision, which says because—this was a decision that was made when the Bush administration said exactly what my friend said, greenhouse gas emissions are not included in the Clean Air Act. This is what the Supreme Court said. "Because greenhouse gases fit well within the Clean Air Act's capacious definition of air pollutant, we hold that EPA has the statutory authority to regulate the emissions of such gases."

So let's not make things up. Let's deal with it. Now, people didn't like it, on the other side of the aisle. That was this Supreme Court in a five-four ruling.

So the other thing my colleague said, and this is my question to you, Administrator Jackson, my friend said, my friend Senator Inhofe said that the Clean Air Act is being implemented "in a way Congress never intended." And I don't, he was not that specific about it. Could you respond to that charge? Are you doing anything that is out of the ordinary in terms of implementing this? Or are you following what the law says?

Ms. JACKSON. To the contrary, all of our rules are authorized by the Clean Air Act. The mercury standards are authorized by the Toxics Rules, Chairman, and the standards for soot, the standards for smog, the standards that are designed to fight asthma, bronchitis, heart disease and premature deaths are all specifically called out in the Clean Air Act.

Senator BOXER. OK. I just realized that you didn't give your testimony. My friend was right.

So what I will do is, at this point I will stop and turn it over to Senator Inhofe for 5 minutes to respond to me, and then we will get to you. I apologize.

Senator INHOFE. Oh, all right. Well, I will make it short.

First of all, because of the length of this thing and I see the participation that will be here, I will have to leave a little bit before 12 o'clock. So I am really concerned about the second panel.

I would just say this. When our friend, Senator Barrasso, talked about the red, white and blue and about all of the above, it is so frustrating when we sit here and we look at the CRA that came out less than a year ago and it documented that we have the largest recoverable reserves in coal, oil and gas in the United States of America, and we could be completely weaned off of all Middle Eastern oil, if we would only develop our own resources. It is so ridiculous to even suggest that somehow if we restrict our recovery of coal, oil and gas, that somehow, somewhere down the road, that is going to reduce our reliance on the Middle East.

Just the opposite is true. I go back to Oklahoma and I talk to people and they say, how can they possibly come up with that? I say, well, only in Washington will they do that.

So I would say that we have those resources. We are going to be able to supply the energy for this Country. I think during the question and answer time, we will be able to pursue this whole idea of what we are talking about in terms of the health situation. We have an excellent witness on the second panel, I just wish I could be here for that.

The last thing I would say, yes, you are right in terms of what you read in terms of the court decision, the five-four decision. It says, you have the authority if you want to do it, it does not mandate that you do it. I think you all understand.

Thank you, Madam Chairman.

Senator BOXER. Well, I promise I am not going to rebut you on this, but I will do it later.

[Laughter.]

Senator BOXER. I am very pleased to call on Hon. Lisa Jackson for her time to talk to us. And bring us all together.

**STATEMENT OF HON. LISA P. JACKSON, ADMINISTRATOR, UNITED STATES ENVIRONMENTAL PROTECTION AGENCY**

Ms. JACKSON. Thank you, Madam Chairman. That is a big order. It is good to see you and the Ranking Member and the other members of this Committee. Thank you for inviting me to testify about EPA's ongoing efforts to protect our health by reducing the air pollution that affects millions of Americans.

I know this subject very personally, because my son is one of the more than 25 million Americans battling asthma. Let me begin my testimony with a matter of fact. Pollution, pollution like mercury and particulate matter shortens and reduces the quality of Americans' lives, and puts at risk the health and the development of future generations.

We know mercury is a toxin, a toxin that causes neurological damage to adults, children and developing fetuses. We know mercury causes neurological damage, including lost i.q. points in children. And we know particulate matter can lead to respiratory dis-

ease, decreased lung function and even premature death. These pollutants and others, including arsenic, chromium and acid gases, come from power plants. These are simple facts that should not be up for debate.

However, Madam Chairman, while Americans across the Country suffer from this pollution, special interests who are trying to gut longstanding public health protections are now going so far as to claim that these pollutants aren't even harmful. These myths are being perpetrated by some of the same lobbyists who have in the past testified before Congress about the importance of reducing mercury and particulate matter. Now, on behalf of their clients, these lobbyists are saying the exact opposite.

The good news is that to address this pollution problem in 1970, Congress passed the Clean Air Act, which was signed into law by a Republican President and then strengthened in 1990 under another Republican Administration. Last year alone, the Clean Air Act is estimated to have saved 160,000 lives and prevented more than 100,000 hospital visits. Simply put, protecting public health and the environment should not be an historically has not been a partisan issue.

Despite all the distractions, let me assure you that EPA will continue to base all of our public health protections on two key principles: the law and the best science. Allow me to focus on two of our current activities.

On March 16th, after 20 years in the making, EPA proposed the first ever national standards for mercury and other toxic air pollution from power plants. While many power plants already comply, the standards will level the playing field by requiring additional power plants to install widely available proven pollution control technologies. Deployment of these technologies will prevent an estimated 17,000 premature deaths, 11,000 heart attacks, 120,000 cases of childhood asthma symptoms, 11,000 cases of acute bronchitis among children, 12,000 emergency room visits and hospital admissions, 850,000 days of work missed due to illness.

This proposed rule, which is going through a public comment process, is the product of significant outreach to industry and other stakeholders.

As we work at EPA to cut down on mercury and other toxins from power plants, we are also trying to reduce sulfur dioxide and nitrogen oxide through the Clean Air Transport Rule we proposed last year. This rule requires 31 States and the District of Columbia to reduce their emissions of these two pollutants which contribute to ozone and fine particle pollution across State lines, thereby significantly improving air quality in cities across the United States. Utilities can achieve these reductions by investing in widely available technology. Once finalized, this rule will result in more than $120 billion in health benefits each year.

EPA estimates this rule will protect public health by avoiding 14,000 to 36,000 premature deaths, avoiding 21,000 cases of acute bronchitis, avoiding 23,000 non-fatal heart attacks, avoiding 240,000 cases of aggravated asthma, avoiding 440,000 cases of upper and lower respiratory symptoms, avoiding 26,000 hospital and emergency room visits, and 1.9 million days of work or school missed due to illness.

These numbers represent a major improvement in the quality of life for literally millions of people throughout the Country, especially working families, children and older Americans. While some argue that public health protections are too costly, history has repeatedly shown that we can cleanup pollution, create jobs and grow our economy all at the same time. Over the 40 years since the Clean Air Act was passed, the U.S. gross domestic product grew, grew by more than 200 percent. In fact, some economic analysis suggest that the economy is billions of dollars larger today than it would have been without the Act.

Simply put the Clean Air Act saves lives and strengthens the American work force. As a result, the economic value of clean air far exceeds the cost. Expressed on dollar terms, the benefits of the Clean Air Act Amendments of 1990 alone are projected to reach approximately $2 trillion in 2020, with an estimated cost of $65 billion in that same year, a benefit to cost ratio of more than 30 to 1.

With legislation pending in Congress to weaken and gut this proven public health protection law, I urge this Committee to stand up for the hundreds of millions of Americans who are directly or indirectly affected by air pollution. I look forward to your questions.

[The prepared statement of Ms. Jackson follows:]

**TESTIMONY OF LISA P. JACKSON**
**ADMINISTRATOR**
**U.S. ENVIRONMENTAL PROTECTION AGENCY**
**BEFORE THE COMMITTEE ON ENVIRONMENT AND PUBLIC WORKS**
**UNITED STATES SENATE**
**June 15, 2011**

## "The Clean Air Act and Public Health"

Madam Chairman, thank you for inviting me to testify about EPA's ongoing efforts to protect the health of Americans by reducing air pollution. Pollutants such as mercury, arsenic, and particulate matter shorten or reduce the quality of Americans' lives and put at risk the health and development of future generations.

All Americans should be very proud of the significant progress we have made cleaning up our air. However, we still have more to do. For example, about 25 million people now battle asthma. One of those 25 million is my youngest son. I am reminded on a regular basis about the importance of cleaning up our air.

The Clean Air Act is one of the most important tools that the EPA has to protect public health. This landmark legislation was passed in 1970, and signed into law by a Republican President. It was substantially amended in 1990 under another Republican Administration. Simply put, protecting public health and the environment should not be – and historically has not been – a partisan issue.

In the 40 years since its enactment, the Clean Air Act has made steady progress in reducing the threats posed by pollution and allowing us all to breathe easier. Last year alone, the Clean Air Act is estimated to have saved 160,000 lives and prevented more than 100,000 hospital visits.[1]

Some may find it surprising that the Clean Air Act also has been one of our country's best economic investments. In contrast to doomsday predictions, history has shown, again and again, that we can clean up pollution at the same time the economy is growing and jobs are created. Over the 40 years since the Act was passed, the Gross Domestic Product of the United States grew more than 200 percent.[2]

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[1] USEPA (2011). *The Benefits and Costs of the Clean Air Act from 1990 to 2020.* Final Report. Prepared by the USEPA Office of Air and Radiation. February 2011. Table 5-5. This study is the third in a series of studies originally mandated by Congress in the Clean Air Act Amendments of 1990. It received extensive peer review and input from the Advisory Council on Clean Air Compliance Analysis, an independent panel of distinguished economists, scientists and public health experts.

[2] Bureau of Economic Analysis, National Economic Accounts, "Table 1.1.5. Gross Domestic Product," http://bea.gov/national/index.htm#gdp.

The Clean Air Act saves lives and strengthens the American workforce, and, as a result, the economic value of clean air far exceeds the costs. Expressed in dollar terms, the benefits of the Clean Air Act Amendments of 1990 alone are projected to reach approximately $2 trillion in 2020 with an estimated cost of $65 billion in that same year – a benefit to cost ratio of more than 30 to 1.[3]

It is also important not to overlook the jobs that come from building and installing pollution control equipment. For example, the U.S. boilermaker work force grew by approximately 35 percent, or 6,700 boilermakers, between 1999 and 2001 during the installation of controls to comply with EPA's regional nitrogen oxide reduction program.[4] In an Op-Ed in the Wall Street Journal, 8 major utilities that will be affected by our greenhouse gas pollution standards said, "Contrary to claims that EPA's agenda will have negative economic consequences, our companies' experience complying with air quality regulations demonstrates that regulations can yield important economic benefits, including job creation, while maintaining reliability."[5]

The Clean Air Act is a comprehensive statute that encompasses many different programs and parts. Each of these plays an important role in meeting the overall goal of improving public health by reducing air pollution. I will focus my remarks today on two current proposals required by the Act that are of critical importance to that goal.

Mercury and Air Toxics Standards Proposed Rule

On March 16, EPA proposed standards for mercury and other toxic air pollution from power plants. Although it has been many years since Congress enacted the requirement for standards to reduce power plants' toxic air emissions, when finalized, these standards would be the first-ever national standards for reducing toxic air pollutant emissions from power plants. While many power plants already meet these standards, the standards will require additional power plants to install widely available, proven pollution control technologies.

In 2016, deployment of these technologies will have the co-benefit of reducing particulate matter and ozone exposures which are estimated to prevent:

- **17,000 premature deaths**
- **11,000 heart attacks**

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[3] Dale W. Jorgenson Associates (2002a). *An Economic Analysis of the Benefits and Costs of the Clean Air Act 1970-1990. Revised Report of Results and Findings.* Prepared for EPA.

[4] International Brotherhood of Boilermakers, *Boilermaker Labor Analysis and Installation Timing,* March 2005, EPA Docket OAR-2003-0053 (docket of the Clean Air Interstate Rule).

[5] Peter Darbee, chairman, president and CEO,PG&E Corp.; Jack Fusco, president and CEO, Calpine Corp.; Lewis Hay, chairman and CEO, NextEra Energy, Inc.; Ralph Izzo, chairman, president and CEO, Public Service Enterprise Group, Inc.; Thomas King, president, National Grid USA,; John Rowe, chairman and CEO, Exelon Corp.; Mayo Shattuck, chairman, president and CEO, Constellation Energy Group; Larry Weis, general manager, Austin Energy , "We're OK With the EPA's New Air-Quality Regulations," Letter to the Editor, Wall Street Journal, December, 8, 2010.

- **120,000 cases of childhood asthma symptoms**
- **11,000 cases of acute bronchitis among children**
- **12,000 emergency room visits and hospital admissions**
- **850,000 days of work missed due to illness.**

The Mercury and Air Toxics Standards will dramatically reduce the amount of mercury emitted by power plants. Mercury is a toxin that, depending on the form and dose, may cause neurological damage to adults, children, and fetuses developing in the womb. Mercury, depending on the form and dose, may cause neurological damage, including lost IQ points, in children who are exposed before birth and is also associated with impacts on children's cognitive thinking, memory, attention, language, and fine motor and visual spatial skills.

In addition, these standards will also significantly reduce emissions of:

- metals such as arsenic, chromium, and nickel, which cause cancer and other health risks;
- acid gases that cause lung damage and contribute to asthma, bronchitis and other chronic respiratory disease, especially in children and the elderly;
- and fine particle pollution, which causes a host of health problems including premature mortality and lung and heart problems.

Charles D. Connor, President and CEO of the American Lung Association said of this rule: "When it becomes final, the cleanup rule that the EPA is putting forward today will save lives, protect the health of millions of Americans and finally bring about an action that is 20 years overdue. This must happen."

This proposed rule, which is going through a public comment process, is the product of significant outreach to industry and other stakeholders. The Clean Energy Group, a coalition of electric power companies, said: "Since 2000, the electric industry has been anticipating that EPA would regulate hazardous air pollutant emissions, and as a result, many companies have already taken steps to install control technologies that will allow them to comply with requirements of the rule on time. The technologies to control emissions at coal-fired power plants, including mercury and hydrochloric acid, are available and cost-effective."

Transport Rule

On July 6 of last year, the Agency proposed the "Clean Air Transport Rule," which would significantly improve air quality in cities throughout the eastern half of the U.S. by requiring 31 states and the District of Columbia to reduce their emissions of sulfur dioxide (SO2) and oxides of nitrogen (NOx) which contribute to ozone and fine particle pollution across state lines.

The proposed Transport Rule replaces EPA's 2005 Clean Air Interstate Rule (CAIR). A December 2008 court decision kept the requirements of CAIR in place temporarily, but directed EPA to issue a new rule to implement the Clean Air Act requirements concerning the transport of air pollution across state boundaries. This action responds to the court's concerns.

The final version of this rule is currently under OMB review; however, at the proposed rule stage, we estimated that the rule would result in more than $120 billion annually in health benefits by avoiding:

- **14,000 to 36,000 premature deaths,**
- **21,000 cases of acute bronchitis,**
- **23,000 nonfatal heart attacks,**
- **26,000 hospital and emergency room visits,**
- **1.9 million days when people miss work or school,**
- **240,000 cases of aggravated asthma, and**
- **440,000 cases of upper and lower respiratory symptoms.**

These numbers represent a major improvement in the quality of life of literally millions of real people throughout the country – especially working families, children, and older Americans. And that improvement translates into substantial benefits for our economy. These two rules demonstrate the common sense actions that have been and can be taken under the Clean Air Act in order to improve public health by reducing harmful pollution through the application of available technologies.

I look forward to your questions.

**Environment and Public Works Committee Hearing**
**June 15, 2011**
**Follow-Up Questions for Written Submission**

Questions for Administrator Jackson

Questions from:

Senator Barbara Boxer

1. Administrator Jackson, in March of this year EPA issued the latest Congressionally-requested analysis of the benefits and costs of the Clean Air Act. The report shows a host of benefits in 2010 and 2020 from the reduction of air pollution, including annual benefits in 2020 of preventing 230,000 premature deaths, 2.4 million asthma attacks, and 5.4 million lost school days.

   Can you tell me, was the data used in this report peer reviewed? And, what does the report tell the American public about the benefits of the Clean Air Act's public health protections compared to its costs?

   ***Response:*** The Report was reviewed by more than 50 peer reviewers and received separate reviews at different stages of the report process from design through interpretation and write-up. The Report tells us the benefits of the Clean Air Act greatly exceed its costs. The ratio of expected benefits to costs is roughly 30 to 1. The Summary Report and Full Report are on EPA's website at: http://www.epa.gov/cleanairactbenefits/prospective2.html

2. Administrator Jackson, EPA has proposed that power plants use modern clean air safeguards to reduce pollutants such as arsenic, mercury and chromium and other heavy metals, which can cause cancer and harm children's neurological development.

   Are power plants a big source of these dangerous pollutants? And, if so, why didn't these facilities have to use modern pollution controls years ago?

   Are the types of technologies to control such pollution already in use or is the agency proposing to require that these facilities use new and uncommon air pollution control technologies?

   ***Response:*** Power plants as a group are the largest emitters of mercury (53 tons per year), acid gases such as hydrochloric acid and hydrogen flouride (397,000 tons per year of those gases) and other toxic metals, such as arsenic, chromium and nickel (about 1600 tons per year in the United States.[1]

[1] All estimates are based on the 2005 National Air Toxics Assessment (NATA) inventory. *See also* 76 Fed. Reg. 25002-06 (National Emission Standards for Hazardous Air Pollutants From Coal and Oil-Fired Electric Utility

EPA's standard to reduce mercury and other air toxics from power plants is 20 years in the making:

- Under the 1990 Amendments to the Clean Air Act (CAA), EPA was required to regulate air toxics emissions from power plants "if the Administrator finds such regulation is appropriate and necessary after considering the results" of the study of power plants required under section 112(n)(1).
- On December 20, 2000, EPA issued a determination that it was appropriate and necessary to regulate air toxics emissions from coal- and oil-fired electric utility steam generating units (EGUs) under section 112 of the law and added such units to the CAA section 112(c) list (112 list) of sources that must be regulated.
- On January 30, 2004, EPA proposed section 112 standards for mercury emissions from coal-fired EGUs and nickel emissions from oil-fired EGUs. The agency also proposed, in the alternative, to remove EGUs from the 112 list, based on a finding that it was neither appropriate nor necessary to regulate EGUs under section 112 of the Clean Air Act, and alternatively set standards under section 111 of the Clean Air Act.
- On March 29, 2005, EPA issued a final revision of the appropriate and necessary finding for coal- and oil-fired EGUs and removed these units from the 112 list. EPA never finalized the proposed section 112 standards for mercury and nickel, and instead, finalized the standards under CAA 111. The removal of EGUs from the 112 list was challenged in court.
- On February 8, 2008, the U.S. Court of Appeals for the D.C. Circuit determined that EPA violated the Clean Air Act by improperly removing EGUs from the section 112 list. As a result, EGUs remain a section 112(c) listed source category.
- On March 16, 2011, in response to the court's vacatur, EPA proposed section 112 air toxics standards for all coal- and oil-fired EGUs. The proposed standards reflect the application of the maximum achievable control technology (MACT), consistent with the requirements of the law.
- On December 21, 2011 EPA finalized standards to limit mercury, acid gases and other toxic air pollutants from power plants.

For all existing and new coal-fired EGUs, the standards establish numerical emission limits for mercury, filterable particulate matter (as a surrogate for other non-mercury toxic metals) and hydrochloric acid (as a surrogate for other acid gases such as hydrogen flouride). For all existing and new oil-fired EGUs, the toxics rule establishes numerical emission limits for filterable particulate matter (as a surrogate for other toxic metals, including mercury), hydrochloric acid and hydrogen fluoride.

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Steam Generating Units and Standards of Performance for Fossil-Fuel-Fired Electric Utility, Industrial-Commercial-Institutional, and Small Industrial-Commercial-Institutional Steam Generating Units; Proposed rule).

A range of widely available, technically and economically feasible practices, technologies and compliance strategies is available to power plants to meet the emission limits, including wet and dry scrubbers, dry sorbent injection systems, activated carbon injection systems and bag houses.

3. Administrator Jackson, some industry lobbyists are denying that the reduction of toxic air pollution, such as mercury and toxic soot, protects public health and prevents premature deaths.

   One of these lobbyists is a former head of EPA's Office of Air and Radiation whose previous testimony before Congress is at odds with his current statements on behalf of utility clients.

   Has the science changed in the last few years to show that these air pollutants are not as dangerous as studies have shown them to be in the past?

   ***Response:*** The scientific evidence regarding the impacts of exposure to mercury and fine particle pollution clearly indicates that exposure to these pollutants can result in adverse human health effects.

   The scientific evidence regarding the impacts of exposure to mercury clearly indicates that exposure to these pollutants can result in adverse effects on children's health. The most common way people are exposed to mercury is by eating fish that are contaminated with mercury (specifically methylmercury). When mercury emitted to the air (such as from coal-fired power plants) deposits to water, it is transformed into the highly toxic form methylmercury. Methylmercury builds up in fish, including species eaten by people in the United States.

   We interpret this question to inquire specifically about the health effects of certain constituents of fine particles that are defined as hazardous air pollutants (HAP) under the Clean Air Act, not the health effects associated with all fine particles. Several constituents of PM, more specifically metals, are defined as HAPs and have been shown to cause a wide range of adverse health effects. The primary hazardous metals in PM identified as drivers of risk include chromium, nickel, and arsenic. All three of these metals have been classified by the EPA as human carcinogens (EPA has only evaluated certain forms of chromium and nickel for their carcinogenic potential, i.e., hexavalent chromium, nickel subsulfide and nickel refinery dusts for their carcinogenic potential). In addition, both short- and long-term exposure to these metals have been associated with a range of adverse noncancer health effects including increased cases of bronchitis, decreased pulmonary function, and other respiratory effects; gastrointestinal effects; and potential reproductive effects.

4. Administrator Jackson, the Clean Air Act requires EPA to protect public health from dangerous air pollution, including toxic soot by facilities that burn fossil fuels.

A 2009 New England Journal of Medicine study on toxic soot's impacts found: "A reduction in exposure to ambient fine-particulate air pollution contributed to significant and measureable improvements in life expectancy in the United States."

Is this conclusion consistent with EPA's understanding of the public health benefits of reducing such pollution?

***Response:*** Yes, this is consistent with EPA's understanding of the health benefits of reducing fine particle pollution. EPA researchers recently completed a study published in the peer-reviewed journal *Risk Analysis*, which characterized the public health burden of recent levels of particle pollution and smog.[2] The model, which uses similar assumptions regarding the relationship between fine-particles and premature mortality as we use in our Regulatory Impact Analyses, estimates that if levels of these two pollutants were reduced to natural background, life expectancy would increase by more than half a year, on average in the U.S. This result is similar to the estimate reported in the 2009 New England Journal of Medicine Study.

5. Administrator Jackson, in 2008, EPA issued an updated Clean Air Act National Ambient Air Quality Standard for ozone, which causes smog. In 2009, EPA announced that the Agency would reconsider this decision to ensure it is clearly grounded in science and protects public health.

   Can you please describe the reasons that the Agency made this decision and the status of its reconsideration?

   ***Response:*** In September, President Obama requested that Administrator Jackson withdraw the draft Ozone National Ambient Air Quality Standards. Work is under way on the next regularly scheduled review of the ozone standards, as required under the Clean Air Act. EPA anticipates issuing a proposal in 2013, and taking final action in 2014.

6. Administrator Jackson, USA Today published a series of articles on toxic air pollution and schools, and shortly thereafter I worked with you to increase the Agency's monitoring of such pollution near these places where children learn and play.

   Can you please describe the current status of the Agency's activities to monitor and address toxic air pollution found near the nation's schools?

   ***Response:*** EPA has completed the initial monitoring at the 63 schools in 22 states where outdoor air quality was monitored for toxic air pollution as part of the School Air Toxics Monitoring Initiative. These schools were selected because national modeling results

[2] Fann, N., Lamson, A. D., Anenberg, S. C., Wesson, K., Risley, D. and Hubbell, B. J. (2011), Estimating the National Public Health Burden Associated with Exposure to Ambient PM2.5 and Ozone. Risk Analysis. doi: 10.1111/j.1539-6924.2011.01630.x

suggested that they could be at the highest risk for elevated levels of toxic air pollution. The results show that two thirds of the schools measured pollutants that were sufficiently below levels of concern for both short- and long-term exposure that no additional monitoring beyond the screening study was recommended. At the remaining third, EPA's analysis indicated additional monitoring would be informative, and that monitoring is taking place. There are several reasons EPA recommended additional monitoring, including that:

- EPA's screening analysis found pollutants at levels that are sufficient to need further evaluation;
- Sources of interest were operating below normal capacity during the initial monitoring period, increasing the likelihood that results may not provide a "typical" picture of outdoor air quality at the school.

Senator Thomas R. Carper

1. **Mercury.** It is my understanding that we have a wealth of scientific knowledge on the health effects of mercury – and that since the late 1990's EPA has found that mercury emissions from uncontrolled coal-fired power plants are a health hazard to our children. Is that correct? Can you explain what we know about mercury exposure and developing children's health?

   ***Response:*** The scientific evidence regarding the impacts of exposure to mercury clearly indicates that exposure to these pollutants can result in adverse effects on children's health. The most common way people are exposed to mercury is by eating fish that are contaminated with mercury (specifically methylmercury). When mercury emitted to the air (such as from coal-fired power plants) deposits to water, it is transformed into the highly toxic form methylmercury. Methylmercury builds up in fish, including species eaten by people in the United States.

   Mercury, depending on the form and dose, may cause neurological damage, including lost IQ points, in children who are exposed before birth and is also associated with impacts on children's cognitive thinking, memory, attention, language, and fine motor and visual spatial skills.

   Additional information can be found in the Revised Technical Support Document: National-Scale Assessment of Mercury Risk to Populations with High Consumption of Self-caught Freshwater Fish In Support of the Appropriate and Necessary Finding for Coal- and Oil-Fired Electric Generating Units, December 2011[3] and in the preamble to the final Mercury and Air Toxics Rule.

2. Didn't EPA also determine that other air toxics emitted from a dirty coal plants can harm public health? I'm thinking of toxics like dioxins and acid gases to name a few. Can you

[3] On the web at: http://www.epa.gov/mats/pdfs/20111216MercuryRiskAssessment.pdf

provide more information on what these other toxics might do to my health if I lived near one of these uncontrolled coal plants? Are the health benefits from reducing these pollutants in EPA's cost-benefit analysis of the air toxics regulation?

***Response:*** In addition to mercury, a number of hazardous air pollutants, also known as air toxics, emitted by coal-fired power plants have been shown to cause adverse health effects. In addition to mercury, the primary air toxics emitted are arsenic, chromium, nickel, cadmium, dioxins, hydrogen chloride, and hydrogen fluoride. Exposure to these hazardous air pollutants, depending on exposure duration and levels of exposures, is associated with a variety of health effects, with the severity of effects increasing as the exposure levels increase. These adverse health effects may include chronic health disorders (e.g., irritation of the lung, skin, and mucus membranes; detrimental effects on the central nervous system; damage to the kidneys; and alimentary effects such as nausea and vomiting). Two of these hazardous air pollutants are classified as human carcinogens (arsenic and hexavalent chromium) and two as probable human carcinogens (cadmium and nickel).

EPA was not able to monetize the health benefits associated with reducing exposure to cadmium and these other air toxics in the cost-benefit analysis for the proposed Mercury and Air Toxics Rule, because of a lack of sufficiently specific data. The analysis does include a discussion of the health effects of these toxics that could be expected to be reduced as a result of reducing emissions.

3. **Particulate Matter.** In previous hearings, we have had a few economists testify before us questioning EPA's science linking small particle pollution to negative impacts on public health. What do we know about small particles and how they impact our lungs? Is the science robust in this area?

   ***Response:*** EPA's review of currently available scientific information indicates there is compelling evidence that long- and short-term exposures to fine particle pollution ($PM_{2.5}$) cause premature mortality and cardiovascular-related effects resulting in increased hospital admissions. In addition, there is strong evidence that long- and short-term $PM_{2.5}$ exposures likely cause respiratory-related effects such as increased hospital admissions and emergency department visits, exacerbation of asthma and decreased lung function growth in children. These conclusions are presented in the 2009 Integrated Science Assessment[4] for the current review of the fine particle standards and have been unanimously endorsed by EPA's independent science advisors, the Clean Air Scientific Advisory Committee (CASAC).[5,6]

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[4] *Integrated Science Assessment for Particulate Matter* (December 2009). EPA 600/R-08/139F. Available at http://cfpub.epa.gov/ncea/cfm/recordisplay.cfm?deid=216546.

[5] A summary of the causal determinations for health effects reached in the PM Integrated Science Assessment, including the determinations that short- and long-term exposure to $PM_{2.5}$ cause cardiovascular effects and mortality

EPA has invested heavily in particulate matter (PM) research since 1998 to improve our understanding of PM-related effects. For fine particles ($PM_{2.5}$), thousands of studies, including more than 300 new epidemiological studies, make up the overall scientific data base considered in the development of the 2009 Integrated Science Assessment. In addition, hundreds of new controlled human exposure and toxicological studies, which provide support for the effects observed in epidemiological studies, also were considered in the current PM NAAQS review. Collectively, this evidence strongly reinforces our understanding of the health effects associated with $PM_{2.5}$ exposures.

EPA considers the currently available scientific evidence to be stronger and more consistent than in previous reviews. The new epidemiological evidence includes extended analyses of the seminal studies of long-term $PM_{2.5}$ exposures (i.e., the American Cancer Society and Harvard Six Cities studies[7]) as well as a substantial increase in new long- and short-term exposure studies. The epidemiological studies were conducted in numerous locations across the U.S. and abroad with consistent results, indicating that the scientific evidence is robust. Some more recent studies report effects at lower ambient $PM_{2.5}$ concentrations than were reported earlier.

Controlled human exposure and toxicological studies which directly expose test animals to particles in a laboratory setting, provide insights and support for the effects observed in the epidemiological studies by demonstrating how inhalation of particles result in premature death or adverse cardiovascular or respiratory effects.[8]

4. **Coal Retirements.** Recently, American Electric Power (AEP) stated that they are retiring 6,000 Megawatts in the next few years and all of these retirements are due to recent clean air regulations proposed under your watch. However, didn't AEP agree to

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effects and likely cause respiratory effects is presented in Table 2-6 on p. 2-32. A summary of the causal determinations for welfare effects is presented in Table 2-7 on p. 2-33.

[6] Samet J (2009). Letter from Dr. Jonathan M. Samet, Chair, Clean Air Scientific Advisory Committee to the Honorable Lisa P. Jackson, Administrator, US EPA. CASAC Review of EPA's Integrated Science Assessment for Particulate Matter –Second External Review Draft (July 2009). November 24, 2009. Available: http://yosemite.epa.gov/sab/sabproduct.nsf/264cb1227d55e02c85257402007446a4/151B1F83B023145585257678006836B9/$File/EPA-CASAC-10-001-unsigned.pdf.

[7] Extended analyses of studies important in previous reviews of the national ambient air quality standards (NAAQS) for particulate matter (PM) are being considered in the current review including:

- Krewski D, Jerrett M, Burnett RT, Ma R, Hughes E, Shi Y, Turner MC, Pope AC III, Thurston G, Calle EE, Thun MJ (2009). Extended Follow-Up and Spatial Analysis of the American Cancer Society Study Linking Particulate Air Pollution and Mortality. HEI Research Report 140, Health Effects Institute, Boston, MA. Available: http://pubs.healtheffects.org/view.php?id=315.
- Laden F, Schwartz J, Speizer FE, Dockery DW (2006). Reduction in fine particulate air pollution and mortality: extended follow-up of the Harvard Six Cities Study. Am. J. Respir. Crit. Care. Med. 173: 667-672.
- Gauderman WJ, Avo, E, Gilliland F, Vora H, Thomas D, Berhane K, McConnell R, Kuenzli N, Lurmann F, Rappaport E, Margolis H, Bates D, Peters J (2004). The effect of air pollution on lung development from 10 to 18 years of age. NEJM 351:1057-67.

[8] US EPA, 2009 (PM ISA). This information is discussed throughout ch 4-7 of the ISA

retrofit or retire most of the megawatts in question under consent decrees with President George W. Bush's EPA? Is it your understanding that the AEP retirement announcement includes facilities listed in past consent decrees?

***Response:*** AEP has made prior public statements announcing these steps, and they have acknowledged these public health standards were only one of several factors driving the decision regarding plant retirements – other factors include the fact that these plants were less efficient, the economic slowdown, the increasing price of coal and decreasing price of natural gas. The record also indicates that AEP's decision to close these plants occurred before CSAPR was finalized and while MATS was still in proposal stage. EPA does not believe that decisions to close these specific plants were tied to EPA's actions on the CSAPR and MATS rules.

5. Ms. Wollums's testimony cites several independent studies conducted last fall that tried to analyze reliability, coal retirements, and your new utility clean air regulations. However, correct me if I am wrong, I don't remember any of the new utility clean air regulations being final by last fall. Wasn't the utility air toxics rule just proposed this March? Were assumptions made about your regulations in these studies that are no longer valid?

   ***Response:*** Many of the independent, industry reports released last fall, including reports by NERC, Credit Suisse, and Brattle, overstate the impact of EPA's rules on reliability and coal retirements due to pessimistic assumptions of the rules' requirements. These assumptions were unfounded and were made prior to EPA's proposal of several rules, most significantly EPA's Mercury Air Toxics Standards (MATS) and Cooling Water Intake Structures (CWIS) rules, which were not proposed until March and April of this year, respectively. A review by the Congressional Research Service (CRS) found that the NERC report "assumed requirements that appear to be substantially more stringent than what EPA proposed" for the MATS rule. As such, NERC's assessment of necessary pollution control equipment for coal-fired plants to comply with the MATS rule is exorbitantly high. CRS also found that NERC's assessment of the CWIS rule (which NERC concluded would be the most costly of the four EPA rules that it examined) assumed that the agency would propose a more stringent rule with a more rapid timeline for compliance than was actually proposed by the agency. These findings were corroborated for the NERC report and extended to the Credit Suisse and Brattle reports by an assessment conducted by the Bipartisan Policy Center. Due to incorrect assumptions, made in advance of several rule proposals, the conclusions of these industry reports do not apply to the MATS and CWIS rules as they exist today.

6. **Jobs.** Earlier this year, my subcommittee looked at the Clean Air Act and the impact clean air regulations had on our economy. We had companies testify about the positive impacts the Clean Air Act had on our economy and will have for years to come if you are allowed to do your job. In fact, I believe we heard that we are a lead exporter in clean air technology as a result of our clean air regulations. I've also heard from labor groups saying just set the new standards and get out of the way because they are ready to work.

Can you discuss the job opportunities the Clean Air Act has provided historically and will do so again with these new upcoming clean air regulations?

**Response:** In contrast to doomsday predictions, history has shown, again and again, that we can clean up pollution, create jobs, and grow our economy all at the same time. Over the 40 years since the Act was passed, the Gross Domestic Product of the United States grew by more than 200 percent.

Some may find it surprising that the Clean Air Act also has been a good economic investment for our country. A study led by Harvard economist Dale Jorgenson found that implementing the Clean Air Act actually increased the size of the US economy because the health benefits of the Clean Air Act lead to a lower demand for health care and a healthier, more productive workforce. According to that study, by 2030 the Clean Air Act will have prevented 3.3 million lost work days and avoided the cost of 20,000 hospitalizations every year.[9] Another study that examined four regulated industries (pulp and paper, refining, iron and steel, and plastic) concluded that, "We find that increased environmental spending generally does not cause a significant change in employment."[10]

The EPA's updated public health safeguards under the Clean Air Act will encourage investments in labor-intensive upgrades that can put current unemployed or under-employed Americans back to work. Environmental spending creates jobs in engineering, manufacturing, construction, materials, operation, and maintenance. For example, EPA vehicle emissions standards directly sparked the development and application of a huge range of automotive technologies that are now found throughout the global automobile market. The vehicle emissions control industry employs approximately 65,000 Americans with domestic annual sales of $26 billion.[11] Likewise, in 2008, the United States' environmental technologies and services industry of 1.7 million workers generated approximately $300 billion in revenues and led to exports of $44 billion of goods and services,[12] larger than exports of sectors such as plastics and rubber products.[13] The size of the world market for environmental goods and services is

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[9] Dale W. Jorgenson Associates (2002a). *An Economic Analysis of the Benefits and Costs of the Clean Air Act 1970-1990. Revised Report of Results and Findings.* Prepared for EPA. http://yosemite.epa.gov/ee/epa/eerm.nsf/vwAN/EE-0565-01.pdf/$file/EE-0565-01.pdf

[10] Morgenstern, R. D., W. A. Pizer, and J. S. Shih. 2002. "Jobs versus the Environment: An Industry-Level Perspective." *Journal of Environmental Economics and Management* 43(3):412-436.

[11] Manufacturers of Emissions Control Technology (http://www.meca.org/cs/root/organization_info/who_we_are)

[12] DOC International Trade Administration. "Environmental Technologies Industries: FY2010 Industry Assessment. http://web.ita.doc.gov/ete/eteinfo.nsf/068f3801d047f26e85256883006ffa54/4878b7e2fc08ac6d85256883006c452c/$FILE/Full%20Environmental%20Industries%20Assessment%202010.pdf (accessed February 8, 2011)

[13] U.S. Census Bureau, Censtats Database, International Trade Data--NAICS, http://censtats.census.gov/naic3_6/naics3_6.shtml (accessed September 6, 2011)

comparable to the aerospace and pharmaceutical industries and presents important opportunities for U.S. industry.[14]

Jobs also come from building and installing pollution control equipment. For example, the U.S. boilermaker workforce grew by approximately 35 percent, or 6,700 boilermakers, between 1999 and 2001 during the installation of controls to comply with EPA's regional nitrogen oxide reduction program.[15] Over the past seven years, the Institute for Clean Air Companies (ICAC) estimates that implementation of just one rule – the Clean Air Interstate Rule Phase 1 – resulted in 200,000 jobs in the air pollution control industry.[16]

7. Compared to payroll, labor, fuel and material costs, do you know how much an average manufacturer pays in pollution abatement control technology?

   **Response:** According to US Census data, below are the relative costs of these items for manufacturing firms. All percentages are a function of total revenue for the firm.

| | |
|---|---|
| Materials | 52% |
| Profit, Taxes, Interest on Debt and Other | 32% |
| Labor | 12% |
| Depreciation | 2% |
| Energy | 2% |
| Pollution Abatement and Control Costs | 0.40% |

8. **Pollution crossing state boundaries.** As you have heard me say, Delaware is at the tailpipe of America – in that our neighbor's air pollution comes across our state boundaries, making our citizens sick, raising our health care costs, and impacting our economy. In fact, up to 90% of our state's air pollution is coming from sources out of

[14] Network of Heads of the European Environment Protection Agencies, 2005. "The Contribution of Good Environmental Regulation to Competitiveness." http://www.eea.europa.eu/about-us/documents/prague_statement/prague_statement-en.pdf (accessed February 8, 2011).

[15] International Brotherhood of Boilermakers, *Boilermaker Labor Analysis and Installation Timing,* March 2005, EPA Docket OAR-2003-0053 (docket of the Clean Air Interstate Rule).

[16] November 3, 2010 letter from David C. Foerter, Executive Director of the Institute of Clean Air Companies, to Senator Thomas R. Carper (http://www.icac.com/files/public/ICAC_Carper_Response_110310.pdf (accessed February 8, 2011).

state. Can you take a moment to discuss how the Transport Rule tries to ensure we are all good neighbors when it comes to air pollution?

***Response:*** As you mention, air pollution emitted in one place, particularly from smokestacks that spew pollutants high into the air, travels up to hundreds of miles downwind, crosses state lines, and impacts air quality and human health and ecosystem services in all downwind states, including Delaware. The Cross-State Air Pollution Rule identifies the amount of emissions in one state that interfere with a downwind state's ability to meet EPA's health-based National Ambient Air Quality Standards and creates a cost effective program for states to eliminate these emissions. In so doing, the Cross-State Air Pollution Rule will help avoid tens of thousands of premature deaths and illnesses, achieving billions of dollars in public health benefits. By 2014, the required emissions reductions will annually avoid: 13,000 to 34,000 premature deaths; 15,000 nonfatal heart attacks; 19,000 hospital and emergency room visits; 1.8 million lost work days or school absences; and 400,000 aggravated asthma attacks. Pollution reductions will also lead to improvements in visibility in national and state parks, and increased protection for sensitive ecosystems including Adirondack lakes and Appalachian streams, coastal waters and estuaries, and forests.

9. **Grandfathering old plants.** In the 1970 and 1990 Clean Air Act Amendments, Congress delayed older coal power plants air control requirements because it was thought that most of the old plants would die off in the decade after the legislation passed. It was thought there was no need to invest in new technologies at these old, dying plants. Did many of these coal plants actually retire? What is the average age of our coal fleet today?

   ***Response:*** As of 2010, there were 1,270 coal electric generating units in the U.S. fleet. Of these units, 1,077 are over 25 MW, which is the size requirement for applicability of the CSAPR. The average on-line year for these 1,077 units is 1970 (40 years old as of 2010):
   - 573 of these units are older than 1970
   - 956 of these units are older than 1990

Senator David Vitter

1. Administrator Jackson, EPA has spent a great deal of time and energy touting a supposed economic boost you attribute to Clean Air Act regulations. You say something on the order of "*$40 of economic benefit for every one dollar spent.*"

   Would you mind explaining to me in greater detail – with empirical data and proof points – how EPA arrived at these numbers?

   ***Response:*** The EPA study, titled The Benefits and Costs of the Clean Air Act from 1990 to 2020, was a 10-year long study conducted by a team of experts in economics, emissions sector modeling, air quality modeling, health science, and environmental science, among other relevant disciplines. The design of the study, including the data and modeling methodologies used, were reviewed in detail by outside experts serving as

independent peer reviewers. The study was then carried out by the project team, with periodic interim reviews by a total of four different panels of outside experts in economics, health science, environmental science, and emission and air quality modeling. These interim reviews were conducted to check intermediate results and refine methodologies as data were developed and opportunities to further improve the study emerged. Every one of these peer review meetings was open to the public and anyone wishing to comment on the study's data, methods, and results was invited to do so in a public forum. The final results were then reviewed by these four panels of outside experts, and the final reports were reviewed by the parent review committee of economists and chairs from each of the technical subcommittees. In the end, more than 50+ outside experts who are leaders in their field were involved in the peer review of this study, which showed that over the period from 1990 to 2020 Clean Air Act Amendment programs overall returned more than $30 in benefits to public health and the environment per $1 spent to implement these clean air protections. In their review closure letter, the peer reviewers, who are experts in economics, health science, environmental science, and emission and air quality modeling, called the study a "state-of-the-art analysis of the benefits and costs of the 1990 [Clean Air Act ... which is] comprehensive in scope, sophisticated in methodology ... and includes methodological innovations that enhance our understanding of the benefits and costs of air-quality regulations." All of the details regarding the study and its methods and findings are available in the full report available to the public at www.epa.gov/cleanairactbenefits. A summary version of the report is available at the same web page, along with a number of detailed supporting reports and memoranda documenting the methods used for all aspects of the study, including estimation of emissions, cost, air quality, health effects, environmental effects, economic valuation, economy-wide effects, and uncertainty.

2. We've heard this figure -- $40 for every dollar spent -- bandied about liberally of late. I'd like to talk more about this claim.

   A new study commissioned by the National Taxpayers Union found that most of the analysis you included focused on abstract, non-empirical measures of consumer willingness and openness to pay for emissions reductions. Meanwhile, the study notes, your own review of the CAA found negative impacts on everything from GDP to purchasing power to manufacturing output.

   If the CAA has been such an economic boon, why is it that people around the country – my constituents among them – view these regulations as so burdensome and costly?

   ***Response:*** The NTU-funded paper criticizes EPA's study of the benefits and costs of the Clean Air Act, a study which was 10 years in the making, and which went through dozens of public meetings involving peer review by more than 50 highly qualified experts in economics, health science, atmospheric science and other relevant fields. Those 50+ expert economists and other scientists called the EPA study a "state-of-the-art analysis of the benefits and costs of the 1990 [Clean Air Act ... which is] comprehensive in scope, sophisticated in methodology ... and includes methodological innovations that enhance our understanding of the benefits and costs of air-quality regulations." The

NTU-funded paper, by contrast, appears to be a brief assessment by two economists which has apparently not been subject to any kind of peer review. Contrary to the assertions by the NTU-funded study authors, the extent to which the American people have benefitted from cleaner air was measured in the EPA study using sound methods and data, reflecting standard welfare economic analytical measures and principles. These economic valuation methods were specifically reviewed and approved by leading outside economists; and the results reflect the value Americans place on reducing premature mortality, disease, and other adverse effects of air pollution, not just the value of market transactions measured by Gross Domestic Product. It would be unfortunate if there actually were widespread misconceptions regarding the value of America's investment in clean air, especially since the most rigorous, comprehensive, and thoroughly peer-reviewed study ever conducted to examine this question demonstrates clearly how the American people have benefited from our collective success in achieving cleaner air, even as the US economy has grown throughout the decades since the Clean Air Act and its amendments were enacted by Congress.

3. Administrator Jackson, EPA claims that its regulations under the Clean Air Act will provide an economic boost of around $2 trillion. But upon reading through a new report commissioned by the National Taxpayers Union, it seems that the logic used to arrive at the claim of economic benefit is a bit strained.

   a. Is it true, as the NTU study suggests, that your own macroeconomic analysis of regulation under the Clean Air Act found negative impacts on GDP, jobs, manufacturing, and other economic measures?

   ***Response:*** The NTU-funded study seems to imply that clean air is only valuable if it increases manufacturing output or other economic activity measured by Gross Domestic Product. If that were true, it would mean Americans place no value on the lives and health of the elderly and children, simply because they do not hold down jobs which boost Gross Domestic Product. EPA does not agree with this concept of only assigning value to the lives and well-being of some Americans. The best available evidence shows that clean air programs yield direct health and environmental benefits to the American people which vastly exceed the costs of achieving those gains. The $2 trillion net direct benefit estimate from the benefit-cost comparison documented in the EPA study tells us that, as does the fact that the same study shows that in 2010 alone, clean air programs achieved risk reductions from air pollution equivalent to saving 160,000 from early death and millions from air-pollution-related illness and disease. Furthermore, as part of the study, EPA conducted economy-wide modeling to assess the effects of clean air programs on markets and economic productivity. Contrary to the NTU-funded study authors' claims, the modeling results showed that not only is long-term economic growth as measured by GDP higher with clean air programs than without them, but household economic well-being is immediately and significantly improved. The NTU-funded paper's interpretations and characterizations of the EPA study are inconsistent with the views of the 50+ outside economists and other experts who reviewed the EPA study, a study which in fact demonstrates the tremendous value of America's investment in cleaner air.

b. During times like these, is it acceptable in EPA's eyes to be anything other than fully open with the public regarding the cost of your agenda? What is the disconnect that leads empirical, numerical analysis to such wildly different conclusions than your own?

***Response:*** Unlike the NTU-funded paper, the EPA study was conducted in a fully open and transparent manner and went through rigorous peer review by outside experts throughout the design, implementation, interpretation, and write-up of the study. Every peer review meeting was held in accordance with the Federal Advisory Committee Act (FACA) as a public meeting where anyone who wished to comment was invited to do so. Similarly, EPA Regulatory Impact Analyses (RIAs) conducted as part of EPA's rulemaking agenda are shared in draft with the public and the public is invited to comment on the RIA along with other elements of the rulemaking package. EPA is committed to an open and transparent rulemaking process, and that transparency includes sharing with the public the data, methods, and results of our economic analyses.

The disconnect between the EPA study and the NTU-funded paper arises primarily because the EPA study used methods and data which are consistent with mainstream scientific and economic theory and practice and led the external peer review experts in economics, health science, environmental science, and emissions and air quality modeling to call the study a "state-of-the-art analysis of the benefits and costs of the 1990 [Clean Air Act ... which is] comprehensive in scope, sophisticated in methodology ... and includes methodological innovations that enhance our understanding of the benefits and costs of air-quality regulations." The NTU-funded paper, by contrast and among many other flaws, adopts a concept of value which assumes that preventing early death and disease for Americans has no value unless doing so leads to a bigger economy, more jobs, and more output of goods and services. We think that this is a position at odds with the views of mainstream economists and most likely the American public as well.

NAS/Formaldehyde:

4. Apart from the specific problems of the formaldehyde IRIS draft assessment, the NAS panel found that the risk assessment policies and practices of the IRIS office continue to fall well short of meeting the benchmarks of objectivity, scientific accuracy and transparency necessary to ensuring high quality, reliable assessments. Time after time, assessment after assessment, the IRIS program continues to use inconsistent data evaluation methods, to put forward assessments based on unjustified assumptions rather than relying on the scientific data, and to obfuscate rather than use transparent, reliable study integration procedures.

    a. Administrator Jackson, do you agree with the NAS recommendations that to properly assess the safety of chemicals, the IRIS Program needs to adopt a consistent, systematic weight of evidence framework that incorporates transparent and rigorous data evaluation methods, 21st century knowledge of toxicological modes of action, not just defaults and proven approaches for evaluating cause and effect and dealing with uncertainty?

b. And equally important, following rigorous independent peer review of a draft IRIS assessment, can we have your assurance that the when the assessment is revised, the Office of Research and Development Assistant Administrator will certify that public comments and peer review findings and recommendations have been adequately and transparently addressed?

c. Finally, please provide a list of the exact changes, providing comprehensive detail, of what work is being done at EPA to reform the IRIS process following the NAS review.

**Response:** EPA is committed to developing timely, high quality, accessible human health assessments for chemicals of concern. IRIS assessments provide health effects information on chemicals to which the public may be exposed from releases to air, water, and land, and through the use and disposal of products. These assessments provide critical information about chemical hazards to citizens, communities, businesses, environmental groups, and government leaders as they make decisions that impact the health and lives of the American people. The Agency is dedicated to delivering this important information and continuously improving the IRIS process.

In April 2011 the National Academy of Sciences (NAS) made suggestions to improve the development of draft IRIS assessments. EPA welcomed those suggestions and is addressing all of them. The Academy recognized that EPA's implementation of these suggested changes would require a phased-in approach. EPA began phasing in the NAS recommendations to IRIS assessments in the pipeline in July 2011.

Specifically, EPA is revising IRIS assessments in development that have undergone or been submitted to peer review to reflect peer review comments, especially those that call for increased transparency of study selection and evidence evaluation. The Agency is also editing the text of these assessments to make the documents more understandable to readers. As for assessments in the pipeline that have not yet been released for peer review, EPA is revising these assessments to ensure clarity of study selection rationale and evidence evaluation. These assessments will also be streamlined and edited to reduce redundancy. Finally, for assessments in the early stages of draft development, EPA will comprehensively implement the NAS recommendations, including development of a more concise document structure, the use of evidence tables to summarize details from pertinent studies, increased transparency in study selection and evaluation criteria, improved emphasis on clear analysis and synthesis of available data, and clear evaluation of the weight of the evidence for potential health effects.

In their report, the Academy did not suggest that EPA should slow down or suspend the pace of IRIS assessment development.

EPA is also working closely with the Agency's Science Advisory Board to develop a dedicated advisory committee that will focus on the quality, transparency, and scientific rigor of IRIS assessments and guide EPA's response to the NAS recommendations. A

hallmark of the IRIS Program is strong independent peer review of IRIS assessments – a commitment that was reinforced in 2009 with Administrator Jackson's announcement of a new IRIS process and again in 2011 when EPA announced plans to implement the NAS recommendations. The Agency has also committed to creating a new peer consultation step early in the development of major IRIS assessments to enhance the input of the scientific community as assessments are designed.

Boiler MACT:

1. Do you have any concerns about environmental groups challenging your administrative stay of the Boiler MACT and CISWI rules?

   **Response:** EPA issued a notice delaying the effective dates of the boiler MACT and the CISWI rule on May 20, 2011. Sierra Club challenged the delay notice in the federal district court for the District of Columbia. On January 9, 2012, the court vacated and remanded the delay notice. While it agreed with EPA that the Agency had the legal authority to delay the effective dates of the rules, the court held that EPA did not provide the justification for the stay that the court concluded was required.

   Following the court's vacatur of the delay notice, EPA issued a no action assurance letter stating that it did not intend to take enforcement action against sources that may have missed administrative notification requirements under the rules. Moreover, EPA intends to complete action on reconsideration of both rules this spring.

2. Are you concerned about litigation risks to the rules, given that the Sierra Club already has challenged in court the Boiler MACT, CISWI and Boiler GACT rules? For example, in the final rules EPA has adopted work practices for gas fired boilers, for limited-use boilers, for periods of shutdowns, and for boilers at areas sources. Are you confident that these provisions will survive legal challenge?

   **Response:** The final rules for major and area source boilers and for CISWI units have been challenged by Sierra Club and by industry as well as by several states. Those challenges are being held in abeyance until EPA completes its reconsideration of the rules. The Agency will thoroughly review and consider all public comments received on the proposed reconsideration and is confident that its final rules will be fully consistent with the requirements of the Clean Air Act.

   The Clean Air Act authorizes EPA to adopt work practice standards in lieu of numeric emissions limits for boilers, if the Agency determines that certain conditions are met. EPA explained its rationale for adopting the work practice standards in the final rule, and has provided additional opportunity for public comment for certain work practice standards in its proposed reconsideration action. EPA will thoroughly review and consider all public comments received on the proposed reconsideration of the work practice standards and is confident that the final rules will be fully consistent with the requirements of the Clean Air Act.

3. If we are concerned that additional time is needed for compliance (such as 5 years from the issuance of the final rules rather than 3 years), do you disagree that legislation is needed to ensure that?

   ***Response:*** The Clean Air Act (CAA) established a system of compliance dates for section 112 which has worked well over the life of the MACT program. There is a three-year time frame for compliance with air toxics emission standards. In addition, the Administrator, or a state with an approved Title V permitting program, may issue a permit that allows an extension permitting an existing source up to one additional year to comply with the standards, if the additional period is necessary for the installation of controls.

4. As you know, the regulated community has serious concerns that the strict "legitimacy criteria" in the Non-Hazardous Secondary Materials rule will classify as "solid waste" currently valuable fuels such as renewable biomass residuals, thereby leading to increased use of fossil fuels and land filling millions of tons of valuable materials. Why has EPA not stayed the rule? Do you believe that "comfort letters" can give facilities the legal certainty they need?

   **Response:** EPA is in the process of re-examining the 2011 Non-Hazardous Secondary Material (NHSM) final rule and has proposed amendments and clarifications on certain issues on which EPA has received new information, as well as specific targeted revisions that are appropriate in order to allow implementation of the rule as EPA originally intended. The proposed rule was in the Federal Register on December 23, 2011.[17] With regard to the legitimacy criteria, in the proposed rule EPA is clarifying that similar groups of pollutants (such as volatile organics, semi-volatile organics) can be compared rather than individual contaminants. The proposal also clarifies that in cases where a unit can burn traditional fuels from several categories, such as a boiler that can burn either coal or biomass, contaminant comparisons could be made using data from either fuel category at the combustor's discretion. In other words, if a facility burns biomass in its combustion unit, but that same combustion unit could also burn coal, the facility could compare its secondary material to either traditional fuel.

5. Regarding the Boiler MACT and CISWI rules, do you have litigation concerns about adopting the source-based approach based on what best-performing boilers can achieve across the range of emissions?

   **Response:** To the extent that a source-based approach refers to setting MACT standards based on facility-specific emissions for all pollutants, rather than on a pollutant-by-pollutant basis, such an approach would be inconsistent with EPA's long-standing practice in establishing MACT standards under sections 112 and 129. The Agency has explained its reasons for establishing MACT standards on a pollutant-by-pollutant basis

[17] See Commercial and Industrial Solid Waste Incineration Units: Reconsideration and Proposed Amendments; Non-Hazardous Secondary Materials That Are Solid Waste, 76 FR 80452.

in the boiler MACT and the CISWI rule, as well as in other MACT rules and in briefs filed before the D.C. Circuit Court of Appeals. As explained in those rules and briefs, EPA believes that the pollutant-by-pollutant approach reflects the best interpretation of the language of the Clean Air Act, and results in standards that are based on what the best-performing sources can achieve.

6. We have heard that EPA is on an accelerated schedule to reconsider the Boiler MACT and CISWI rules in the next year that will limit opportunities to develop new emission data, yet we hear even this schedule may be challenged. Do you disagree that legislation to give EPA 15 months would provide helpful certainty, allow new testing and time to get the rules right?

   **Response:** EPA does not need legislation to provide the appropriate time or an appropriate process to reconsider the boiler MACT and CISWI rules. Proponents of legislation to delay issuance of the boiler and incinerator rules claim that the delay is consistent with what EPA told the Court we needed to finish the rules. It is not. EPA asked the Court to extend the deadline for finalizing the rules to April 2012. In contrast, if the House boiler bill were enacted this spring, it would prevent EPA from finalizing the rule prior to summer 2013.

Senator Jeff Sessions

1. Under the Clean Air Act, EPA must allow an "adequate margin of safety" when setting air quality standards for ozone, but the Act's legislative history shows that the standards should be set at "the *maximum* permissible level ..."[18] In its ozone rulemaking, does EPA intend to set standards that are the maximum levels permissible under the Act?

   **Response:** On September 2, 2011, the Administration withdrew the final rule for the reconsidered 2008 ozone National Ambient Air Quality Standards (NAAQS) from interagency review and is now proceeding with implementation of the current ozone NAAQS of 0.075 ppm (or 75 parts per billion).

2. Administrator Jackson, I am concerned about how EPA evaluates the costs and benefits of its rules. For example, when adopting standards for one pollutant, it appears that EPA relies on the "co-benefits" from reductions in other pollutants, even though those co-benefits are already taken into account when adopting those separate standards. In other words, EPA double-counts the benefits across multiple programs. If EPA did not double-count co-benefits, EPA's change in the ozone standard would clearly show negative net benefits. The regulatory costs are much higher than the benefits we get from reducing ozone. Have you informed President Obama that the benefits from reducing ozone are smaller than the costs of reducing that ozone?

[18] S.Rep. No. 91–1196, 91st Cong., 2d Sess. 10 (1970).

**Response:** Many pollution control strategies and technologies reduce more than one pollutant. For all of our rules, EPA examines both the direct benefits of reducing a particular pollutant, and any co-benefits that may result. Co-benefits are appropriate to include in a comprehensive estimate of the benefits, so that we are comparing the complete benefits of a rule to the complete costs.

On September 2, 2011, the Administration withdrew the final rule for the reconsidered 2008 ozone National Ambient Air Quality Standards (NAAQS) from interagency review and is now proceeding with implementation of the current ozone NAAQS of 0.075 ppm (or 75 parts per billion).

3. The rise in asthma cases in our society is concerning. According to an April 2009 report by the Alabama Department of Public Health, approximately 1 in 10 Alabamians currently has asthma." The Alabama Department of Public Health has prepared a State Asthma Action Plan that will hopefully assist in reducing the rate of asthma. It does seem counter-intuitive that our nation's air quality is actually continuing to improve and has consistently improved over the last 30 years. Over the past 30 years, total emissions of the six principal air pollutants have decreased by 57%. EPA National Emissions Estimates show that in 1980 there were 267 million tons per year produced of these emissions. That number decreased dramatically to 107 million tons in 2009. But, particularly in hot and humid areas like the South, there will always be background levels of ozone that will make further reductions in ozone levels below a certain level exceedingly difficult, if not impossible. Are your agency's proposed ozone standards justified on the basis of preventing asthma and other respiratory illnesses, and if so, how do you explain increases in asthma cases during a long period of lower pollution levels?

   **Response:** While the increase in the prevalence of asthma is not attributable to air pollution levels, exposure to ozone results in worse health outcomes for those with asthma and related diseases. Ozone exacerbates asthma and other respiratory effects, leading to increased asthma attacks, medication use, doctor and emergency room visits, and hospital admissions. As a result of these significant health impacts, there are substantial benefits to society from reducing ozone levels.

   The scientific evidence that ozone exposure is associated with significant public health impacts is robust and well-understood. Ozone – commonly called smog – is one of the most widespread air pollutants. Even with the significant improvements in air quality under EPA's leadership and many areas meeting the current standards, ozone remains linked to tens of thousands of emergency room visits by Americans each year for serious respiratory conditions, including asthma. Asthma affects 25 million people in the United States, including seven million children. One out of every 10 school-aged children is affected, and approximately 13 million people have reported having an asthma attack in the past year.

4. It seems that EPA is going out of its way to issue an unprecedented number of new regulations. No Administration has ever updated the national air standards for more than

two criteria pollutants in a single term. But this Administration is taking steps to tighten the standards for all 6 criteria pollutants. As you are aware, the Clean Air Act provides for the review of the air quality standards once every 5 years. This provides some degree of regularity to the process, and affords an opportunity for new science to develop. In this case, however, EPA proposed new ozone standards just 2 years after issuing the 75 parts per billion standard. This seems to be an unjustified departure from the normal review process. Was your decision to propose new standards outside the 5-year review process based on new scientific evidence, and if so, what new evidence do you have to support a change from 2008?

**Response:** In September, President Obama requested that Administrator Jackson withdraw the draft Ozone National Ambient Air Quality Standards. Work is under way on the next regularly scheduled review of the ozone standards, as required under the Clean Air Act. That review will be based on a new assessment of studies.

Senator BOXER. Thank you so much.

Because I already asked one of my questions, I am going to give my turn over to Senator lautenberg, and I will ask last.

Senator LAUTENBERG. Thank you, Madam Chairman.

I listen carefully to what our colleagues say. And I must say, I have to scratch my head in wonderment. When I hear that President Obama, such an ogre, that he wants to prevent everybody from exercising their free will to poison the atmosphere, to use material that we know is dangerous to the human race, and when I look and I hear that, and I think, I ask myself, and forgive me, I am asking my first question of me, if you don't mind, and that is——

Senator CARPER. Who is going to answer?

Senator LAUTENBERG. You are listening? Senator Carper is listening.

When do we hear about the courageous decision that President Obama made to take a huge risk to eliminate a giant terrorist threat to our people, and the post-mortem shows that they had more plans to kill our people and disrupt our functioning? So frankly, I have to tell you, I don't get it. And I know that o the other side, they read the same papers and everything else. But the interpretation is quite different.

What is the cost of having a healthy child, of having a child that doesn't need constant medical attention? What about the financial side of that, that drains family incomes and doesn't permit them to think about positive things and how to have their families progress, but they have to take care of that sick child, they have to make sure that the environment is right?

So things sound a little backward to me, I must tell you. And I hope that the American people understand that cut, cut, cut, cutting brings wounds, often, and wounds that are lethal in their final outcome.

Thanks, Administrator Jackson, for those wonderful comments. Our planet has warmed at an unprecedented rate since we began burning fossil fuels for energy on a massive scale. What is the effect of these warmer temperatures on air quality, public health?

Ms. JACKSON. EPA's endangerment finding includes information that shows that as the climate changes in those areas that become noticeably warmer, that exacerbates what we talked about earlier, ozone alert days. Certain types of pollution in warmer temperatures actually combine to form ground level ozone, which is smog, which is one of the major triggers for asthma, bronchitis, respiratory problems in our children and in the elderly. But also, as you noted, in some healthy adults who are particularly susceptible to ozone.

Senator LAUTENBERG. Madam Chairman, since I have very little time, I have to ask myself another question. And that is, do we look at the President and understand some of the things that are so positive, rescued the automobile industry, which was an American finding, and going down the tubes, and people are back to work and the companies are competing, jobs exist there.

So the easiest thing to do, and we saw it the other night in the Republican debate, almost to a person, the only thing they could do was talk about how bad President Obama is, not offering any

solutions that are positive. And that is what we get to see here as well, I am sorry to say, is that we hear about jobs that are lost, because we don't permit pollution to take place. You are darned right, that is what we are going to keep on doing.

Madam Chairman, I have exhausted my questions of me. Thank you very much.

Senator BOXER. Well, I thought your questions and the answers that you gave to them were excellent. But I know there is some division about that on the panel here.

So we will go to our first Republican here, Senator Barrasso.

Senator BARRASSO. Thank you, Madam Chairman.

Administrator Jackson, I would like to highlight a letter that was sent on June 10th to you by Congressman John Dingle and by 26 other House Democrats. As you know, former Chairman Dingle is one of the architects of the Clean Air Act. The letter states, and I have a copy of the letter, I don't know if you have had a chance to read it yet, this letter, signed by Congressman Dingle as the first signator and then 26 others.

The letter states that the Utility MACT rule is "unparalleled in its size and scope for maximum achievable control technology rule, presents a set of new regulations with possible wide-reaching impacts on the way our Country generates and consumes electricity." The letter goes on, he says "We must be mindful of the economic impact new regulations could have, especially with the complexity and breadth of applicability for this rule being so significant."

The letter continues: "By the EPA's own analysis, this proposed rule will cost nearly $11 billion per year with retail electricity rates increasing." The letter also highlights errors in calculations that have come to light since your rule was proposed. The letter asks for extension of the public comment period for this rule. Given that one of the authors of the Clean Air act is asking for an extension, will you grant the extension of the public comment period?

Ms. JACKSON. EPA has not responded to the letter. I am certainly aware of it, Senator, and we will be responding shortly. We have made no determination yet.

Senator BARRASSO. Well, I am not a signator of the letter. But I am a member of this panel. Do you intend to expand the time for which comment can be made?

Ms. JACKSON. As soon as we have a decision, I am happy to give it to you, sir.

Senator BARRASSO. OK. Let me ask you a question about particulate matter. It is a revision that the EPA is currently undergoing. The particulate matter revisions include what we in the west call farm dust. You have said it is a myth that you intend to regulate farm dust. But yet you set the standard and the States have to implement that standard.

So isn't it true that one of the recommendations that your staff has made was to lower the standard for farm dust in the final policy assessment that came out earlier this year?

Ms. JACKSON. Yes. The staff recommended either lowering it or retaining the current standard.

Senator BARRASSO. So I want to give you an opportunity to clear this up right now. Just, if you could please, tell rural America right

now that you plan to retain the current standard and reject the recommendation of lowering the standard.

Ms. JACKSON. Senator, I know you are not asking me to, but to answer your question today would be to violate the administrative procedures that require us to propose, take public comment and then finalize a new National Ambient Air Quality Standard. So we have, and I have said several times, that we will propose that standard some time this summer. My words to rural America are, and I have said it myself as I have gone out to Iowa, to California, and will continue to go out and speak directly to people in rural America, is that we are concerned about your health, but we also are pragmatic and practical people. And our standards and proposal will reflect that.

Senator BARRASSO. You have already said it is a myth that you intend to regulate farm dust. So what——

Ms. JACKSON. No, sir, it is a myth for people to promulgate and continue to say that we are planning to do it. Because we have made no proposal. And so you cannot characterize our actions when there is no proposal for the American people to comment on.

Senator BARRASSO. Respectfully, it just sounds like a lot of bureaucratic response to some legitimate questions that a lot of people around the Country have. So I look forward to the response coming out of the agency.

Ms. JACKSON. I have to say that if someone says that we are doing something we are not doing, that is a myth. And we have not made a proposal to change the coarse particulate standard. We are required by law every 5 years to review the science, ensure that people in this Country are protected, including in rural America. I take very seriously that obligation.

But I also am a practical woman who will look at how that plays out on the ground. Our staff have had listening sessions in rural America to do just that.

Senator BARRASSO. We appreciate that approach.

My final question, according to the National Cattlemen's Beef Association, out of all the other agencies that regulate food safety and animal health, your agency is responsible for 65 percent of the regulations that they face. These regulations are affecting the smallest producers around the Country, who can't afford the number of regulations coming at them.

What I hear from our members of the Cattlemen's Beef Association, is this proportional? Have you done any kind of a cost estimate on the impact that this has on smaller operations and how they may end up having to consolidate and move to bigger companies?

Ms. JACKSON. Certainly our regulations do impact some, some of the cattlemen and ranchers and members of that organization. We work quite closely with them and will continue to do so.

Senator BARRASSO. Thank you, Madam Chairman. My time has expired.

Senator BOXER. Thank you very much.

Senator Whitehouse.

Senator WHITEHOUSE. I show up and I immediately get called on. How fortunate. My timing is right.

Senator BOXER. Well, you were here, the first person here.

Senator WHITEHOUSE. We have had a lot of discussion around the Clean Air Act on the costs of compliance with the Clean Air Act. And in my opening statement, I mentioned the cost benefit comparisons. Clearly there is a cost here. There is also a benefit. And they were as low as four to one, benefit exceeding cost by four to one, and as high as 145 to one, potentially, for the Transport Rule.

I have a particular interest in the AEP situation, because of the claims that they are shutting down because of something that you are doing. I thought it was that they were shutting down because it was something that a number of us did many years ago. I gather that the vast majority of that megawattage that is going, being taken offline is going to, is being done in compliance with that settlement from years ago. And my recollection of that settlement is that release that went out that AEP itself I don't believe objected to was that they would have to pay $4.6 billion to clean up to comply, but that the EPA indicated the savings to the Country from that cleanup would be not just one time $30 billion, but $30 billion plus every year.

Could you tell us a little bit about the methodology and the rigor by which EPA and in some cases I guess OMB go about creating those cost comparisons? Are they fictional? Are they fancy? Are they well-founded in science and data? How do you do them?

Ms. JACKSON. Senator, both our cost analysis as well as our estimate of benefits are done by economists and by specialists in the field who have literally decades of experience in understanding the Clean Air Act rules. In general, our costs are an over-estimate and our benefits are accurate. We know that because there have been peer-reviewed studies and peer-reviewed economics which we cite in our analyses that have confirmed the numbers we have.

Senator WHITEHOUSE. You have been doing this for a long time, it has been subject to criticism, critique and review.

Ms. JACKSON. We have heard doomsday stories——

Senator WHITEHOUSE. And in response to those criticisms, critique and review, it has held up.

Ms. JACKSON. Excuse me, Senator. Yes. Yes, it is not, it is common practice for industry to make doomsday claims about the cost and the impact of EPA regulations. It is why we have an entire Center for Environmental Economics to estimate costs. Because we do agree that those are critical in making decisions about the costs and benefits of rules.

Senator WHITEHOUSE. And of course, on the health side, some things are hard to cost.

Ms. JACKSON. I think that is right. I think every equation has two sides. One side is cost, but the benefits side, the things we can cost, we already know the benefits far outweigh the costs. But one of the more odd discussions we had early on is what is the value of a human life. And we actually have to value it, but of course, that doesn't value all the pain and suffering that goes along with illness and chronic disease.

Senator WHITEHOUSE. We had a witness from Rhode Island at that table a week ago describing the asthma problem in Rhode Island. Again, completely caused by out of State pollution sources, like the AEP plants that are being taken offline, thankfully, for

Rhode Island's sake. And that the average length of stay in the hospital for a child who gets admitted to the hospital for an asthma attack is 2 days. As a parent, you think, if your child is in the hospital for 2 days, those aren't two regular days for you as a parent. Those aren't days when, particularly if you are a single parent, those aren't 2 days when you are going to work. If you are paid by the hour, those aren't 2 days when you are getting a pay check. Those are 2 days you are probably going to have to cover for later on.

And is that the kind of cost that is hard to catch, and therefore you often underState the true cost?

Ms. JACKSON. We can calculate days away. But the cost to the economy, the cost to that employer who now has to make do, if she or he is compassionate, with one less employee for the day. But let me just say, as someone who has done that 2-day stint, I think it was a 3-day stint, I will never forget being under an oxygen tent with my less than a year old son, hoping he could breathe.

And children do die. I received a letter last week from a mother in Philly, her 17 year old son died of asthma. My son is 14, my other son is 16. It really hit home for me.

Senator WHITEHOUSE. And that whole cost of worry and concern is completely not counted in the industry equations, correct?

Ms. JACKSON. I think it is probably underestimated. We can count days, but we can't count everything that it means to a family, and their own economics, if they lose a job because they are not there.

Senator WHITEHOUSE. Thank you.

Senator BOXER. Thank you, Senator.

Senator Inhofe.

Senator INHOFE. Thank you, Madam Chairman. I am just going to cover two things real quick here.

First of all, a lot of us contend that the EPA doesn't really need the Air Toxics rule to regulate utility emissions. The EPA already has the National Ambient Air Quality Standards for PM 2.5 and a variety of other regulations, to make sure that these standards are met. The regulatory impact analysis, that is yours, that is the EPA, for the MACT rule estimates that the rule would create some 30,000 construction jobs during the compliance period and perhaps another 9,000 that would be more permanent jobs in the electric sector.

However, it also states, and I am going to quote from it now, it says, "Industries that use electricity will face higher electricity prices as a result of the Toxic Rule, reduce output and demand less labor. We do not currently have sufficient information to quantify these as a potential employment gains or losses."

We talked about for quite some time trying to be able to determine the cumulative effect of all these things. You have heard this so many times from me and from others of what all these things are actually costing in terms of jobs, in terms of money. And we have heard from a lot of the labor unions that have been testifying.

But anyway, I have on the floor right now, the bill that I have, I have turned into an amendment that would go on the EDA that I am going to try to offer that would provide in advance the cumulative effect, financial effect of all these regulations. Would you

support that? I am talking about looking forward, not looking back. Because you were just talking about this, and you were kind of analyzing what has that cost. I am talking about in anticipation of new rules would you support what we——

Ms. JACKSON. Senator, I believe that the economic analysis that EPA does is it proposes the rule. You cited one of our regulatory impact analyses. It is thorough, it is complete and goes very far in estimating what the real impacts of a rule will be.

Senator INHOFE. My problem with that is, that is one rule at a time. I am talking about the cumulative effect. Right now there are some six different rules. And the cumulative effect is what really concerns me and what affects jobs.

Ms. JACKSON. Well, two points, sir, and I am happy to take a look at your legislation. Does it include benefits? Does it look at the cumulative benefits on American health?

Senator INHOFE. Yes, at the net.

Ms. JACKSON. And so how is it—I would wonder about the difference in the OMB peer-reviewed report that shows that EPA's regulations have benefits that are literally an order of magnitude more than their cost.

Senator INHOFE. All right. In the benefits and costs of the Clean Air Act from 1990 to 2020, that is a 30-year period, and it is your report, it makes some claims, the benefits of about $2 trillion a year and possibly as high as $5.5 trillion a year. And your statement to Congress and to the public led many to believe that this $2 trillion in benefits means the economy will be $2 trillion larger.

Do you expect, or let me ask you three questions real quick here. Do you expect the $2 trillion in benefits would result in higher economy growth as measured by GDP by 2020? And will the $2 trillion that is referred to in estimated benefits result in any additional tax revenues at the Federal or State level in 2020? And do you think benefit would result in any way in higher wages, personal or household income for the American public?

Ms. JACKSON. OK, let me first——

Senator INHOFE. They are all the same question.

Ms. JACKSON. Yes, let me give you a couple of facts that may answer those three questions. First, over the 40-year history of the Clean Air Act, our GDP has grown 200 percent. So if history is any guide, we can do this. We can have safer, healthier air, and have a growing economy.

No. 2, the study you referenced is a peer-reviewed study. So although it is an EPA work, it has been reviewed by others who look independently at real benefits. And in my testimony, I noted that some say our GDP would be even larger. I don't think dollar for dollar, I am not an economist, I am not claiming that there would be $2 trillion more in our GDP. But those are health care costs avoided in many cases. That means more money for someone to buy groceries, some money to pay bills that they would not otherwise have. And those things are all part of the——

Senator INHOFE. My time has almost expired. But the study suggests that the effect of Clean Air regulations from 1990 to 2010 will lower GDP by over .5 percent in 2020 and lower overall economic welfare by .3 percent. It is important to note that these are, that even these estimates don't reflect over $1 trillion of new costs.

Let me make one comment about the farm dust thing, because it was kind of funny, when I go back to Oklahoma, they say, they are talking about regulation of farm dust, and there is no technology there. So I had a news conference. And a lot of people had, we two people that had never been west of the Mississippi before. So we are down in Southwestern Oklahoma. I said, this brown stuff down here, it is dirt. Now, that round green thing, that is cotton. This up here is wind. Now, are there any questions?

How do I tell these people that there is some kind of a technology up there that is going to allow them, in States like Oklahoma, States out west, that there is any kind of technology that is going to allow us to regulate farm dust?

Ms. JACKSON. Two things, Senator. First off, farm dust is already regulated under the coarse particle standards of the Clean Air Act. It is done because health studies show that by minimizing that you protect the health of people in rural America. It is done oftentimes by States who work very closely with conservationists at ways to try to keep the dirt on the farm, which I now know from my trips to rural America is a very good thing for farmers. They want their dirt on their farm.

Senator INHOFE. Yes, they do.

Ms. JACKSON. So again, I would ask you to tell your constituents for me, until I can see them myself, that the EPA is mindful of the limits of practicality in trying to protect their health. But I don't think we want to turn our back on it.

Senator INHOFE. All right, and I appreciate that. Because they contend that with everything they have and the technology available, they have reached that limit. And they look forward and say, what are we going to do?

Thank you, Madam Chairman.

Senator BOXER. Thank you. Thank you so much.

Senator Carper.

Senator CARPER. Thanks very much.

Ms. Jackson, great to see you. Let me just say, from the outset, you have been before us any number of times. We have had a whole lot of other administrators, your predecessors who have been before us, and many other witnesses, as you know. It is a joy to watch you do your job before this panel. Never lose your cool, always good with your answers. Just a great way about you. Don't change.

I have just come from addressing the folks from the Ozone Transport Commission here on the East Coast from I guess Maine down to Virginia. I apologize for being late. One of the things I said to them I just want to mention here at the outset. I have worked with them and with a number of folks here on this Committee for almost a decade to try to reduce harmful emissions into our air. And by doing so, we sought to provide greater certainty to industry, some predictability and to States about the time tables, about the reductions that need to occur in the next decade.

Ultimately, we have not been successful enacting legislation, to my disappointment. So it falls, my colleagues, it falls on EPA to do the job for us, to ensure we continue to clean our air and to strengthen at the same time our economy. And I contend that we can do both.

I just want to go on record here today to say, I can do everything in my power to work with the Administration, to work with my colleagues, Democrat and Republicans, to protect the Clean Air Act. And the reason why is I am convinced that by doing so, we will go a long way toward ensuring that our children will have a chance to live longer lives, healthier lives, more productive lives and happier lives. So I just wanted to start off with that.

I always like to quote different people of note. I like to quote Harry Truman. And one of my favorite Harry Truman quotes is, the only thing that is new in the world is the history that we forgot or never learned. That is a paraphrase. But if you go back to 1970, the guy who signed into law the Clean Air Act was not a Democrat, he was a Republican, as I recall.

The other thing that I recall, I was over in Southeast Asia at the time as a naval flight officer in the Vietnam War when he signed this. But as I recall, there was a lot of naysayers who said, you know, it is going to kill the economy. And, why are we doing this? And it didn't kill the economy. We did clean the air, we saved a lot of lives, and we did it in a way that was actually good for the economy.

In 1990, another Republican comes along, George Herbert Walker Bush. And what does he do? He signs the Clean Air Act Amendments of 1990, and some of the naysayers said at the same time, same thing, history repeats itself here, said, you know, this is going to kill the economy. Well, it didn't. It did clean the air, and we did it in a way that, tried to enact the legislation and implement it in a way that actually strengthen the economy. And ultimately, it did.

And here we are again, 20 years later, and people are saying, you know, we have not done our job here. We should have passed the legislation. God knows some of us tried. But we have not done our job. And now it falls on you to make sure that we actually comply with the Clean Air Act.

And folks are again saying, well, we can't do that because it is going to kill the economy. There is a lot of, room for a lot of empirical data to say that is not the case.

The other thing I want to say, I just want to get this off my chest. I live in the State of Delaware. I used to work very closely with Christine Whitman, when she was Governor of your State, and later when she was EPA Administrator, we were part of the National Governors Association. Very active players in the National Governors Association. And it burned the heck out of us that in our States we had, I could literally close down my State. I could have closed down the highways, I could have closed down our plants, and we still would have been out of compliance for attainment for a number of Clean Air, dirty air emissions. We could have put our States out of business.

It is not fair. I would just State to my friends that don't have to face this problem, there is a moral imperative here. In terms of the equity of the issue, that why should some States have to suffer, not from bad stuff that we put into the air, but the bad stuff that others do? It is like Sheldon was saying, it is just not fair. We need to level the playing field for all of us. Part of what we are doing here is to try to be fair.

Here is my question. It deals with mercury. It is my understanding that we have a whole lot of scientific knowledge on the health effects of mercury. We have talked about it here before. Since the late 1990's, the EPA has found that mercury emissions from uncontrolled and from coal-fired plants are a health hazard to our kids. Is that correct, and can you take just a minute or so and give us a little more detail on what we know about mercury exposure and developing children's health?

Ms. JACKSON. Certainly, Senator, and thank you for your kind words.

Mercury is inhaled and can cause serious neurological toxicity, pre-natal toxicity and toxicity in young children. So the concern then becomes reproductive or developmental defects as a result of exposure to mercury. Power plants are still overwhelmingly the No. 1 source of mercury in the air. And localized pollution from power plants that emit mercury end up in water bodies and can have significant impacts, well over 50 percent of the impact. Because there is some global transport of mercury. But there is still a significant localized problem around those plants that emit it.

Senator CARPER. If I could just ask a quick followup to that, Madam Chair? Could you just give us a snapshot of what it is like for folks who are, particularly young people, to inhale, whether it is mercury or other toxics like dioxin, what is it actually like? What does it do to their health, if they live near one of those uncontrolled coal-fired plants? Are the health benefits from reducing these pollutants in EPA's cost benefit analysis of the air toxic regulation?

Ms. JACKSON. Yes, absolutely. For mercury, because of its neurological impacts, the end points are things like lost i.q. points. Very measurable and in children who are exposed before birth, we see impacts on thinking, cognitive thinking and memory and attention and language development and fine and visual motor skills. In addressing mercury, there are also other metals. You heard me speak about arsenic and cadmium. There are acid gases, hydrochloric acid and other acids that are emitted and are also toxins and are being addressed by this rule.

Senator CARPER. All right. I just would close with this. To my colleagues, I would say, we are in a battle, an economic battle with the rest of the world. Competition is a lot tougher than it was when some of us were born. And we need to be on our A game. And we need to be not taking away i.q. points, we need to be adding them if we are going to have a work force that is going to be able to compete.

And with a health care system whose costs don't crush us, as they are today. Thank you, Madam Chair.

Senator BOXER. Thank you.

Senator Vitter.

Senator VITTER. Thank you, Madam Chair, and thank you, Madam Administrator.

Madam Administrator, a lot of the discussion has been, and I think properly so, about science at EPA being fully objective, being sound science. And just as a comment, I think a lot of our disagreement and a lot of our debate is the fact that this side of the podium, certainly myself included, doesn't have that confidence on a

regular, ongoing basis, that decisions are based on rigorous, sound science.

I truly feel, I know you are going to disagree, but forget about our disagreement, I am just trying to communicate a problem that is objective, it exists. I feel that there is a lot coming out of EPA based on ideology and not objective, sound science. I mentioned a particular experience we have had together regarding formaldehyde. I pushed for and eventually got a National Academy of Sciences panel to work on that.

Do you agree that as an organization, National Academy of Sciences has with good reason a lot of credibility in terms of scientific assessment?

Ms. JACKSON. Yes, sir.

Senator VITTER. And so I assume you would agree it is not some industry-captured group?

Ms. JACKSON. No, sir. They ensure that they are, do conflict of interest and rigorous review on their panels.

Senator VITTER. Right. Well, as you know, there has been a lot of concern in general about the IRIS process across the board before that. And that National Academy of Science formaldehyde study was about the IRIS process. And they found that the risk assessment policies and practices of the IRIS office fell well short of meeting the benchmarks of objectivity and scientific accuracy and transparency in a number of significant ways.

So my question in light of that is simple. What specific changes, reforms to the IRIS office and process overall have been made as a result of that report?

Ms. JACKSON. Well, thank you. First, let me just acknowledge that there were changes to the IRIS process prior to the report. Because upon becoming Administrator and Dr. Paul Anastas, as he came in as head of the Office of Research and Development, after he was confirmed, agreed and believed that there needed to be more transparency in the process, there needed to be peer review, there needed to be opportunities that brought the process out publicly, but also brought it to a close. Because we have so many IRIS assessments that because we haven't closed them, we are not able to say to the American people what risks they may or may not face.

So that was done before the study. I have since charged Dr. Anastas, although he didn't need me to do it, but he has been charged with giving us further recommendations to respond to any unmet suggestions and recommendations made by the National Academies. Because I do agree with, I think your point, which is their review on formaldehyde made broader recommendations about EPA's process.

Senator VITTER. Correct.

Ms. JACKSON. And I am committed to ensuring that each and every one of them is implemented to get the most robust risk assessment process we can have.

Senator VITTER. Well, first of all, in terms of any changes prior to the report, I just point out that you and EPA fought like the dickens to avoid the NAS report. And you were basically, in that formaldehyde case, absolutely defending the IRIS process as fully competent and fully adequate. So to say that——

Ms. JACKSON. Well, I would say——

Senator VITTER [continuing]. already making changes to that process that produced that flawed analysis seems to me completely inconsistent with that.

Ms. JACKSON. Well, let me just respond, because I would say that, fraud is not a word I would like to use in a U.S. Senator. But I disagreed strongly with your hold on Dr. Anastas' confirmation. Because I believe strongly that someone of his caliber and integrity was essential to ensuring we got the best science at EPA, which I am very much committed to.

The formaldehyde assessment has indeed come out since that time. Just recently the National Toxicology Program listed formaldehyde as a carcinogen. And formaldehyde, as we both know, being from Louisiana, is an interest of primary importance to residents down there who feel that they were poisoned by FEMA trailers that included high levels and emissions of formaldehyde. So it is an emotional issue and one which I could not agree with you more, we need to bring the best science to bear on.

Senator VITTER. Two quick questions. And I will close. Would the NAS report have happened without the hold?

Ms. JACKSON. No, sir, not at all.

Senator VITTER. Just point that out for the record.

Ms. JACKSON. Absolutely.

Senator VITTER. Second, go back to my original question. What specific reforms, what specific changes to IRIS after the NAS report have been made?

Ms. JACKSON. Why don't I get you, in writing, exactly what we are doing to change the IRIS process? All I would say is that the changes, if they were done before the report I would think we could both applaud. Because if they are responsive to the report and we have already instituted the changes, they will happen. And probably sooner than the report came out.

Senator VITTER. Well, you can include that, but I would like to specifically know what changes and reforms have been made after the report, responding to what I think are clearly significant findings of the report that go to the broader integrity of the broader IRIS process.

Ms. JACKSON. Yes, sir.

Senator VITTER. Thank you.

Senator BOXER. Thank you, Senator.

I am going to put in the record the Department of Commerce report that since the Clean Air Act was passed and signed into law by Richard Nixon, we have seen a 210 percent increase in gross domestic product. And you mentioned that, but I think it is important. Because what we are seeing here is hostile questions, in my opinion, this is the eye of the beholder, you may not feel that way, but I feel they are hostile questions from the other side of the aisle, the Republican side of the aisle, during this entire hearing. And in general, whenever we have a hearing on the environment. And they have every right to be hostile about it or feel, not support it.

But I think it is important that we understand that the support among the American people for the work you do and your predecessors did and those who will follow you is huge. We have a chart, 69 percent of the people, and this was just done February this year, 69 percent think EPA should update the Clean Air Act standards

with stricter air pollution limits. Stricter air pollution limits. Sixty-eight percent, this is a national poll, 68 percent believe that Congress should not stop EPA from enforcing Clean Air Act standards and 69 percent believe that EPA scientists, not Congress, should set pollution standards. And this was a poll done by a Democratic and a Republican polling firms, and their source here on the chart.

Now, I would say, rhetorically speaking, again, probably asking myself a question, as Senator Lautenberg was asking himself, why on earth can't we come together on something that almost 70 percent of the people agree with is important to protect their health, protect their safety, and support the laws that are the foundation for a healthy America and sound economic growth? And I answer it, I don't understand why we can't come together. And I will keep trying to do that, as Chairman of this Committee.

But again, respectful of a counter view, there are 33 percent of the people who don't believe that. So I guess they are represented very well over here. Thank you.

And I want to probe a little bit about these economic advantages. We know from this study, from 1970 to 2010, we saw an annual, annual prevention of more than 160,000 premature deaths. I hope the press hears this. Not just over the period of time, that would be terrific, if every year an average 160,000 premature deaths are avoided.

So when my friends talk about the economic costs of regulation, let me ask you, just as a human being, and a family member, in your family, if the bread winner dies 10 years early and doesn't work, isn't that a cost to the family? Let the record show he is nodding his head yes.

[Laughter.]

Senator BOXER. It is a horrific situation. If you suffer in your family a premature death because of the air pollution, if your child, as you mentioned, this horrible experience that you had, and it is so graphic, it just gives me the chills, as a mother and a grandmother, to think about what you went through, seeing a person you love more than yourself under an oxygen tent, struggling, and that little tiny body, to breathe. And I know what that is like. I had two premature babies. Just watching them gasping and trying to get the air, the fact that we can do something about that ought to bring us together, not having us interrupting each other and arguing.

What a wonderful moment this is today, to look back at this. How good you must feel to head an agency that has that type of record. I don't know of any other agency I don't know any other agency, State or Federal, that could say that, in the first 40 years of this Act, we prevented in every year 160,000 premature deaths. And that is why Richard Nixon lauded it. And that is why George Bush lauded it. This was brought to us by Republican Presidents, and now we struggle with our Republican colleagues who say, you can't, you shouldn't be doing anything about carbon pollution, you shouldn't, you know, you have to do what Congress said you ought to do, when that is exactly what you are doing.

Let me talk about dust. My home base, my home is in a desert. And it is called Riverside County. And it has a tough air pollution problems, by the way, one of the worst in the Country. One of the

reasons is, we have a huge amount, not surprising, of dust. And that dust carries problems with it. And what we do in our State, it is a combination of Federal, I am not talking about farms here, it is a combination of Federal and State law, there are very simple rules so we can mitigate that problem. They are dampened down, if you pass by a constructionsite, those trucks are going back and forth with recycled water, making sure that that dust stays down. Sometimes if an area is going to be vacant, they will put, they will plant it. They are doing that in Mecca, putting some of those, that greenery on top, so that we control it.

So there are so many ways that we can move forward to protect the health and safety. And when that child was, your child, was struggling for life, for air, and you were there, you weren't working, as Senator Whitehouse eloquently said. And you were missing your work. Or you were missing doing things that you needed to do for your family obligations.

And so to me, it is so clear. And that is why almost 70 percent of the people want you to do your job, no matter what other people are saying.

And I will close and ask you this. We saw the GDP growth. But here is the other thing that is overlooked. We are the largest producer, American is, of environmental technology, goods and services that are going to the rest of the world. I too was in that bipartisan trip to China, never saw the sun. Was there 9 days. And they were bragging 1 day, you barely saw it, barely saw it behind the clouds. They said, oh, what a great day. Meanwhile, everybody is thinking, I can't wait to go home and see a blue sky. We never saw that. We take that for granted.

That didn't happen because we sat back. It happened because we put our environment and the quality of life of our families and their health and yes, economics, we put that into the mix. So what we see here in this sector is $300 billion in revenues coming from the environmental technology, goods and services, supports 1.7 million jobs. With small to medium size companies making up 99 percent.

So I would ask you, in addition to the GDP growth, do you not see this as an economic benefit that is often overlooked in our Country?

Ms. JACKSON. Certainly. Even aside from the public health benefit and the money saved for American families, there have been estimates now on the benefits of the Clean Air Act alone with respect to the pollution control industry. The Economic Policy Institute just recently released a study saying that the Air Toxics rule would have a modest net impact on overall employment, likely creating 28,000 to 158,000 jobs between now and 2015. The University of Massachusetts and CERES released a study not long ago estimating that the standards, just two of our standards for mercury, for soot and smog, in addition to being lifesaving standards, will create nearly 1.5 million jobs over the next 5 years.

So these are jobs that would be created in the next 5 years at a time when our economy is certainly, and our President is working to bring jobs to our economy. So it is not our primary job, but one of the happy, I guess outcomes, of an American public and a Congress who have always supported protecting clean air and our

health, is that we have created an entire industry of Americans who lead the world in knowing how to do it.

Senator BOXER. I want to thank you very much, Administrator Jackson. You have been very forthcoming. You had some softball questions and some hardball questions, which is good. And I just want to put in the record a letter signed by various members of the utility industry, including Austin Energy, Grid USA, PG&E, Calpine, defending the EPA. It was a letter in the Wall Street Journal. We are OK with the EPA's new air quality regulations, have you seen that? I think that is a testament to you, the way you handle yourself, the way you reach out to people. And I just want to say, every member here has a right to ask you tough questions and so on and so forth.

But I just want you to know, I believe, my personal view, the American people are on the side of clean air and what you are doing. And I thank you from the bottom of my heart for your work and we say goodbye to you, and we call up our panel.

Sarah Bucic, American Nurses Association, Jerome Paulson, Dr. Paulson, American Academy of Pediatrics, Dr. Harvey Brenner, Ph.D., Professor at the University of North Texas, Cathy Woollums, Senior Vice President and Chief Environmental Counsel, MidAmerican Energy Holdings Company, Dr. Alfred Munzer, Pulmonary and Critical Care at Washington Adventist Hospital.

We are so pleased to have you here. We are sorry we ran late, but it just shows you the importance of this issue. And many Senators feeling very strongly about it.

Senator INHOFE. Madam Chairman.

Senator BOXER. Yes, sir.

Senator INHOFE. I would like to ask if it would be permissible, you just took 8 minutes, I would like to have 8 minutes, which I am sure you will give me, but I would like to ask my questions first. As you know, I have to leave at 5 minutes til. If I could have my 8 minutes of questions, it would be primarily for Dr. Brenner and for Cathy Woollums.

Senator BOXER. So you are going to ask——

Senator INHOFE. Before their opening statements.

Senator BOXER. You want to ask your questions and get answers to your questions before the opening statement?

Senator INHOFE. Yes.

Senator BOXER. Well, that would be highly unusual.

Senator INHOFE. Well, I am highly unusual.

Senator BOXER. Well, I want to accommodate you. So this is what I am going to recommend. Let's just start the opening statements and we will stop in time for 8 minutes——

Senator INHOFE. That won't work with me, as you know.

Senator BOXER. You have to leave at noon?

Senator INHOFE. No, I have to leave at five til. And right now we are looking at——

Senator BOXER. Fine. At five to, we will stop and we will turn to you for questions.

Senator INHOFE. No, no. I have to leave——

[remarks off microphone]. I just request that I could go ahead and ask my questions now and get answers since I have to leave

at 5 minutes til, and I appreciate the fact that Senator Barrasso is back.

Senator BOXER. Well, go ahead. It is very unusual and I don't like this. But because I am so fond of you as a human being, I will say yes.

[Laughter.]

Senator INHOFE. I will always remember the first thing I said after the 2010 elections, when it came in, I said, I just want you to know I am going to be just as nice to you 2 years from now as you are to me. So here we go.

Dr. Brenner, my understanding is that a typical regulatory impact analysis for the rule proposed doesn't attempt to quantify the adverse health effects of negative economic impacts. Now, given your work in this area, and by the way, we had some comments about you from our witness last week, do you believe that we would obtain a better understanding of the total impact of EPA's proposals if the agency quantified the adverse health effects of negative economic impacts?

Mr. BRENNER. Thank you, Senator Inhofe. What we have been missing, I think, in the entire conversation over the impact on health of environmental regulations is the fact that we treat these pieces of legislation as either yes or no, either we have clean air or we do not have clean air. There is no one that I have ever heard of who is not in favor of clean air.

The question is in terms of regulations, how much. Not whether or not. The issue of adverse health effects pertain not just to the quality of air and water and soil, they pertain to the implications for changes in the structure of the economy that would be brought about by changes in regulations generally. The most important implications are in income and employment. GDP is the single most important factor in the health of countries. There is nothing, there is no single factor of greater importance to life expectancy across the world or in industrialized countries or in our Country than the GDP, national income and wealth.

Additional to that, and related to that, is the economic position of individuals, which of course is heavily influenced by their employment rate. Studies going back to those of the Joint Economy Committee of Congress back in 1976 and 1984, under the Humphrey-Hawkins legislation, which were fundamentally much of the basis of the Humphrey-Hawkins legislation, which I was responsible for, studies of this kind, demonstrated clearly, measurably an impact over between six and 10 years of the loss of employment to increases in morality from cardiovascular diseases, suicide, homicide, cirrhosis, diabetes and so on.

So there is another entire side of the equation which the discussion legislatively has not been taking into account. The problem can be resolved mathematically. What it requires is a balanced model in which we estimate the implications of regulations for health, which we have begun to do, and we have heard a bit about that so far in the last discussion. But what has been missing from the entire discussion, and what needs to be placed forward, are the implications for health of any change in the economy, especially income and employment.

Just to point out the general statement, in all of epidemiology, that has to do with the health of national populations, there is no single factor in industrialized countries that is more important than economic status.

Senator INHOFE. For health?

Mr. BRENNER. For health.

Senator INHOFE. And the reason I wanted to hear this is that is because that is all we hear up here, it is so easy to talk about bad health and we must like kids and all this stuff. But the effects of the economy, I spent a lot of time in Africa. That is where it is evident, when they go in there and they say, we are going to have restrictions on emissions there, which would just have a devastating effect on them, because it is related directly to their ability to live, to eat, to survive.

So I appreciate that. So I would just say, in your opinion, would significantly higher energy costs carry with it an adverse public health consequence and would be the leading indicator, is that correct?

Mr. BRENNER. To the extent that such higher energy costs affect the rate of inflation, that is, increase the rate of inflation, or reduce income per capita, or increase the unemployment rate, they would have measurable substantial damaging effects on health.

Senator INHOFE. I appreciated that very much.

Ms. Woollums, according to the United Mine Workers of America, EPA's new regulations will force American energy companies to lay off over 250,000 workers. National Economic Research Associates estimates that the new regulations will cost the American economy almost 1.5 million jobs. Is the MidAmerican Energy Holdings concerned the impact of the EPA's actions on the company's employees? Are these job losses even more troubling in light of Dr. Brenner's testimony on the impacts of economic decline and public health?

Ms. WOOLLUMS. Certainly, Senator. Any time we talk about massive changes in employment within our industry, certainly there are concerns there. We have 1,200 people who work in the generating facilities around our company. The average level of income for those employees among those 1,200 is $70,000 a year. Those are pretty high-paid, high-skilled jobs to lose, given a fundamental shift in the method of generation.

Senator INHOFE. Were you here during my opening statement?

Ms. WOOLLUMS. I was, indeed.

Senator INHOFE. I talked at that time, and since that time I had an occasion to talk to Stuart Solomon, who is the President of the Public Service Company of Oklahoma, which is a subsidiary of the American Electric Power. He said, due to the EPA rejecting Oklahoma's regional haze SIP, and imposing the Federal FIP, it will cost PSO, that is in Oklahoma, $800 million in the installation of scrubbers at two units over a 3-year timeframe, which cannot be met. It is just kind of like the dust regulations, the technology is not there, it can't be done.

Further, another Oklahoma electric company, our other big one, the OG&E, must install scrubbers at four units, costing $1.2 billion. That is $2 billion in increased electricity bills for Oklahomans instead of the EPA working with the State to develop a plan con-

sistent with the Clean Air Act to provide the utilities fuel flexibility and realistic timeframe to implement the new emissions limits.

Do you pretty much agree with these figures? Is Stuart pretty much on target on these?

Ms. WOOLLUMS. I can't speak specifically to the individual company costs. What I can tell you, however, is that one of our utilities, PacifiCorp, who has been similarly preparing for the regional haze requirements, and from whom we have gotten an indication by EPA that our plan is not acceptable, in terms of the emission reductions. But we currently have a plan that includes $1.3 billion of expenditures to comply with those requirements.

Senator INHOFE. Well, things are always of most concern when you hear the figures back home. So I appreciate that very much, and thank you, Madam Chairman, for that opportunity.

Senator BOXER. Thanks.

So what I am going to do in my first round is to just, before you each speak, I am going to ask the two witnesses some questions also.

Well, Mr. Brenner, you should have been heartened by the fact that since the Clean Air Act was signed into law by Richard Nixon, our Nation's GDP has increased by 210 percent, No. 1. No. 2, I think rhetorically we all know if someone dies, the breadwinner in the family dies because they keel over and have a heart attack, and we know that in 2010 alone, is that correct, that 160,000 lives were spared, because of the work of the Clean Air Act, clearly you ought to put that into your little diagrams. Because if somebody is unable to work, their income goes way down.

So I just would hope you would do that.

And then I wanted to ask you, Ms. Woollums, do you agree with this following statement: Scientists generally believe that fossil fuel combustion and other human activities are the primary reason for an increased carbon dioxide concentration in the earth's atmosphere.

Ms. WOOLLUMS. As a general proposition, Madam Chair, yes.

Senator BOXER. OK, good. I am very glad to hear that. And we will put in the record that MidAmerican Energy Holdings representative agreed that fossil fuel combustion and other human activities are the primary reason for an increased carbon dioxide in the earth's atmosphere.

And also, would you say that MidAmerican's expenses incurred by its reducing emissions of toxic air pollution are prudently incurred costs?

Ms. WOOLLUMS. Yes.

Senator BOXER. Good. So it is important that your organization believes that any expenses dealing with reduction of emissions of toxic air pollution are prudently incurred costs. And that really makes me happy, and I wish Senator Inhofe was here to hear that.

Yes, sir?

Mr. BRENNER. May I respond to your question, Senator Boxer?

Senator BOXER. Yes. Well, you already responded to it. But do you disagree with my point that——

Mr. BRENNER. Yes, I disagree, Madam Chairman.

Senator BOXER. You disagree that GDP went up 210 percent?

Mr. BRENNER. No, I disagree with the implications of causality. It is a little like saying, anything that goes up with GDP is a cause of increase in GDP, or that the GDP is responsible for it. There is no necessary relationship between those two things.

Senator BOXER. Well, there is a relationship when people say the opposite, that you had said, that our GDP will suffer because of these rules and regs. Then it seems to me there is a way to disprove or prove your point. And your point is disproven.

Mr. BRENNER. I did not say that the regulations would necessarily disrupt the GDP. That is a function of other studies. My studies are on health. What they demonstrate is that increases in GDP are the fundamental basis for increase in life expectancy. The idea that two factors move together through time has no implication for causation. It would be a little like saying, because our health care expenditures in the United State have gone up astronomically, that has been good for GDP. It has been horrible for GDP, and it is a fundamental debate in our Country.

Senator BOXER. Yes, well, here is what I find so interesting about you. You are here to make a point. And I thought your point was that GDP is a very important part of any country's quality of life, right?

Mr. BRENNER. Essential.

Senator BOXER. We agree so strongly. Economic growth is critical. And I believe, and this is where we may or may not agree, that if you can't breathe, you can't work. And the GDP is a result of people working. And if you can't function, and if you're in the hospital with a heart attack premature, it is a problem.

So I think if I take your very interesting comments, I just think the whole notion that cleaning up the environment harms our economic growth is a myth that has been with us since the time I first got elected to office. I hate to tell you when it was. But the first time I got elected—I won't tell you—no, it was 1976. I was an environmentalist then, and that was the first argument that you got.

And here is the beauty. All these years have gone by and we see the proof. That in fact, we see an industry developing clean energy technology. There are only a couple of industries in America that actually export product here to the tune that we do with our clean energy. The other happens to be the entertainment industry. That is a different hat that I wear in another day.

But thank you both. Now we are going to go back to regular order and call on our representative from the American Nurses Association, Sarah Bucic.

## STATEMENT OF SARAH BUCIC, RN, MSN, AMERICAN NURSES ASSOCIATION AND DELAWARE NURSES ASSOCIATION

Ms. BUCIC. Good morning, Chairman Boxer, members of the Committee, congressional staff and guests. My name is Sarah Bucic, I am a registered nurse with a master's degree in psychiatric mental health. I am currently pursuing a master's in environmental health and will be a clinical instructor in the fall.

I have been a registered nurse for 10 years, practicing in a variety of settings, including inpatient and outpatient mental health, research and geriatrics. It is a privilege to appear before you today on behalf of the American Nurses Association and the Delaware

Nurses Association to discuss the importance of the Clean Air Act, the positive impact it has had on our Nation and the fundamental importance of continuing to support the Act that protects public health.

The ANA is the only full service professional organization representing the interests of the Nation's 3.1 million registered nurses through its State nurses associations, including the Delaware State Nurses Association. Nurses constitute the single largest group of health care workers. And the ANA clearly recognizes the fundamental tie between the quality of our environment and the health of the Nation.

Since the early years of the nursing profession, nursing leaders such as Florence Nightingale and Lillian Wald have recognized the role of nurses in controlling the influence of environmental factors on health. Florence Nightingale herself sated, "Keep the air within as pure as the air without." I too now understand the connection between the environment of our health, having been diagnosed with cancer shortly after the birth of my daughter. Since its initial enactment and subsequent amendments, the Clean Air Act has had a proven track record of success, cost effectively cutting dangerous pollution and positively impacting our environment and health.

The American Lung Association's 2011 State of the Air report shows, despite the Clean Air Act Amendment's successes, we have a long way to go. The American Lung Association's State of the Air report looked at levels of ozone and particulate matter, types of pollution with the most significant known health impacts at monitoring sites across the Country from 2007 to 2009, and it revealed some startling facts.

While the study identified clear improvement in both categories over past years, serious problems remain. More than 154 million people, that is just over half the Nation, endure pollution levels that make the simple act of breathing hazardous to their health. For nurses, these are our patients. They receive Albuterol treatments in the ER, they stay to rest sometimes in the hospital for several days. This is an avoidable consequence of pollution that has a direct impact on people's lives and on our Country's health care costs.

The negative effects of exposure to pollutants are premature death, increased mortality, exacerbation of asthma and more. Approximately 1.2 million children and 3.8 million adults with asthma live in areas with high levels of short-term particulate matter pollution. A bad air day for them isn't just an inconvenience when they have to wait until late at night to go get their gas. A bad air day can mean life or death. A bad air day can keep people from living their lives.

I have a straw here. This is the size when you have an asthma attack. Your throat gets smaller than that. During nursing school, we did an experiment, when we were nursing students. We had to breathe through it and hold our nose for about 30 seconds or a minute, and imagine trying to do any productivity during that. It is very difficult. And I have heard by people with asthma that it is even worse than this, because you actually have less profusion.

Your airway is much smaller than this during an asthma attack. I want to make it clear that asthma isn't a condition where you get

your medication and move on . It can be deadly. According to the National Heart, Lung and Blood Institute and the National Institutes of Health, each day 11 Americans die from asthma. That is 4,000 Americans each year. In addition, individuals need to be seen in the emergency room.

A friend of mine, while driving her son to the emergency room during an asthma attack, had to answer the following question: Mommy, am I going to die? Imagine having to answer and say, no, you can't die from asthma, but in truth, you don't really know. Because this is the reality for asthma patients.

According to the EPA, by 2016, cleaning up toxic emissions from power plants will save 17,000 lives each year, prevent 11,000 heart attacks each year, prevent 110,000 asthma attacks each year, eliminate 12,200 hospitalizations and emergency room visits each year, add 850,000 days when people don't miss work each year. Healthy people means more work days, more productivity.

Human health is linked to our environment. We are all in this together. As nurses, we encourage our patients to make responsible, healthy choices. But this personal responsibility alone only goes so far. We need to have discharge instructions for industry to be as clean as possible. Investments in clean air benefits all of us and will pay dividends in lower health care costs.

The bottom line is pollution creates more patients. We owe it to ourselves and our children to build on the success of the Clean Air Act by supporting life-saving standards under this landmark public heath law. Thank you.

[The prepared statement of Ms. Bucic follows:]

Written Statement of

Sarah Bucic, MSN, RN

On behalf of the

American Nurses Association
and
the Delaware Nurses Association

# "The Clean Air Act and Public Health"

Before the
Committee on Environment and Public Works
U.S. Senate
Washington, DC

June 15, 2011

It is a privilege to appear before you today on behalf of the American Nurses Association and the Delaware Nurses Association to discuss the importance of the Clean Air Act, the positive impact it has had on the health of our nation, and the fundamental importance of continuing to support the Act to further protect public health.

The ANA is the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses through its constituent member nurses associations--including the Delaware State Nurses Association. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

Since the early years of the nursing profession, nursing leaders such as Florence Nightingale and Lillian Wald have recognized the role of nurses in controlling the influence of environmental factors on health. This underpinning of nursing practice was expressed by Florence Nightingale in her First Rule of Nursing: "Keep the air within as pure as the air without" (Nightingale 1859). ANA clearly recognizes the fundamental tie between the quality of our environment and the health of the nation, and I am honored to have the opportunity to appear before you today to discuss that connection.

Since its initial enactment and subsequent amendments, the Clean Air act has had a proven track record of success, cost-effectively cutting dangerous pollution, and positively impacting our environment and our health. According to a March 2011 report by the Environmental Protection Agency's Office of Air and Radiation, under the 1990 Clean Air Act Amendment Programs, the economic value of the substantial air quality improvements that would be realized by the year 2020 is estimated at almost $2 trillion, an amount which vastly exceeds the cost of compliance with the law.

This same report estimates that by 2020 the 1990 Clean Air Act Amendment Programs will have resulted in the prevention of 230,000 deaths, 2,400,000 incidences of asthma exacerbation, 120,000 emergency room visits, 3,200,000 lost school days and 13,000,000 lost work days. These statistics represent not only the Act's impact on health and quality of life, but its value in ensuring economic productivity.

Still, as the findings of the American Lung Association's 2011 *State of the Air* report show, despite these successes, we have a long way to go to ensure that we all have clean air to breathe. The *State of the Air* report looked at levels of ozone and particulate matter —types of pollution with the most significant known health impacts--at monitoring sites across the country from 2007-2009, and it revealed some startling facts. While the study identified clear improvement in both categories over past years, serious problems remain. More than 154 million people, just over half the nation, endure pollution levels that make the simple act of breathing hazardous to their health.

The negative health effects of exposure to these pollutants, including ties to premature death, increased mortality, exacerbation of asthma, increased susceptibility to pulmonary and respiratory infection, and more, are well established. In addition, there is a growing body of evidence that even exposure to lower levels of ozone and particulate matter poses a greater health risk than once thought.

For vulnerable populations—children, the elderly, people with asthma, those with diabetes, cardiovascular disease, or chronic bronchitis and emphysema-- the dangers posed by exposure is even greater. Approximately 3.2 million children and nearly 9.5 million adults with asthma live in parts of the United States with high levels of ozone, 1.2 million children and 3.8 million adults with asthma live in areas with high levels of short-term particulate matter pollution.

For these populations, a bad air day isn't just an inconvenience: a day when they are told not to mow their lawn, or have to wait until dark to fill their gas tank. A bad air day can be life or death. A bad air day can keep them from school, from work, from the grocery store, in short from living life.

Ozone is formed by chemical reactions in the atmosphere between gases that are emitted primarily when fossil fuels are burned. Alarmingly, one of the factors in that reaction is temperature, and as a result, warmer temperatures associated with climate change have the real potential to increase ozone pollution. A June 2011 report from the Union of Concerned

Scientists analyzed the health and economic impact of this climate-related ozone increase, with striking results. The report cites that by 2020, the US could pay an average of $5.4 billion in health impact costs associated with increases in ozone due to climate, and that the resulting higher concentrations of ozone could lead to hospitalization of an average of 3,700 more seniors and 1,400 more infants for respiratory-related problems by that same year.

The American Lung Association gives all three counties in my home state of Delaware an "F" grade placing close to 28,000 pediatric asthma cases at risk. An "F" is given if 9 days are over the ozone standard. There were approximately 3,000 asthma-related hospital admissions involving children through age 9 from 1994-2000 statewide. 46,000 adults are estimated to have asthma; and as many as 72,000 have had asthma at some time during their lives, and a new report on asthma in Delaware estimates that total direct charges for asthma-related health care could be between $25 and $30 million a year.

For nurses, these aren't just numbers, they are our patients. We see them in the emergency room on bad air days, struggling to breathe. They receive their albuterol treatments and stay to rest--sometimes for several days – this is an avoidable consequence of pollution that has a direct impact on individual lives and on our country's health care costs.

To be clear, asthma isn't always a condition where you get your medication and move on. In 2000 and 2001, the most recent years for which data are available, there were 17 deaths per year from asthma in Delaware, a state with less than 1 million people.

Ozone and particulate matter are by no means the only air pollutants that threaten our health. As a psychiatric nurse, I feel obligated to testify to the negative health effects of mercury. The harmful effects of mercury on children's developing brains is well known, as are its effects on memory, attention, language, fine motor and visual spatial skills. In addition, toxic metals such as arsenic, chromium, and nickel can cause cancer. According to the EPA, by 2016, cleaning up toxic emissions from power plants will save 17,000 lives each year, prevent 11,000 heart attacks each year, prevent 110,000 asthma attacks each year, eliminate 12,200 hospitalizations and emergency room visits each year and add 850,000 days when people don't miss work each year.

We encourage our patients to make responsible, healthy choices, but this personal responsibility alone only goes so far. What good is eating fruits and vegetables if they were grown in contaminated soil? What good is exercise if the air in their community is full of pollution? We must hold industry just as accountable as we hold our patients. We need to have "prescription/discharge instructions for industry" to be as clean as possible – investments in clean air benefit all of us and will pay dividends in lower health care costs.

The bottom line is pollution creates more patients. From a nursing perspective, our interventions remain limited if the environment remains polluted. We are fixed in a state of keeping patients with chronic conditions like asthma and other pulmonary and cardiovascular conditions stabilized, when we all know that prevention is the only real, effective and long-term treatment.

Our health is clearly and inextricably linked to the health of our environment, and we owe it to ourselves and our children to build on the success of the Clean Air Act by supporting the life-saving standards advanced under this landmark public health law. We cannot afford to roll back these vital protections, and we must ensure that the standards set for regulating ozone, particulate matter, mercury and other air toxics reflect the best science and truly protect the public.

Respectfully submitted,

Sarah B. Bucic, MSN, RN

Sarah Bucic, MSN, RN

1. Ms. Bucic, as you know, mercury is a toxic heavy metal that is emitted by industrial facilities into the air and can wind up in the food that families eat. Your testimony states: "The harmful effects of mercury on children's developing brains is well known, as are its effects on memory, attention, language, fine motor and visual spatial skills."

   As a nurse, can you describe how these types of effects can harm a child's ability to do normal things that other children take for granted?

   Dear Senator Boxer,

   Thank you for giving me the opportunity to elaborate on this topic. In today's world where there is an increased need for the ability to navigate complex social situations, disruptions, like the ones caused by mercury can affect one's life trajectory greatly.

   Any affect on a child's ability to perform activities of daily living will have ramifications for the person, their family and society as a whole. When a child has problems, like the ones caused by mercury, they need special attention in school from teachers, they require IEPs (individualized education plans), counselors and sometimes require a teacher's aide to help them in the classroom. This creates not only stress for a person, but for a whole family, as families must become experts and advocates for their child's disorder. Parents and caregivers experience more stress, as there are parent teacher meetings, medical evaluations and more money spent on medication and specialists.

   There are also financial costs from these kinds of effects on development. Financial costs are not limited to doctor's appointments and medications. If a child cannot remember things easily or has trouble learning, more time is required of parents and caregivers, sometimes paid caregivers.

   A stressed family system often requires parents and caregivers to leave jobs to take care of children who require 1:1 attention. Families sometimes leave jobs with private insurers and go onto Medicaid as many private insurers have inadequate coverage for mental disorders. In addition, the medical sequelae of having even one medical problem like an attention disorder or language or motor skill deficiency can lead to anxiety disorders and depression in later years and in adult life.

   According to *In Harm's Way* (2000), a report by the Physicians for Social Responsibility of Greater Boston;

   > "the impact of children's developmental disorders on children and families is immense. Parents, teachers, school administrators, and communities spend increasing amounts of time, money, and energy trying to help children acquire skills that once came more naturally.

> Afflicted children risk early school dropout, teen parenting, drug abuse, crime, institutionalization and suicide. A constant, consuming struggle at the verge of failure is known all too well by the children, their families, and providers. "

As a nurse, I have seen mothers stressed to the brink when a child not only *does not* behave but actually *cannot* behave in a manner that is conducive to regular classroom behavior or have normal developmentally appropriate relationships. For a child with attention problems, the act of getting to school on time may take extensive periods of time. These types of events eventually causing increased friction within families and marriages due to the additional responsibilities of caregivers. Memory problems require the family and school support system to have an increased role in directing behaviors of a child to keep them from harm. Delays in learning put children out of sync with their peers emotionally, as their intellectual capacity remains with that of a younger age group. Physical problems can cause problems with sports but even more necessary activities like writing, using computers and driving. These types of experiences have long ranging effects making getting gainful employment difficult once students "age out of the system" at age 18. Families are then left to decide what to do when services, still so much needed cease, as their child becomes an adult. Parents worry who will care for a child or will their child be able to navigate the increasingly competitive complex social world into which they are being thrust. Families with extra money may have the benefit of putting money aside for care of a child with developmental disabilities to be cared for once they are gone. Many families do not have this option.

Schettler T., Stein, J., Reich F., Valenti, M. & Wallinga, D. (2000). *In Harm's Way* http://action.psr.org/site/DocServer/ihwcomplete.pdf?docID=5131

2. Can you take a few moments to discuss further the health impacts of mercury on a developing child's brain? As a psychiatric nurse, what are the health costs associated with a child that has a neurological disorder?

Dear Senator Carper,

Thank you for this question.

As a nurse, it is concerning that environmental standards that are health based almost never consider the effects on children and the fetus. Health based standards are typically set on the basis of preventing adverse health effects in white, adult, mostly healthy, men who weigh about 160 pounds. These individuals have already gone through critical brain development.

Mercury can affect a child's developing brain differently than an adult's brain because children's bodies are already working in distinctly different ways. Children's bodies have mechanisms that make it easier for them to absorb nutrients to help them grow. These same accelerated processes enhance the uptake of unwanted heavy metals, such as mercury.

Some protective mechanisms that are well developed in young adults, like the blood-brain barrier, are immature in young children, making them more vulnerable to toxic chemicals. The nervous system is the most vulnerable during embryonic, fetal and early infant development. This, in addition to the differences in how children metabolize toxicants, can cause different responses in children from exposure to the same toxicant as an adult. The kidneys of newborns and very young children are less effective at filtering out undesirable toxic chemicals, allowing them continued circulation and accumulation. And children's circulation is more rapid, causing increased exposure to individual organs by circulating toxicants.

We know that even before conception, maternal exposures and paternal exposures can play a role in compromising child development. Mercury crosses the placental barrier and can be found in the umbilical cords of those mothers who are exposed. A famous case of mercury reeking havoc on young children occurred in Minimata, Japan in the 1950s. Children of mothers, who consumed fish contaminated with methylmercury discharged from local industry, were being born with an increase in cerebral palsy, mental retardation; diffuse brain atrophy and visual field deficits. Mothers seemed significantly less effected than their children indicating that the methylmercury interfered with critical developmental stages.
(Sattler & Lipscomb, 2003)

According to the U.S. Geological Survey (2000), "although its potential for toxicity in highly contaminated areas such as Minamata Bay, Japan, in the 1950's and 1960's, is well documented, research has shown that mercury can be a threat to the health of people and wildlife in many environments that are not obviously polluted...Eating contaminated fish and wildlife exposes people and fish-eating wildlife to the most toxic form of mercury,

methylmercury...methylmercury is the most toxic form. It affects the immune system, alters genetic and enzyme systems, and damages the nervous system, including coordination and the senses of touch, taste, and sight. Methylmercury is particularly damaging to developing embryos, which are five to ten times more sensitive than adults."

There are health costs to society, which can be quantified depending on the particular disorder (however, many times people have more than just one neurological disorder, such as having a neurological disorder such as seizures in addition to having a psychiatric diagnosis such as schizophrenia). But there are also less recognized costs to families as a whole. These health costs related to psychiatric diagnosis are virtually immeasurable as they affect essentially eradicating one's ability to function at one's highest level. To quote the Surgeon General's Report on Mental Health:

"The costs of mental illness are exceedingly high...The direct costs of mental health services in the United States in 1996 totaled $69.0 billion. This figure represents 7.3 percent of total health spending [This does not include Alzheimer's Disease or substance abuse treatment]... Direct costs correspond to spending for treatment and rehabilitation nationwide. When economists calculate the costs of an illness, they also strive to identify indirect costs. Indirect costs can be defined in different ways, but here they refer to lost productivity at the workplace, school, and home due to premature death or disability. The indirect costs of mental illness were estimated in 1990 at $78.6 billion...More than 80 percent of these costs stemmed from disability rather than death because mortality from mental disorders is relatively low." (U.S. Department of Health & Human Services, 1999)

In a study by Hylander & Goodsite (2006), they calculated health costs due to loss of intelligence caused by excessive prenatal exposure to methylmercury. The calculated loss of one IQ point corresponded to a 2.578% decrease in lifetime expected earnings. In another study by Trasande, Landrigan & Schecter (2005), findings showed that lost productivity associated with methylmercury toxicity in the U.S. amounts to about $8.7 billion a year, with $1.3 billion being attributable to mercury emissions from coal-fired power plants.

As a psychiatric nurse, I see the largest and most hidden costs, not as financial, but as a personal cost paid by the individual patient, so that others can reduce their costs in adapting technology to more strict standards. I have tried to list some costs here, but you cannot put a financial price on spending time inpatient on a hospital unit rather than being at home with your family. It is difficult, if not impossible, to put a financial price on spending afternoons at a doctor's office instead of afterschool activities. I have no idea how to put a financial price to the added family stress of having a child with a disability. Because mercury affects intelligence, attention, language, memory and motor

skills – all things required to function in society and work at most jobs, many measures of underemployment, unemployment, and long-term disability can all reflect the type of health costs we see with mercury related neuro-psychiatric disorders. And the bottom-line with these costs? Any disability related to mercury is entirely preventable. Decreasing any current exposure helps current and future generations.

Davies, K. (2005). How much do environmental diseases and disabilities cost? *Northwest Public Health*, University of Washington School of Public Health & Community Medicine, WF5 1-3.

Hylander, L.D., & Goodsite, M.E. (2006). Environmental Costs of Mercury Pollution, *Science of the total environment, 368*, p. 352-370.

Sattler, B. & Lipscomb J. (2003). *Environmental health and nursing practice: Children's environmental health.* Springer Publishing Company, New York, NY.

Trasande, L., Landrigan, P.J., & Schecter, C. (2005). Public health and economic consequences of methyl mercury toxicity to the developing brain, *Environmental Health Perspectives, 113*, p. 590-596.

U.S. Department of Health and Human Services. *Mental health: A report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

U.S. Geological Survey, (October, 2000). *Mercury in the environment, Fact sheet 146-00*, http://www.usgs.gov/themes/factsheet/146-00/

Senator BOXER. Thank you so much.

Dr. Paulson, welcome. American Academy of Pediatrics.

**STATEMENT OF JEROME A. PAULSON, M.D., FAAP, AMERICAN ACADEMY OF PEDIATRICS**

Dr. PAULSON. Thank you. Good morning, Madam Chair and members of the Committee.

I am Jerome Paulson, and I am proud to represent the American Academy of Pediatrics at this hearing regarding the Clean Air Act and public health.

In the last 40 years, the Clean Air Act has led to incredible improvements in the environment, in the health of infants and children and in the quality of life for all Americans. However, the impacts of the Clean Air Act have not been uniform across the Country. Millions of Americans still live in areas where monitored air fails to meet EPA standards for at least one of six criteria pollutants and in some areas, air quality has actually decreased.

Since the Clean Air Act was enacted, scientific research on air pollution has shown that the serious health effects of air pollutants are experienced at levels much lower than were previously considered safe, and has consistently proven that reducing exposure to air pollution leads to healthier individuals. The American Academy of Pediatrics believes it is necessary for Congress to strengthen the Clean Air Act, and the EPA's authority to set, implement and enforce Clean Air Act regulations throughout the Country.

As a pediatrician who has cared for children suffering from the health impacts of air pollution, I am incredibly concerned about potential threats to clean air and the effects of air pollution on children's heath. Children are disproportionately vulnerable to all environmental exposures. But as it relates to the air, they breathe more air in and out of their lungs every minute. They have higher levels of physical activity. They spend more time outdoors, and they also have proportionately greater skin surface exposed to the environment.

Children are also more impacted by air pollution due to their extensive lung growth and development after birth. Eighty percent of the air sacs in the lung where oxygen is absorbed and carbon dioxide is released are formed after birth. And changes in the lungs continue through adolescence until children reach their adult height. Air pollution is associated with impaired lung growth that may have permanent, lifelong impacts on an individual's ability to breathe.

Ambient air pollution has also been linked to sudden infant death syndrome, and mortality due to respiratory disease in normal birth weight infants. Children with underlying or chronic respiratory disease are even more susceptible to the adverse effects of air pollution. For children with asthma, the most common chronic disease in childhood, ozone levels below current EPA standards are associated with increased respiratory symptoms and the need for rescue medication.

According to the EPA's recent report, the benefits and costs of the Clean Air Act from 1990 to 2020, the Clean Air Act requirements will cost about $65 billion per year, but the benefits are projected at $2 trillion per year, most of which is saved through re-

duced morbidity and mortality. As a pediatrician, the Clean Air Act is a tremendous cost savings representing not just economics, they represent children, fewer children suffering from asthma attacks, fewer hospitalizations, less respiratory tract illness, improved lung capacity and function for growing children and healthier infants and newborns. Treating chronic conditions that are created or exacerbated by air pollution is currently expensive to our public and private health sectors. And the costs continue to increase.

At a time when lawmakers and we as a Nation are focused on trying to control costs, controlling air pollution may be part of the answer to that problem. The American Academy of Pediatrics recommends in the strongest terms that the Clean Air Act should not be weakened in any way that decreases the protection of children's health. Weakening standards now will almost certainly result in increased emergency room visits and hospital admissions, increased direct costs and increased indirect costs. Air quality standards should ensure the most vulnerable groups are protected, potential effects of air pollution on the fetus, infant and child should be evaluated and all standards should include a margin of safety for protection of children.

If we fail to protect children against air pollution, we accept the cost of living with and treating preventable birth defects, chronic diseases and disability among our Nation's infants and children.

In conclusion, the American Academy of Pediatrics commends you, Madam Chairwoman, for holding this hearing today to call attention to the public health impacts of the Clean Air Act. We look forward to working with you to continue to improve air quality and children's health throughout the Country. I appreciate this opportunity to testify and I will be pleased to answer any questions.

[The prepared statement of Dr. Paulson follows:]

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Wednesday, June 15, 2011

Testimony of
**Jerome A. Paulson, MD, FAAP**

On behalf of the
**American Academy of Pediatrics**

**Senate Environment and Public Works Committee hearing:**
**"The Clean Air Act and Public Health"**

**American Academy of Pediatrics • Department of Federal Affairs**
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**Jerome A. Paulson, MD, FAAP**
American Academy of Pediatrics
"Clean Air and Public Health"
Wednesday, June 15, 2011

Good morning. I appreciate this opportunity to testify today before the Committee on Environment and Public Works regarding the Clean Air Act and public health. My name is Jerome A. Paulson, MD, FAAP, and I am proud to represent the American Academy of Pediatrics (AAP), a non-profit professional organization of more than 60,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults. I am the incoming chair of the AAP's Council on Environmental Health, and I direct the Mid-Atlantic Center for Children's Health & the Environment, one of ten Pediatric Environmental Health Specialty Units (PEHSU) in the United States, based at Children's National Medical Center here in Washington, D.C.

It has been more than 40 years since the Congress first passed the Clean Air Act, which, for the first time, gave the Environmental Protection Agency (EPA) the authority to enforce regulations to limit air pollution. Since the Clean Air Act was enacted, we have learned much about the relationship between air pollution and health through thousands of epidemiologic and controlled studies. The Clean Air Act has made incredible improvements in the environment, in the health of infants and children, and in the quality of life for all Americans. However, the impacts of the Clean Air Act have not been universally felt. Air quality in some areas of the United States has improved, but in some areas it has actually decreased, and millions of Americans still live in areas where monitored air fails to meet EPA standards for at least one of six criteria pollutants. In addition, in the last 40 years, we have learned that serious health effects of air pollutants are experienced at levels much lower than previously considered "safe" levels of exposure,

particularly for vulnerable populations such as infants, children, the elderly, and individuals with respiratory diseases.

There is overwhelming evidence linking air pollution with a variety of adverse health outcomes. The AAP believes it is necessary for Congress to strengthen the Clean Air Act and the EPA's ability and authority to set, implement, and enforce Clean Air Act regulations throughout the country. Congress must not weaken or restrict these efforts. As a pediatrician who has cared for children suffering from the health impacts of air pollution, I am incredibly concerned about threats to clean air and the effect of air pollution on children's health.

**Children are Disproportionately Impacted by Air Pollution**

All aspects of the environment have especially profound effects on children's health. Children are disproportionately vulnerable to all environmental exposures; they breathe faster than adults, spend more time outside, and have proportionately greater skin surface exposed to the environment. A given dose of a pollutant will have a greater impact on a child than on an adult not only due to their smaller size, but because of the nature of their growing bodies and minds. At sensitive points in child development, environmental exposures can have especially harmful effects.

Infants and children are among the most susceptible to the adverse effects of ambient air pollution and are far more vulnerable compared to adults for a number of health and developmental reasons. First, children are more greatly impacted by air pollution due to their

**Jerome A. Paulson, MD, FAAP**
American Academy of Pediatrics


extensive lung growth and development after birth. Eighty percent of alveoli (the part of the lungs where oxygen is absorbed and carbon dioxide is released from the blood) are formed postnatally, and the developing lung is highly susceptible to damage from environmental toxicant exposure during the early post-neonatal period.[1, 2, 3] Changes in the lungs continue through adolescence as respiratory cells actively proliferate and differentiate during this period of increased growth and development, creating increased susceptibility to the harmful effects of air pollution's chemicals and particulates.

Children also have increased exposure to many air pollutants compared with adults because of their higher minute ventilation (the amount of air breathed in or out of the lungs per minute), higher levels of physical activity, and because they spend more time outdoors. [4, 5, 6] Children in communities with higher levels of urban air pollution and children who spend more time outdoors are likely to have decreased lung function and growth. In addition to the increase in short-term respiratory symptoms, long-term exposure to air pollution may have lifelong consequences for children. In fact, air pollution is associated with impaired lung growth that may have permanent, lifelong impacts on an individual's ability to breathe. [7, 8] These impacts can have health consequences and impose increased health costs across the lifespan.

Ambient air pollution has been associated with several adverse birth outcomes. Air pollution has been linked to sudden infant death syndrome and mortality due to respiratory disease in normal birth weight infants,[9] with one study demonstrating that nearly one-quarter of deaths were attributable to elevated particulate matter.[10]

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Because the lung is in direct contact with the air, children with underlying or chronic respiratory diseases are even more susceptible to the adverse effects of air pollution. In individuals with cystic fibrosis, elevated levels of particulate matter and ozone are associated with an increased risk of exacerbations and decline in lung function. For children with asthma, the most common chronic disease in childhood, ozone levels—even those below current EPA standards—are associated with increased respiratory symptoms and the need for rescue medication. School absences, emergency room visits, and hospital admissions are all directly associated with ambient air pollution. In a prospective cohort of children living in southern California, children with asthma living in communities with increased levels of air pollution (especially particulates, nitrogen dioxide, and acid vapor) were more likely to have bronchitis symptoms. The same mix of air pollutants was also associated with deficits in lung growth (as measured by lung function tests).

**Impacts of Specific Air Pollutants on Children's Health**

The scientific research on air pollution and its impacts on child health is comprehensive and has consistently proven over the past four decades that reducing exposure to toxicants and particulates in the air leads to healthier individuals. The following list of air pollutants have all been proven to have significant impacts on child health, and Congress and the Administration should take every effort to reduce their emissions and prevalence in the environment. It is also important to note that air pollutants never occur alone or in isolation from one another. Air pollutants occur in mixtures with different concentrations in different geographic areas

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throughout the United States. Air pollutants interact with each other in the environment in different and sometimes exacerbating ways and it is less clear how pollutants interact once they enter the human body. In order to promote child health, it is necessary to address air pollutants as a whole and not take a piecemeal approach in addressing these environmental and health hazards.

**Mercury:** Coal fired power plants are the largest human-caused source of mercury emissions in the United States. Power plants that burn fossil fuels release mercury into the air, which then deposits in water, where living organisms convert it to methylmercury. Mercury emissions from power plants are of particular concern because mercury settles in our waterways and then accumulates in fish that are consumed by humans.

Methylmercury consumed through seafood is toxic to the developing brain of the fetus and young child. The damage it causes is permanent and irreversible. In studies of areas with high exposures to mercury outside of the United States, mothers gave birth to infants who initially appeared normal, but who went on to develop problems such as blindness, deafness, and seizures. In utero exposure to lower levels of mercury has been associated with more subtle effects on memory, attention, and language. The developing fetus and young children are disproportionately affected by methylmercury exposure, because many aspects of development, particularly brain maturation, can be disturbed by the presence of methylmercury. Minimizing mercury exposure is essential to optimal child health.

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**Ozone:** Ozone is a powerful oxidant and respiratory tract irritant in adults and children, causing shortness of breath, chest pain when inhaling deeply, wheezing, and cough.[11] Children have decreases in lung function, increased respiratory tract symptoms, and asthma exacerbations on days with higher levels of ambient ozone. [12, 13, 14, 15] Increases in ambient ozone have been associated with respiratory or asthma hospitalizations, [16, 17]emergency department visits for asthma, and school absences for respiratory tract illness.[18] In Atlanta, Georgia, summertime children's emergency department visits for asthma increased 37% after six days when ozone levels exceeded 0.11 ppm.[19] In southern California, school absences for respiratory tract illness increased 63% in association with a 0.02-ppm increase in ozone.[20]

Ozone may be toxic at concentrations lower than 0.075 ppm, the current federal regulatory standard. Field studies suggest potential thresholds of as low as 0.04 ppm (one-hour average) for effects on lung function.[21, 22, 23] Studies of hospitalizations for respiratory tract illness in young children and emergency department visits for asthma suggest that the effects of ozone may occur at ambient concentrations below 0.09 ppm.[24, 25] In addition to studies on short-term effects, two studies of college freshmen suggest that increasing cumulative childhood exposure to ozone may affect lung function when exposed children reach young adulthood, particularly in measures of flow in small airways.[26, 27] Early childhood exposures may, therefore, be particularly important.

**Particulate Matter:** In children, particulate pollution affects lung function[28, 29, 30] and lung growth.[31] Recent studies in different countries have also found associations between ambient air pollution (especially particulates and/or carbon monoxide) and preterm birth,[32,33, 34, 35] low birth

weight, and post-neonatal infant mortality (attributable to respiratory causes and possibly sudden infant death syndrome).[36,37]

Particle pollution contributes to excess mortality and hospitalizations for cardiac and respiratory tract disease. The mechanism for particulate matter–associated cardiac effects in adults may be related to disturbances in the cardiac autonomic nervous system, cardiac arrhythmias, or increased blood concentrations of markers of cardiovascular risk.[38,39] Daily changes in mortality rates and numbers of people hospitalized are linked to changes in particulate air pollution.[40,41,42,43] These studies and others have estimated that for every 10 microg/$m^3$ increase in PM10, there is an increase in the daily mortality rate between 0.5% and 1.6%.

**Nitrogen Dioxide:** Controlled-exposure studies of people with asthma have found that short-term exposures (30 minutes) to nitrogen dioxide at concentrations as low as 0.26 ppm can increase the allergic response after subsequent challenge with allergens.[44, 45] These findings are of concern, because some urban communities that are in compliance with the federal standards for nitrogen dioxide (annual average) may experience substantial short-term peak concentrations (one-hour average) that exceed 0.25 ppm. Epidemiologic studies have reported relationships between increased ambient nitrogen dioxide and risks of respiratory tract symptoms[46, 47]and asthma exacerbations.[48]

**Traffic-Related Pollution:** Motor vehicles represent the principal source of air pollution in many communities, and concentrations of traffic pollutants are greater near major roads.

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Increased respiratory tract complications in children (e.g., wheezing, chronic productive cough, and asthma hospitalizations) have been associated with residence near areas of high traffic density, particularly truck traffic.[49, 50, 51, 52] Other investigators have linked various childhood cancers to proximity to traffic.[53, 54, 55]

Diesel exhaust, a known carcinogen and respiratory tract irritant as well as a source of fine particulate matter, is a particular concern for children. On the basis of extensive toxicologic and epidemiologic evidence, national and international health authorities, including the EPA and the International Agency for Research on Cancer, have concluded that there is considerable evidence of an association between exposure to diesel exhaust and an increased risk of lung cancer.[56, 57] Additionally, fine particles in diesel exhaust may enhance allergic and inflammatory responses to antigen challenge and may facilitate development of new allergies or worsen symptoms in individuals with allergic rhinitis or asthma.[58, 59]

School buses operate in close proximity to children, and most of the nation's school bus fleets run on diesel fuel. The EPA and some state agencies are establishing programs to eliminate unnecessary school bus idling and to promote use of cleaner buses to decrease children's exposures to diesel exhaust and the amount of air pollution created by diesel school buses (www.epa.gov/cleanschoolbus). One recent study found that a child riding inside a school bus may be exposed to as much as four times the level of diesel exhaust as someone riding in a car.[60] These findings underscore the need for increased regulation of diesel emissions, especially in areas where children congregate, such as school buses. The EPA should be encouraged to

continue to work with school districts to replace or retrofit diesel buses with pollution-reducing devices and limit school bus idling where children congregate.

**Indoor Air Pollutants:** Secondhand smoke is among the most harmful and common indoor dangers to children. According to the 2006 Report of the Surgeon General almost 60 percent of children aged 3-11 years are exposed to secondhand smoke. These children are at increased risk for multiple serious health effects like asthma, respiratory infections, decreased lung growth and exercise tolerance, and sudden infant death syndrome. This exposure is most dangerous for the youngest children because their lungs are not fully developed and they often spend time in close proximity to their parents who smoke. Other effects of secondhand smoking may include childhood cancer, childhood leukemia, childhood lymphomas, and childhood brain tumors. Smoking and exposure to secondhand smoke among pregnant women contributes to low birth-weight babies, preterm delivery, perinatal deaths, and sudden infant death syndrome. Well over 30,000 births per year in the U.S. are affected by one or more of these problems.

**Other Air Pollutants:** Airborne levels of lead, sulfur dioxide, and carbon monoxide have decreased dramatically over the past 40 years because of the implementation of the Clean Air Act. However, levels of these pollutants may still be high near major sources. For example, high lead levels may be found near metals-processing industries, high sulfur dioxide levels may occur near large industrial facilities (especially coal-fired power plants), and high levels of carbon monoxide may occur in areas with heavy traffic congestion.[61]

In addition to criteria air pollutants, there are numerous other air pollutants produced by motor vehicles, industrial facilities, residential wood combustion, agricultural burning, and other sources that are hazardous to children. More than 80,000 chemicals are used commercially, and many are released into the air. For most of these chemicals, data on toxicity are sparse.[62] Some pollutants remain airborne or react in the atmosphere to produce other harmful substances. Other air pollutants deposit into and contaminate land and water.

**The Clean Air Act and Health Care Costs**

As a pediatrician, I know that preventive health care is a fundamental investment in the health of all children and preventive health care at a young age can have lifelong impacts. Healthy children are far more likely to grow up into healthy adults. Conversely, children who experience poor health are more likely to suffer from ill health in adulthood. Inadequate attention to preventive health care mortgages the future health and welfare not only of children, but of society itself. Research across a broad range of interventions has shown that preventive health and wellness for children consistently produces a high return on investment. Ensuring that children breathe air that is free of chemicals and pollutants is an extremely effective and economical intervention for promoting lifelong health and reducing long term health costs.

According to the EPA's recent report "The Benefits and Costs of the Clean Air Act from 1990 to 2020," in 2010, the Clean Air Act prevented 160,000 cases of premature adult mortality, 230 cases of infant mortality, 130,000 heart attacks, 3.2 million lost school days, 86,000 emergency

department visits, and 1.7 million asthma attacks. These health quality measures and lives saved are expected to continue to improve significantly over the next decade.

According to the EPA's report, complying with the Clean Air Act will cost about $65 billion per year, but the benefits are projected at $2 trillion per year, most of which is saved through reduced morbidity and mortality. As a pediatrician, the Clean Air Act's tremendous cost savings represent not just economics, they represent children: fewer children suffering from asthma attacks, fewer hospitalizations, less respiratory tract illnesses, improved lung capacity and function for growing children, and healthier infants and newborns. Treating chronic conditions that are created or exacerbated by air pollution is currently expensive to our public and private sectors, and health care costs will continue to increase each year. At a time when lawmakers are intensely focused on reducing health care costs, expanding efforts to regulate and limit air pollutants could prove to be a successful and effective tool in accomplishing this goal.

**AAP Recommendations**

The AAP recommends in the strongest terms possible that the Clean Air Act should not be weakened in any way that decreases the protection of children's health. Weakening standards now will almost certainly result in increased emergency room visits and hospital admissions for children with respiratory issues, resulting in increased direct costs for medical care, and increased indirect costs from lost productivity due to missed school and work. Weakening standards now will almost certainly result in adults with increased chronic lung disease as they age.

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Air quality standards should be drafted or revised to ensure that the most vulnerable groups are protected. Potential effects of air pollution on the fetus, infant, and child should be evaluated and all standards should include a margin of safety for protection of children. Congress and the Administration must keep these principles in mind when considering any changes or modifications to the Clean Air Act. If we fail to protect children against air pollution, we accept the cost of living with and treating preventable birth defects, chronic diseases, and disability among our nation's infants and children. If we fail to protect children against air pollution, we also accept the cost of permanently reduced lung capacity and productivity in adults.

In addition, the American Academy of Pediatrics submits the following recommendations to the Committee, which we believe will lead to cleaner air and better health for all American infants, children, and families:

Children's exposure to diesel exhaust particles should be decreased. Idling of diesel vehicles in places where children live and congregate should be minimized. Ongoing programs to fund conversion of diesel school bus fleets to cleaner alternative fuels and technologies should be pursued and supported.

Federal and state governments' policies should encourage reductions in mobile and stationary sources of air pollution, including increased support for mass transit, carpooling, retiring or retrofitting old power plants that do not meet current pollution-control standards, and programs

that support marked improvements in fuel emissions of gasoline- and diesel-powered vehicles. Additionally, the development of alternative fuel fleets, low-sulfur diesel, and other "low-emission" strategies should be promoted. Before promoting new alternative fuels, these alternative fuel sources should be critically evaluated and determined by governmental authorities to have a good safety profile.

EPA should increase funding for Pediatric Environmental Health Specialty Units. Pediatric Environmental Health Specialty Units serve a vital function in providing each of the ten EPA regions with direct access to pediatric environmental health experts. The PEHSUs could be directed to use a portion of this funding to increase the education of health and education professionals and others about air pollution and the impact of those pollutants on the health of children.

In conclusion, the American Academy of Pediatrics commends you, Madame Chairwoman, for holding this hearing today to call attention to the public health impacts of the Clean Air Act. We look forward to working with you to continue to improve air quality and children's health throughout the country. I appreciate this opportunity to testify, and I will be pleased to answer any questions you may have.

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August 17, 2011

The Honorable Barbara Boxer
Chairman
Senate Committee on Environment and Public Works
410 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Boxer:

The American Academy of Pediatrics (AAP) appreciates this opportunity to answer your additional questions and Sen. Tom Carper's additional question in response to my testimony at the Senate Environment and Public Works Committee hearing, "The Clean Air Act and Public Health," on June 15, 2011.

**Chairman Boxer:**
*1. Dr. Paulson, you have testified that infants and children are especially vulnerable to the impacts of mercury and that "minimizing mercury exposure is essential to optimal child health." Can you please describe the types of well-established health impacts that mercury exposure can cause in infants and children?*

Coal fired power plants are the largest human-caused source of mercury emissions in the United States. Power plants that burn fossil fuels release mercury into the air, which then deposits in water, where living organisms such as fish, convert it to methylmercury. When humans consume these fish, the methylmercury is absorbed into the body. In order to prevent the human health impacts of mercury, it must be controlled at the source.

Mercury is a neurotoxin; i.e. mercury causes brain damage. The developing fetus and young children are disproportionately affected by methylmercury exposure, because many aspects of development, particularly brain maturation, can be disturbed by the presence of methylmercury. The impact of mercury exposure at commonly observed levels generally results in only subtle impacts on individual children. However, and very importantly, the impact of even low mercury exposures across society results in very significant population-wide decreases in IQ and other neurocognitive problems. In utero exposure to low levels of mercury has been associated with subtle effects on memory, attention, and language. The damage mercury causes on an infant or child's development is permanent and irreversible. There is no treatment for brain damage among children who have been exposed to mercury. Minimizing mercury exposure is essential to optimal child health.

*2. Dr. Paulson, your testimony states that even low levels of smog ("ozone") can trigger "respiratory symptoms and the need for rescue medication" in children with asthma. Can you please explain the types of symptoms that can occur, and the types of medical attention that such children need in response to this type of dangerous air pollution?*

Inhaling ozone causes a chemical burn inside the lungs, resulting in irritation of the bronchial tree. Even in otherwise healthy individuals, this irritation can result in chest discomfort and cough, as well as a measurable decrease in pulmonary function. Asthma is the most common childhood chronic illness. Among these children, ozone exposure can provoke an asthma attack, consisting of wheezing, coughing, shortness of breath, and chest tightness, pain or pressure. For many children, these symptoms last a relatively short time and are relieved by the use of a rescue inhale. However, some children may experiences much more severe asthma attacks that necessitate emergency medical attention. As I stated in my testimony, there is a direct correlation between elevated levels of ozone in the atmosphere and increased visits to hospital emergency departments due to asthma attacks.

*3. Dr. Paulson, you have testified about the harmful effects of air pollution to children's health. What is the science telling us about whether these health effects can have long-term impacts on our children's mental and physical development?*

It is very clear from a number of research studies that long-term exposure to air pollution can decrease the growth of a child's lungs. While this decrease is permanent, it may not cause obvious symptoms in childhood, but instead may only manifest itself as the child grows into adulthood. Every adult experiences a decrease in lung function as he or she ages. If an individual has a smaller set of lungs in early adulthood as a result of air pollution exposure during childhood, then this individual will be at greater risk of a number of serious, chronic pulmonary problems as he or she ages, including chronic obstructive pulmonary disease (COPD, also known as emphysema), and others.

**Senator Thomas R. Carper:**
*1. Can you take a few moments to describe why do you think children's lung function and growth can be stunted by spending long periods of time in high levels of pollution?*

There is a large body of evidence linking impaired lung growth with exposure to high levels of air pollution. Most of this research consists of longitudinal studies performed in Southern California. This research shows that children growing up in an area of higher pollution will have smaller lungs when they are finished growing. In early adulthood, this smaller lung capacity and function is not so severe as to cause symptoms. However, the concern is that individuals with decreased lung function in early adulthood are more likely to develop chronic lung problems as they age.

Again, thank you for providing the opportunity to respond to your questions. Please do not hesitate to call upon the AAP whenever we may be of assistance on children's health issues.

Sincerely,
Jerome A. Paulson, MD FAAP

1. *In your testimony, you mention that your company has several coal-fired units that are currently not being scrubbed and therefore may have to close down or switch to natural gas if possible due to the air toxics regulations. A few of these sites, Carbon Units 1 and 2 and Dave Johnston Units 1 and 2 are also mentioned in your testimony as having been installed on or before 1960 - making these plants 50 years old. How efficient are these coal plants today if they are running on 50 year-old technology? When is it time to retrofit or retire these really old, dirty facilities? How does $4 natural gas influence your company's decisions on coal retirements?*

**Response to Question 1:** MidAmerican operates its electricity generating fleet, regardless of fuel source, in a manner that provides low cost electricity to its customers and achieves compliance, including environmental compliance, with all applicable laws and regulations. MidAmerican does not determine the value of a generating unit based on its age. In determining whether a facility should be retired or repowered, several factors are considered, including, but not limited to: whether it is possible to install controls to meet new environmental requirements; the cost of installing available controls in comparison to alternatives such as fuel switching and/or replacement generation (with market purchases or new facilities); and other key factors such as transmission capacity associated with procurement of alternative generation options. In certain circumstances, it is not feasible to shut down a unit without implementing major transmission upgrades which are costly and time consuming. An older generating unit will be retired when it makes economic sense to do so.

Expected natural gas prices over the life of a repowered unit or a new natural gas unit is an important consideration – but not the only one – when judging whether it makes economic sense to retire or repower an older coal unit. In general terms, the fuel costs of a combined cycle natural gas unit will overwhelm capital cost competitiveness when compared to a retrofitted coal fueled facility. At current prices, natural gas on a dollars per million Btu basis is approximately triple the cost of coal; and even when considering efficiency differences, the cost of electricity generated by an emission controlled coal fuelled facility will be significantly less than the cost of electricity from a new combined cycle unit.

MidAmerican's PacifiCorp utility undertakes an Integrated Resource Plan process that considers a variety of factors that influence generation resource decisions. PacifiCorp's most recent IRP[1] acknowledges the recent decline in natural gas prices, largely driven by the unprecedented and unexpected burst of growth from unconventional domestic supplies across the lower 48 states, primarily due to the rapid advancements in horizontal drilling and hydraulic fracturing technologies.

MidAmerican is currently evaluating its smaller coal-fueled units to determine whether environmental regulatory compliance can be maintained with the use of dry sorbent injection or other emerging low-cost technology solutions. If not, repowering to natural gas may be an option depending on overall repowering costs; access to natural gas at the site; and the price for natural gas over time when compared to wholesale power prices, customer energy efficiency programs,

[1] See "PacifiCorp 2011 Integrated Resource Plan (Volume 1)", pages 26-29. Available online at: http://www.pacificorp.com/content/dam/pacificorp/doc/Energy_Sources/Integrated_Resource_Plan/2011IRP/2011IRP-MainDocFinal_Vol1-FINAL.pdf

or new build options. Transmission constraints will be a significant factor in the ability to consider unit shutdowns.

2. *Can you tell me how many of your coal plants were built prior to the 1970 Clean Air Act Amendments? How about prior to the 1990 Clean Air Act Amendments?*

**Response to Question 2:** Figure 3 "Overview of MidAmerican's Environmental Control Projects" (at the end of Ms. Woollums' testimony) provides a column with the calendar year each coal unit was installed. Twelve units (out of thirty-seven) were installed prior to 1970. Thirty-six units (out of thirty-seven) were installed prior to 1990.

Senator BOXER. Thank you, Doctor.

Next we will hear from, again, Dr. Harvey Brenner, his opening statement.

**STATEMENT OF M. HARVEY BRENNER, PH.D., PROFESSOR, SOCIAL AND BEHAVIORAL SCIENCES, UNIVERSITY OF NORTH TEXAS**

Mr. BRENNER. Again, thank you, Madam Chairman. It is truly a great honor to be in this house and to be addressed by you.

Senator BOXER. Well, thank you.

Mr. BRENNER. Epidemiological studies on the effect of environment and occupational toxins on health have been done for a long time. As we have heard testimony and as is well known in the field, there are certainly significant health effects, particularly in areas of lung disease and cardiopulmonary effects and asthma.

But we have had no estimates on the potential effect on health of highly stringent regulation or on losses of income and employment in the industries affected. Interestingly, as I will show, we do have studies at the national level on the effect of income loss and unemployment on health, but almost none for environmental risks. In a word, we do not know at this point what the effect of environmental risks are at the national level.

In fact, income per capita for a society is the single most important factor influencing mortality throughout the world and especially in industrialized countries like the United States. In industrialized countries, we know that the higher the level of income of individuals, the lower the illness and morality rates attributed to the great majority of infections, chronic diseases and mental disturbances.

Moving from the individual to the National level, however, real GDP per capita indicates the availability of basic goods and services, nutrition, potable water, sanitary engineering, housing and other means of climate control, transportation and primary care. At the national level, real GDP per capita, especially for industrialized societies, also conveys the capacity of the society to invest in the development of science and technology, improved working conditions at higher technological levels of safety and health, financing of education at all levels, stabilization of the income of individuals and small businesses, and the many types of social protection, unemployment insurance, active labor market policies, health insurance, disability issuance, social welfare payments, to impoverishment and frail populations and children, social security and retirement benefits.

To the point, again, Madam Chairman, that you raised on the relation between economic growth and cleaner air, there is a real relationship, as you say, there is no disagreement on the relationship in our Country in particular between economic growth and cleaner air. The question is, why is that true? It is true because that GDP allows us to invest in the technology which provides the clean air. So in the first instance, it is the bolstering of the GDP that allows any of this to happen, and of course, allows implementation of the regulations put forward.

Second, the unemployment rate is well established as a risk factor for elevated illness and mortality rates in epidemiological stud-

ies performed since the 1980's. In addition to influences on mental disorders, suicide and alcohol abuse and alcoholism, unemployment is also an important risk factor in cardiovascular disease and overall decreases in life expectancy.

Subsequent studies of historical change in unemployment and mortality rates, especially cardiovascular in other European and western countries supported the early United States and British studies. These countries included France, Germany, Italy, Belgium, Netherlands, Finland, Sweden, Japan, Australia and New Zealand.

At this point, I would like to just make reference to the chart over there. This is a study during the year 2005. You can see in two-letter acronyms the relationship between mortality rates, which are at the very top, as you see, this little RU for Russia, and close to the bottom we see Japan with the highest life expectancy in the world. The Untied States is somewhere close to Japan. I wish it were a little closer.

But in any case, the two major predictors of life expectancy here are the gross domestic product and employment, especially labor force participation.

Next slide, please.

[Slide shown.]

Dr. BRENNER. This is the same picture, but now I have these little circles, where you can see the Roman numerals I, II and III. The countries in the III level are the countries with the lowest level of income. And we have Russia, Moldavia, Ukraine. And down at the bottom, we have the western countries with the highest levels of income in the world with the highest level of expectancy in the world.

Next slide, please.

[Slide shown.]

Dr. BRENNER. This is the same sort of picture. This time we have 40 countries. And this is the year 2008. This is the year of the great recession, the initial year. And you can see the connection between the two, the lineup of the countries along a 45 degree line is very, very tight. This means a very, very high degree of predictability. In fact, we can account for over 90 percent of life expectancy among all of our different countries in the western world and in Europe, based largely on GDP and factors like employment.

The final implications, the conclusion of this is, there is no doubt in anyone's mind that regulation of the environment is fundamental to health. There is no doubt in anyone's mind. The question only is the degree to which the regulations should be ahead of or behind the level of technology and income that the society holds.

I think you were perfectly right in your initial comments of the need to bring the two sides together. When we have the research that will concentrate on the income and employment side, I think we can actually do that and do not just cost benefit analyses but cost effective analyses as we taught them where the ultimate objective is health. Thank you.

[The prepared statement of Dr. Brenner follows:]

# Major Factors in the Prediction of National Life Expectancy: GDP and Unemployment

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**Testimony before the United States Senate**
**Committee on Environment and Public Works**
**Washington, D.C.**
**June 15, 2011**

**Major Factors in the Prediction of National Life Expectancy: GDP and Unemployment**

*1. Income*

At the individual level of analysis – i.e., in epidemiological studies – individual income is a standard and fundamental inverse predictor of illness and early mortality (Andersen, Gamborg, Osler, Prescott, Diderichsen' 2005; Ecob, Davey Smith, 1999; Ettner, 1996; Kahn, Wise, Kennedy, Kawachi, 2000; Kivimäki, Shipley, Ferrie et al., 2008; Lynch, Smith, Kaplan, House, 2000). In industrialized countries, the higher the level of income of individuals, the lower the illness and mortality rates attributed to the great majority of infections, chronic diseases and mental disturbances. In developing countries similar relations are found, but the impact of income is substantially stronger. Moving from the individual to the national level, however, real GDP per capita indicates the availability of basic goods and services: nutrition, potable water, sanitary engineering, housing and other means of climate control, transportation and primary health care. At the national level, real GDP per capita – especially for industrialized societies also conveys the capacity of the society to invest in the development of science and technology, improved working conditions at higher technological levels of safety and health, financing of education at all levels, stabilization of the income of individuals and small businesses, and the many types of social protection: unemployment insurance; active labor market policies; health insurance; disability insurance; social welfare payments to impoverished, frail populations and children; social security and retirement benefits.

Income, of course, inasmuch as it conveys the purchase of goods and services of different price and quality, also conveys the special 'social status' of the purchaser. Thus, certain aspects of purchases take on the meaning of 'status symbols' by which different levels of social prestige are attributed to the purchasers. Prestige, in turn, is a principal marker of the socioeconomic status of individuals and is understood to convey differential levels of psychological wellbeing (Marmot, 2002; Marmot, Wilkinson, 2001).

*2. Unemployment*

The unemployment rate is well established as a risk factor for elevated illness and mortality rates in epidemiological studies performed since the early 1980's. In addition to influences on mental disorder, suicide and alcohol abuse and alcoholism, unemployment is also an important risk factor in cardiovascular disease and overall decreases in life expectancy (Linn, Sandifer, Stein, 1985; Morris, Cook, Shaper, 1994; Jin, Shah, Svopoda, 1995; Martikainen, Ma, Ja, 2007; Virtanen, Vahtera, Kivimäki, et al., 2005; Bambra, Elkemo, 2008; Catalano, 1991; Catalano, Dooley, Novaco, Wilson, Hough, 1993; Dooley, Catalano, Wilson, 1994; Kasl, Jones, 2002; Tausky, Piedmont, 1967).

The first group of studies with a prospective epidemiological and demographic orientation were at the national level and used time-series analysis. These include the studies in the United States for the Joint Economic Committee of the U.S. Congress in 1976 and 1984 (Brenner, 1976; 1984). These studies demonstrated a temporal relationship between national levels of unemployment, on the one hand, and on the other age-adjusted mortality rates, cardiovascular

mortality rates and suicide over a six-year period following economic recessions in which unemployment was elevated. These long-term effects of unemployment at the national level were further supported by a study of England and Wales with elevated unemployment rates being related to increased age-adjusted mortality rates over the subsequent ten years (Brenner, 1979). These studies controlled for the impact of national income and wealth (GDP per capita), as well as inflation and the short-term impact of rapid economic growth. Subsequent studies of historical change in unemployment and mortality rates (especially cardiovascular), in other European and Western countries supported the earlier U.S. and British studies. These countries included: France, Germany, Italy, Belgium, Netherlands, Finland, Sweden, Japan, Australia and New Zealand (Brenner, 1997; 1987a; 1987b; 1982). For the entire 20th Century this finding was again confirmed, with respect to historical time in the United States in 2005 (Brenner, 2005). Most recently, the country-level relationship between unemployment and decreased life expectation has been confirmed for 31 industrialized countries for the year 2008 (Brenner, 2010) (see also table and graph below). In the European and industrialized country studies, adjustment was made for GDP per capita as well as alcohol, tobacco, and dietary risk factors. A study based on United States data not confirming the positive relation between unemployment and mortality rates, did not adjust for other economic factors (especially income inequality) and lifestyle factors was published in 2000 (Ruhm, 2000).

Rigorous epidemiological studies, at the individual level of analysis were conducted in England and Wales (Morris et al 1994, Moser et al 1987, Bethune 1997, Mitchell et al 2000) and in several Scandinavian countries, among others (Martikainen & Valkonen 1996, Iversen et al 1987, Pensola & Martikainen 2004, Voss et al 2004, Ahs & Westerling 2006, Gallo et al 2004),

documenting elevated risks of fatal or non-fatal cardiovascular or cerebrovascular events or of all-cause mortality among *unemployed* as compared to permanently employed people. Risks are particularly high among the long-term unemployed. Effect sizes of hazard ratios are usually quite substantial, i.e. in the range of 1.5 to 2.5.

Many less rigorously conducted studies support these results, demonstrating elevated risks of a range of other health outcomes. For instance, unemployment increases rates of depression, particularly in the young. Parasuicide rates in young men who are unemployed are substantially higher than for those in employment (Dorling 2009). In a longitudinal study in England, excess mortality from suicide was obvious among unemployed men (Moser et al 1984). In the British Household Panel Study unemployment among people in the most disadvantaged social group was related to elevated risk of incident limiting illness (Bartley et al 2004). Other studies point to impaired mental health, specifically depression, as a consequence of unemployment (Kasl & Jones 2000, Kaplan et al 1987), whereas becoming depressive in turn increases the probability of future unemployment and loss of income (Whooley et al 2002). Becoming reemployed is generally associated with a reduction in symptomatology (Kessler et al 1989, Kasl & Jones 2000), but not in the rate of mortality (Bethune 1997).

Several mechanisms are understood to operate in the relationship between unemployment and damage to health. One of these concerns the psychological stresses of loss and mental depression that separates the individual from his/her place in economic organizations – a position in which the content of work and social relations give meaning and direction to life. A second mechanism involves the loss of social relationships at work, which often constitute the major

social networks and friendship patterns for many individuals as well as a definition of their position in society. Thirdly, and over the longer term, there is the problem of loss of income – which could be transitory or relatively permanent. In the case of transitory income loss, the period of unemployment may be relatively short, and new employment will restore previous wage and salary levels. More common, as with lengthy recessions and structural unemployment, is the inability of the unemployed individual to find reemployment in the same industry and/or at the same level of seniority (Podgursky, Swaim, 1987a, 1987b).

In that case the unemployed person may find subsequent work in a different firm, or different industry altogether, in which the starting position will be at a very junior level. It may then take many years – if ever – f or the previously unemployed person to resume the level of income that prevailed prior to the unemployment. A far more serious situation occurs when the unemployed person becomes discouraged from seeking new work which would make use of the individual's skills and length of experience (Moore, Ranjan, 2005; Wilson, 1990; Blank, Blinde, 1985). In that case, the individual may leave the labor force entirely (or retire), and the likelihood of considerable loss of permanent income is relatively high (Uchitelle, Kleinfield, 1996). Finally, as we have seen in the case of loss of income – indicating permanent loss of socioeconomic status – there is then a significantly increased risk of illness and early mortality.

**The Model: Influences of GDP and Unemployment on Life Expectancy**

The most extensive and robust findings in epidemiology of mortality patterns in industrialized countries is that "socioeconomic status" is the single most dominant, pervasive (or powerful)

factor that routinely influences comparative length of life among industrialized country populations.

Thus it can be seen that the national income and wealth of a society, i.e., real GDP per capita, is the foundation of much of individual material welfare that is described in the concept of socioeconomic status. Beyond those sources of investment in socioeconomic status are societal investments in a variety of public health and safety measures to insure social protection. These include health care sciences and technology, health and safety regulations in the workplace, environmental regulations, investment in the epidemiological and clinical sciences that identify risks to population health in terms of the monitoring of food and drug safety, safety of water and sanitation systems, new knowledge of optimal diets and the effects of alcohol and tobacco on health, and transportation safety.

In addition, of course, growth in GDP per capita is almost by definition the antithesis of recession and, therefore, unemployment. It is indeed specified under the "law" proposed by the economist Okun that a specified quantitative increase in potential GDP will reduce the unemployment rate by a specified amount.

Finally, real GDP per capita is also the source of investment in new innovation and new employment, largely through the initiation of new small firms, frequently via self-employment. The strength of self employment, then, in a well developed industrialized society, represents much of the source of innovation that will maintain or advance the rate of economic growth. Equally important, however, self-employment serves as a source of opportunity to avoid

unemployment – whether that unemployment originates with economic cycles, technical and productivity development, globalization or other structural changes in the economy. Self-employment, thus, can provide a "safety catch" by which unemployment is reduced and through the development of small firms, can be an avenue through which active labor market policies can result in successful reemployment.

To exemplify this true set of factors which affect health and social wellbeing both directly and indirectly stemming from GDP growth, a model is presented which encompasses a number of the factors which are related to GDP-based investment and consumption patterns. This is a model which attempts to account for variation among industrialized countries in the age-standardized mortality rate.

The model includes a measure of the rate of productivity, namely GDP per employee. It includes as well, the rate of self-employment and both the unemployment rate for males in relation to population as well as the source of inflation, namely the consumer price index. This model also includes publicly-funded health expenditures which are derived from GDP investments. Finally it controls for a major risk factor that is well-known in the epidemiological literature for its ability to exert a short-term effect of a multiplicity of sources of illness and disability, including cardiovascular diseases, diabetes, work and home accidents and injuries, transportation accidents, suicide and homicide. This factor is alcohol consumption per capita.

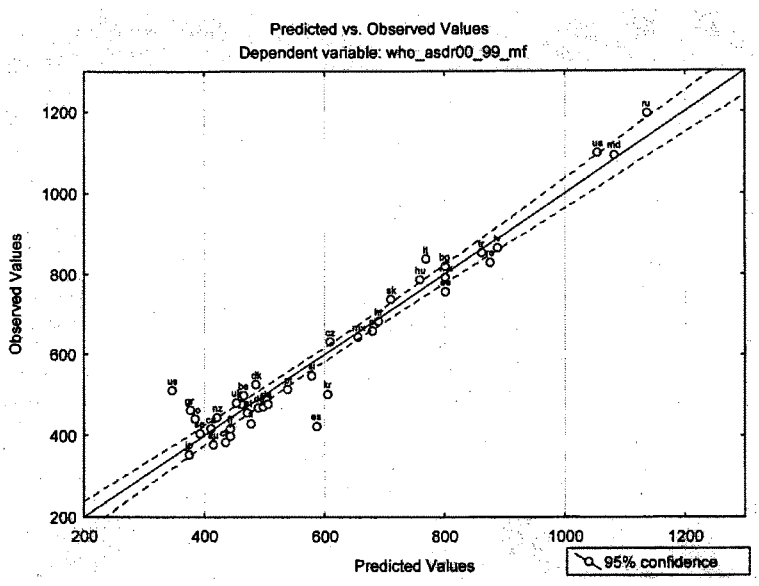
**Figure 1**

**Relation of economic variables to age adjusted total mortality 40 European, CIS and OECD Countries, Year 2005**

R= .97027845 $R^2$= .94144027 Adjusted $R^2$= .92863033

F(7,32)=73.493 p<.00000 Std.Error of estimate: 57.996

| N=40 | Beta | Std.Err. | B | Std.Err. | t(32) | p-level |
|---|---|---|---|---|---|---|
| Variables | | | 422.1625 | 113.2121 | 3.72895 | 0.000745 |
| GDP per employee (productivity) | -0.275164 | 0.084246 | -0.0038 | 0.0012 | -3.26619 | 0.002602 |
| Shadow economy as proportion of GDP | 0.442261 | 0.090652 | 7.8362 | 1.6062 | 4.87866 | 0.000028 |
| Public health expenditure as proportion of GDP | -0.218179 | 0.062863 | -29.1464 | 8.3978 | -3.47072 | 0.001507 |
| Self employed as proportion of total employment | -0.223634 | 0.045491 | -4.5745 | 0.9305 | -4.91595 | 0.000025 |
| Unemployment rate, males | 0.117708 | 0.050753 | 6.9823 | 3.0106 | 2.31922 | 0.026924 |
| Alcohol consumption per capita | 0.206031 | 0.046603 | 15.4188 | 3.4876 | 4.42102 | 0.000106 |
| Consumer Price Index (Index Year 2000) | 0.258445 | 0.050777 | 1.3576 | 0.2667 | 5.08979 | 0.000015 |



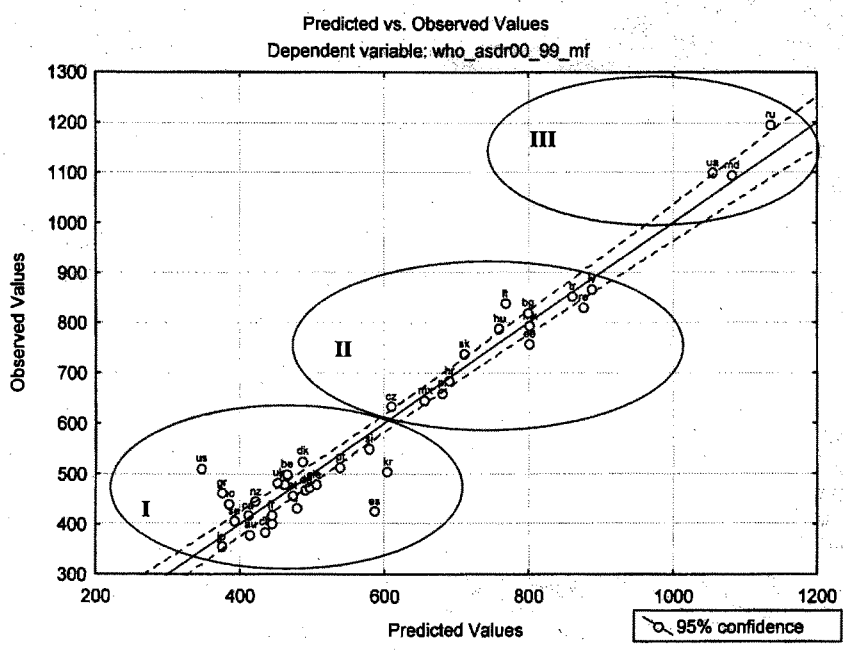
**Importance of National Income to National Mortality Rates**

The model above uses seven factors to account for the levels of age-standardized mortality rates among 40 industrialized countries. However a fundamental distinction among the 40 countries can be seen by distinguishing these countries by region and by average real GDP per employee. Figure 2 below repeats Figure 1 but groups the countries in terms of major regional classification and average GDP per employee. The first region enclosed in circle I, includes Western Europe, North America (except Mexico) and the highly industrialized Pacific countries of Australia, New Zealand, Japan and Korea with average GDP per employee of $ 45, 766. The second group of countries, in circle II, includes Eastern Europe and Mexico, with average GDP per employee of $20,292. The third group of countries, are within the Community of Independent States (CIS) and include Moldova, the Russia Federation and Ukraine, with average GDP per employee of $8,022.

Thus the basic differentiation among the group of countries is by geography and national income/wealth as well as productivity as measured by real GDP per employee. Within each of the three circles, one can see a relatively straight line representing the extent to which the entire set of seven predictors accounts for variation in age-standardized mortality rates among countries within the three regional groups. While the alignment of the three circles in a upward slope is essentially accounted for by GDP per employee, the variation of mortality among countries within the circles is largely accounted for by the remaining six variables in the model (shadow economy, self-employment, inflation rate, pubic health expenditures, male unemployment rate, and alcohol consumption per capita).

**Figure 2**

**Relation of economic factors to age-standardized mortality rates: countries grouped according to average GDP per employee and geographic region.**

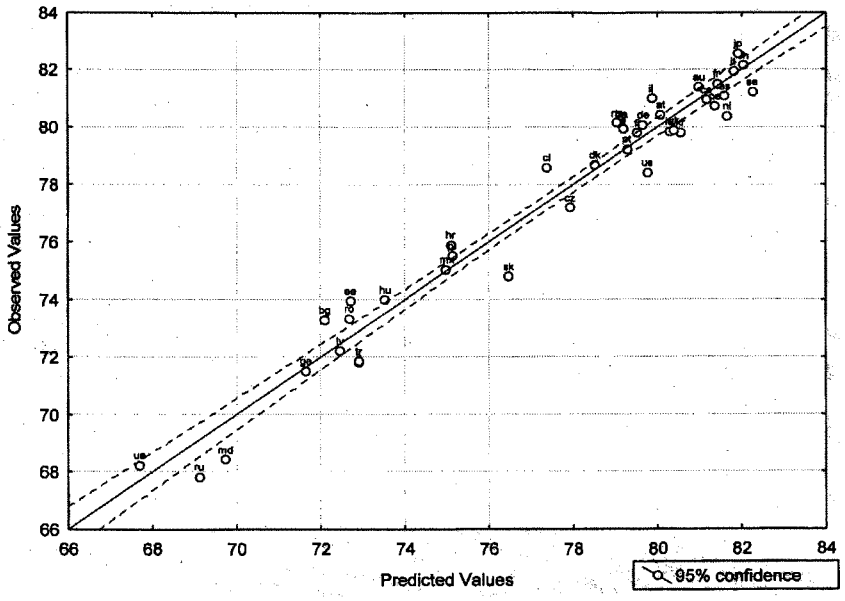



| | Region | Real GDP per Employee (Average USD) |
|---|---|---|
| I. | Western Europe<br>North America<br>Pacific | 45,766 |
| II. | Eastern Europe<br>Mexico | 20,292 |
| III. | CIS<br>Moldova<br>Russia Federation<br>Ukraine | 8,022 |

**Figure 3**
**Regression Summary for total life expectancy at birth (in years)**
**for 40 European (West, Central and East) and OECD countries, years 2008**

R= .97896360 $R^2$= .95836974 Adjusted $R^2$= .93986740
F(12,27)=51.797 p<.00000 Std.Error of estimate: 1.0379

| | Beta | Std.Err. | B | Std.Err. | t(27) | p-level |
|---|---|---|---|---|---|---|
| Intercept | | | 22.78837 | 5.798625 | 3.92996 | 0.000533 |
| Logarithm of GDP per capita in constant 1990 international $ | 0.836529 | 0.068515 | 6.37221 | 0.521905 | 12.20951 | 0.000000 |
| Social security expenditure as percentage of general government expenditure on health | 0.158444 | 0.047908 | 0.01823 | 0.005513 | 3.30728 | 0.002671 |
| Male self-employment as percentage of total male employment (15+ years old) | 0.268693 | 0.055326 | 0.13455 | 0.027705 | 4.85654 | 0.000045 |
| Male unemployment rate as percentage of male labor force | -0.134057 | 0.047406 | -0.27670 | 0.097849 | -2.82782 | 0.008724 |
| Total food consumption in kilocalories per capita and day | -0.251139 | 0.070873 | -0.00371 | 0.001046 | -3.54349 | 0.001460 |
| Protein consumption in grams per capita and day | 0.234765 | 0.075766 | 0.07445 | 0.024027 | 3.09857 | 0.004506 |
| Vegetable fat consumption in grams per capita and day | 0.271082 | 0.061580 | 0.06312 | 0.014339 | 4.40213 | 0.000152 |
| 5 years average of total tobacco consumption in grams per adult and day (5 years lag) | -0.154843 | 0.055524 | -0.06636 | 0.023796 | -2.78876 | 0.009578 |
| Current smoker prevalence in male adult population | -0.187336 | 0.056437 | -0.06453 | 0.019441 | -3.31938 | 0.002590 |
| Crude birth rate (births per1,000 of total population) | -0.141387 | 0.045526 | -0.21448 | 0.069061 | -3.10566 | 0.004428 |
| Carbon dioxide emission in metric tons per capita & year | -0.159418 | 0.052442 | -0.16602 | 0.054614 | -3.03989 | 0.005209 |
| Dummy (Baltic countries=1, all others=0) | -0.218855 | 0.046422 | -3.47263 | 0.736588 | -4.71448 | 0.000066 |

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# Explaining aggregate health status (mortality). Insights to the possible impact of the economic crisis

**Technical Report of the European Commission**
**DG Employment, Social Affairs, Inclusion**

**September 28, 2009**

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**Introduction**

The most extensive and robust findings in epidemiology of mortality patterns in industrialized countries is that "socioeconomic status" is the single most dominant, pervasive (or powerful) factor that routinely influences comparative length of life among industrialized country populations.

It can be seen that socioeconomic status of individuals, thus defined, is based on, firstly, investments in education (and other human capital including occupational training and skill). This investment in training will be a precondition to employment at different levels of occupational remuneration, including wages/salaries and benefits. Many of the benefits associated with specific wage levels will include elements of social protection that are based on both state and private sources of material welfare. This type of social protection will include various forms of social insurance i.e. unemployment insurance, involvement in active labor market policy initiatives, health and disability insurance, and payments and pensions.

Thus it can be seen that the national income and wealth of a society, i.e., real GDP per capita, is the foundation of much of individual material welfare that is described in the concept of socioeconomic status. Beyond those sources of investment in socioeconomic status are societal investments in a variety of public health and safety measures to insure social protection. These include health care sciences and technology, health and safety regulations in the workplace, environmental regulations, investment in the epidemiological and clinical sciences that identify risks to population health in terms of the monitoring of food and drug safety, safety of water and sanitation systems, new knowledge of optimal diets and the effects of alcohol and tobacco on health, and transportation safety.

In addition, of course, growth in GDP per capita is almost by definition the antithesis of recession and, therefore, unemployment. It is indeed specified under the "law" proposed by the economist Okun that a specified quantitative increase in potential GDP will reduce the unemployment rate by a specified amount.

Finally, real GDP per capita is also the source of investment in new innovation and new employment, largely through the initiation of new small firms, frequently via self-employment. The strength of self employment, then, in a well developed industrialized society, represents much of the source of innovation that will maintain or advance the rate of economic growth. Equally important, however, self-employment serves as a source of opportunity to avoid unemployment – whether that unemployment originates with economic cycles, technical and productivity development, globalization or other structural changes in the economy. Self-employment, thus, can provide a "safety catch" by which unemployment is reduced and through the development of small firms, can be an avenue through which active labor market policies can result in successful reemployment.

To exemplify this true set of factors which affect health and social wellbeing both directly and indirectly stemming from GDP growth, a model is presented which encompasses a number of the factors which are related to GDP-based investment and consumption patterns. This is a model which attempts to account for variation among industrialized countries in the age-standardized mortality rate.

The model includes a measure of the rate of productivity, namely GDP per employee. It includes as well, the rate of self-employment and both the unemployment rate for males in relation to population as well as the source of inflation, namely the consumer price index. This model also includes publicly-funded health expenditures which are derived from GDP investments. Finally it controls for a major risk factor that is well-known in the epidemiological literature for its ability to exert a short-term effect of a multiplicity of sources of illness and disability, including cardiovascular diseases, diabetes, work and home accidents and injuries, transportation accidents, suicide and homicide. This factor is alcohol consumption per capita.

Drawing on this logic, we present a second model, which examines the relation of economic change to the suicide rate in industrialized countries. Similar factors, such as GDP, self-employment, the unemployment rate, health services expenditure, as well as lifestyle factors and measures of social integration are able to produce a multi-variable model of coherence and predictability.

In a third approach, time series analyses are presented of some of the policy factors that influence age-standardized mortality in the United Kingdom and United States over the years 1970-2005. Attention is especially given to health care expenditures as a percent of GDP and the unemployment rate. Also examined is the potential effect of the dependency ratio on mortality. A time-series regression analysis is presented as well as a graphic display of the activity of the historical time-series during 1970-2005.

Finally, a concluding section is devoted to a numerical estimation of the impact, on mortality, of potential changes in the health care expenditures and the unemployment rate. Mortality figures are simulated and estimates are given under conditions where there are separate changes in health care expenditures and the unemployment rate. Estimates are also given for scenarios where both factors change simultaneously.

**Major Factors in the Prediction of National Life Expectancy**

*1. Income*

At the individual level of analysis – i.e., in epidemiological studies – individual income is a standard and fundamental inverse predictor of illness and early mortality (Andersen, Gamborg, Osler, Prescott, Diderichsen' 2005; Ecob, Davey Smith, 1999; Ettner, 1996; Kahn, Wise, Kennedy, Kawachi, 2000; Kivimäki, Shipley, Ferrie et al., 2008; Lynch, Smith, Kaplan, House, 2000). In industrialized countries, the higher the level of income of individuals, the lower the illness and mortality rates attributed to the great majority of infections, chronic diseases and mental disturbances. In developing countries similar relations are found, but the impact of income is substantially stronger. Moving from the individual to the national level, however, real GDP per capita indicates the availability of basic goods and services: nutrition, potable water, sanitary engineering, housing and other means of climate control, transportation and primary health care. At the national level, real GDP per capita – especially for industrialized societies also conveys the capacity of the society to invest in the development of science and technology, improved working conditions at higher technological levels of safety and health, financing of education at all levels, stabilization of the income of individuals and small businesses, and the many types of social protection: unemployment insurance; active labor market policies; health insurance; disability insurance; social welfare payments to impoverished, frail populations and children; social security and retirement benefits.

Income, of course, inasmuch as it conveys the purchase of goods and services of different price and quality, also conveys the special 'social status' of the purchaser. Thus, certain aspects of purchases take on the meaning of 'status symbols' by which different levels of social prestige are attributed to the purchasers. Prestige, in turn, is a principal marker of the socioeconomic status of individuals and is understood to convey differential levels of psychological wellbeing (Marmot, 2002; Marmot, Wilkinson, 2001).

*2. Education*

As in the case of income, educational level attained is strongly associated with lower illness and mortality rates in industrialized country populations. Educational level attained by individuals is almost universally associated with lower morbidity and mortality rates in epidemiological studies (Leigh, 1983; Ross, Mirowsky, 1999; Ross, Wu, 1995). This relationship is consistent with the more generally cited relationship – perhaps the single strongest empirical relationship in all of epidemiology – that overall socioeconomic status is a predictor of lower morbidity and mortality for nearly all diagnoses, at all ages, both sexes and populations of different ethnicity and immigration status (Smith, Hart, Hole, et al., 1998; Winkleby, Jatulis, Frank, Fortmann, 1992). The explanation of the positive relationship between educational status and health clearly involves multiple mechanisms. The most common understanding is that education itself, meaning the attainment of knowledge enables the comprehension of the most widely recognized health risks (dealing e.g., with matters of diet, environment, working conditions, stress and addictions) and the ability to secure the most timely and effective health care. Even more generally, education is the basis for adaptation to opportunities and challenges in economic and social areas of life.

Education is, of course, the most important prerequisite of higher skill and managerial levels of employment, and is virtually essential to employment in professional and administrative positions in larger economic and political organizations. Educational attainment level is, therefore, a strong factor in personal income and the maintenance and advancement of careers in technological societies. In this era of rapid technological change and globalization – leading to frequent restructuring of private firms and government organizations – relatively high education levels permit more rapid transition to new jobs and the resumption of careers. This often avoids

he substantial losses in permanent earnings that accrue to individuals who experience structural unemployment or downsizing of firms.

It should be kept in mind that educational level, a standard measure of 'human capital', has long been understood as a significant source of economic growth. Of course, the extent of education in a population is also financed from the wealth developed as a result of economic growth. This close linkage of education to the economic growth process often means that once GDP per capita is used as a variable to account for increases in life expectancy, no additional variables measuring the extent of education in a society is usually needed, even though the level of education in a population may well make a substantial contribution to a population's health. This will be especially true in comparative (i.e., cross-sectional) analyses of industrialized countries. Nevertheless, a variable that deals more directly with the extent to which the working population is highly educated can often make an additional contribution to the explanation of life expectation among industrialized societies. Such a variable, for example, is the proportion of the employed population who have achieved tertiary education.

*3. Unemployment*

The unemployment rate is well established as a risk factor for elevated illness and mortality rates in epidemiological studies performed since the early 1980's. In addition to influences on mental disorder, suicide and alcohol abuse and alcoholism, unemployment is also an important risk factor in cardiovascular disease and overall decreases in life expectancy (Linn, Sandifer, Stein, 1985; Morris, Cook, Shaper, 1994; Jin, Shah, Svopoda, 1995; Martikainen, Ma, Ja, 2007; Virtanen, Vahtera, Kivimäki, et al., 2005; Bambra, Elkemo, 2008; Catalano, 1991; Catalano, Dooley, Novaco, Wilson, Hough, 1993; Dooley, Catalano, Wilson, 1994; Kasl, Jones, 2002; Tausky, Piedmont, 1967).The relationship between increased unemployment and increases in mental disorder and cardiovascular illness was first observed at the macro (national) level using historical time-series analysis in United States, British and Scandinavian populations (Brenner, 1971, 1973, 1976, 1979a, 1979b, 1982, 1985, 1887). This work was further advanced under the sponsorship of the European Commission, where the interest was in the implications of unemployment and employment policies which could promote health (Brenner, 2000, 2002).

Several mechanisms are understood to operate in the relationship between unemployment and damage to health. One of these concerns the psychological stresses of loss and mental depression that separates the individual from his/her place in economic organizations – a position in which the content of work and social relations give meaning and direction to life. A second mechanism involves the loss of social relationships at work, which often constitute the major social networks and friendship patterns for many individuals as well as a definition of their position in society. Thirdly, and over the longer term, there is the problem of loss of income – which could be transitory or relatively permanent. In the case of transitory income loss, the period of unemployment may be relatively short, and new employment will restore previous wage and salary levels. More common, as with lengthy recessions and structural unemployment, is the inability of the unemployed individual to find reemployment in the same industry and/or at the same level of seniority (Podgursky, Swaim, 1987a, 1987b). In that case the unemployed person may find subsequent work in a different firm, or different industry altogether, in which the starting position will be at a very junior level. It may then take many years – if ever – for the previously unemployed person to resume the level of income that prevailed prior to the unemployment. A far more serious situation occurs when the unemployed person becomes discouraged from seeking new work which would make use of the individual's skills and length of experience (Moore, Ranjan, 2005; Wilson, 1990; Blank, Blinde, 1985). In that case, the individual may leave the labor force entirely (or retire), and the likelihood of considerable loss of permanent income is relatively high (Uchitelle, Kleinfield, 1996). Finally, as

we have seen in the case of loss of income – indicating permanent loss of socioeconomic status – there is then a significantly increased risk of illness and early mortality.

*4. Public Expenditure on Health*

It is assumed by some health policy experts that health services expenditures, as a proportion of GDP, should bear some relation to the intensity, and the technological sophistication, of the health care utilized by a population (Musgrove, Zeramdini, Carrin, 2002; Comaish, Holdstock, 1983; Gerdtham, Jonsson, 1994; Gerdtham, Jonsson, 1992; Gerdtham, Jonsson, 1991; Gerdtham, Søgaard, Andersson, Jönsson, 1992; Gerdtham, 1993). The further assumption would be that the intensity and sophistication of health care should, in principle, be associated with decreased mortality rates (other things equal) (Getzen, 2000; Gerdtham, 1993; Murray, Govindaraj, Musgrove, 1994). There is an equally vocal group of health policy specialists who contend that health care expenditures need bear no relationship to improved health. This latter group feels that (1) much of the truly effective care occurs at the primary level which is not expensive and carries a minimum of expenditure of total health care in industrialized societies; (2) there has been little progress in improving mortality due to chronic common degenerative diseases – except perhaps in the case of cardiovascular disease; (3) health care expenditures heavily reflect administrative and management costs rather than actual performance of medicine and surgery; (4) the price of the same pharmaceuticals varies considerably among industrialized countries. Especially intense are critiques from United States health policy specialists who contend that, in the case of privately funded health care typically involving profit-making insurance companies, the cost of care bears little relation to its quality or intensity, since much of private health care expenditure is either medically unnecessary or occurs too late in life to significantly influence life expectancy (Bitton and Kahn, 2003; Woolhandler, Himmelstein, 1997; 2002a; 2002b).

There is some degree of consensus on the part of European and North American health economists that, for publicly funded care there are national criteria that roughly link personal health care procedures to their expenditures (Musgrove, Zeramdini, Karrin, 2002; Murray, Govindaraj, Musgrove, 1994). There is even greater consensus that publically funded health expenditure provides greater coverage to populations at higher morbidity levels – namely, the lowest socioeconomic groups (Ham, 1997; Hurst, 1991; Hurley, 2001) Publically financed expenditures also appear to provide some positive redistributive effects and less differential treatment (Doorslaer, Wagstaff, van der Burg, et al., 1999) There then seem to be some grounds for comparing health outcomes among industrialized countries, in relation to public expenditures on health care as a proportion of their real GDP (Clemente J, Marcuello C, Montañés A, Pueyo, F. 2004). Once this is done, controlling for other factors which measure economic growth and stability as well as lifestyle and environmental risk factors, we do observe a robust positive relationship between public health care expenditures and life expectancy. The more important observation, however, is that we can for the first time actually estimate the effect of health care expenditures on mortality reduction (Mackenbach, 1991). This conclusion takes on added plausibility when one recognizes that nearly all industrialized countries, apart from the United States, have the greatest proportion of their health care expenditure arising from public or not-for-profit sources.

*5. Quality of Work/Working Conditions*

Quality of working life or, more generally, "working conditions", have been traditionally known to influence health. In the oldest epidemiological literature, going back to Great Britain in the 1840's, one observes a powerful relationship between differential occupations, as identified by occupational skill level, and mortality rates at virtually all ages and for occupational, infectious and chronic diseases. Overall, the lower the occupational skill level of a worker, the higher the probability of premature mortality (Susser, Adelstein, 1975; Office of Population Censuses and Surveys Her Majesty's Stationary Office, 1986). Prior to the advent of

quantitative epidemiology, it was commonplace in clinical studies to demonstrate that the lowest-skilled workers (semi-skilled, unskilled) had the highest illness and mortality rates due to deficiencies of occupational safety. The principal problems in occupational safety and health are (1) physical, including toxic emissions, synthetic organic chemicals, carcinogens and ergonomic problems; and (2) psychological, especially including the lack of worker autonomy, stressful work (high demands), monotonous work and underemployment, insecure and unstable work and under-compensation in wages and benefits (Karasek, Theorell, 1990; Kuper, Singh-Manoux, Siegrist, Marmot, 2002; Lynch, Krause, Kaplan, Tuomilehto, Salonen, 1997; Lynch, Krause, Kaplan, Salonen, Salonen, 1997; Marmot, Bosma, Hemingway, Brunner, Stansfeld, 1997).

In cross-sectional analysis comparing countries, or historical time-series analysis, examining the experience of one country through time, it is difficult to identify precise markers of high or poor quality working conditions. However, in the industrialized country setting, it is well known that employment in the "shadow economy" generally offers working conditions of comparatively low quality. The shadow economy, in fact, involves illegal economic activity in that employers and employees do not pay government taxes (Frey, Weck, 1982; Eilat, Zinnes, 2002; Torgler, Schneider, 2009; Buhn, Karmann, Schneider, 2007; Hughes, 2000; Kyle, Warner, Dimitrov, et al., 2001; Chaudhuri, Schneider, Chattopadhyay, 2006; Boeri T, Garibaldi, 2005, 2007. This means, as well, that firms operating in the shadow economy are not subject to the payment of standard wages and do not offer the general benefits of insurance, including unemployment, health, disability, social welfare and pensions. Equally important, firms in the shadow economy often operate at long hours, with minimal health and safety rules and without time off (Centeno, Portes, 2006). In addition, workers in the shadow economy are subject to minimal autonomy and have higher stress levels due to the length of working hours, job instability and minimal wages and benefits.

Perhaps the single most important factor promoting the existence of firms in the shadow economy is either the lack of economic growth and development or the decline of the firm due to industrial restructuring, globalization or national recession (Boeri, Garibaldi, Salasco, Gobbi, 2002; Dell'Anno, Gomez-Antonio, Pardo, 2007). These phenomena reduce the capacity of the firm to pay taxes and to finance the modern technology needed to avoid problems of occupational safety and health, environmental toxins, ergonomically sophisticated work places, stable working conditions and minimally standard wages and benefits. Thus, for industrialized countries, we can conclude that firms in the shadow economy generally have considerably poorer working conditions, and that such conditions are risk factors for occupational safety and health problems, psychological stress and chronic degenerative diseases (Frey, Weck, Pommerehne, 1982; Chaudhuri, Schneider, Chattopadhyay, 2006; Boeri, Garibaldi, 2005, 2007; Bajada, Schneider, 2005).

It is important to bear in mind, however, that the shadow economy is most heavily represented in counties at comparatively low levels of economic development. Thus, one might argue that there is some redundancy in placing GDP per capita and the proportion of GDP that represents the shadow economy as independent variables in a single model by which one wishes to account for changes in life expectancy. In general, this would be true where one was comparing countries in a very large sample that included geographic areas dominated by relatively impoverished developing countries. However, this would not be the case where the comparison is among advanced industrialized societies at comparatively high per capita income levels. In the latter case, the presence of a substantial "shadow economy" tends to connote relatively underdeveloped sectors of the economy or an economy that is undergoing economic distress or extensive restructuring.

Self-employment is another important structural feature of working conditions. The self-employment rate is intended, in this analysis as a measure of entrepreneurship in small and medium-size enterprises (SME's). In traditional economic thinking entrepreneurship is the "fourth" factor of production and is essential to innovation and risk-taking in market economies. It is theoretically the source of continuous renewal of the technology and

structure of the economy and thus at least part of the basis for continuous long-term growth. The self-employment rate in SME's is also the source of a relatively high rate of job creation. And it is a traditional source of absorption into employment of persons unemployed as a result of recession, globalization and economic restructuring (including 'downsizing', 'offshoring', 'delocalization' and 'outsourcing'). Thus, self-employment is a traditional safety net for professional, managerial, skilled and unskilled workers who have lost employment.

There is also considerable theory that contrasts the SME with the large bureaucratic work organization, with its intensely hierarchical and impersonal employment structure. – i.e., the antithesis of "social capital" (Islam, Merlo, Kawachi, Lindstrom, Gerdtham, 2006; Kawachi, 1999; Lochner, Kawachi, Kennedy, 1999; Altschuler, Somkin, Adler, 2004). The hierarchical component itself is a source of enlarged socioeconomic (SES) inequalities within the firm's internal labor market. There is evidence that larger SES inequalities are an important factor in premature mortality (Kahn, Wise, Kennedy, Kawachi, 2000; Lynch, Smith, Kaplan, House, 2000; Steptoe, Kunz-Ebrecht, Owen, et al., 2003). Scholars also point to the importance of the exceptional autonomy of the self-employed, obviously involving control (a risk factor in cardiovascular disease) over the extent of work demands as well as the pace, scheduling and intensity of work (Karasek and Theorell 1990). All of these factors lead to the inference that the rate of self-employment is important to economic growth and renewal, economic survival of the unemployed, and social capital – and for these reasons would provide important sources of societal coping with economic shocks.

*6. Lifestyles*

The primary variables we wish to investigate in relation to mortality concern factors intrinsic to the economy or to economic and social policy. However, in order to appropriately assess the impact of those factors on mortality, we also need to be sure that we have included in our model other risk factors to health that are well established influences on the mortality rate. Failure to include such variables, such as 'lifestyle' factors, may result in an over- or underestimate of the primary relation between the economic or social variables and health. One of these 'lifestyle' factors is high alcohol consumption per capita, which has a wide range of influences on illness including heart disease, stroke, kidney disease, specific malignancies, accidents, suicide, homicide and cirrhosis of the liver (Jernigan, Monteiro, Room, Saxena 2000; Room, Babor, Rehm, 2005; San Jose, Van De Mheen, Van Oers, Mackenbach, Garretsen, 1999). Alcohol consumption per capita can be seen to positively influence the age-adjusted mortality rates in our cross-sectional studies since we examine the effect of such a factor on mortality within the same year. Other high risk behaviors, such as tobacco (Bartecchi, MacKenzie, Schrier, 1994; Brownson, Eriksen, Davis, Warner, 1997), carbohydrate and animal fat consumption, are also known to influence mortality due to cardiovascular diseases and malignancies, but were not tested in the present model.

**Economy, Social Policy and Mortality Among Industrialized Countries**

Figure 1 shows age standardized mortality rates for 40 industrialized countries predicted by three types of variables: (1) economic factors, including GDP per employee, size of the "shadow" economy, the male unemployment rate and self-employment as a proportion of the labor force; (2) health expenditures funded by public sources as a proportion of the total GDP; and (3) alcohol consumption per capita, as representing a high-risk "lifestyle" factor harmful to health.

It can be seen that the mortality rate is distributed across the 40 countries largely in accordance with their income and wealth per capita as represented by the GDP per employee. As discussed above the GDP per capita is also strongly inversely related to the size of the shadow economy and the unemployment rate, while self-employment as a percentage of total employment is a measure of the economic health and density of entrepreneurship in the small and medium enterprises (SMEs).

The countries with the lowest mortality rates are among those with the highest GDP per capita, and the smallest shadow economy and unemployment rates. These relatively high income countries are those of Western Europe, North American and the Pacific. Western European countries include: Switzerland, Italy, Sweden, France, Spain, Norway, Austria, Greece, Germany, Finland, Netherlands, Ireland, United Kingdom, Belgium, Portugal and Denmark (in order of increasing mortality rates). The North American countries are Canada and the United States, while the Pacific countries are Japan, Australia, New Zealand and Korea.

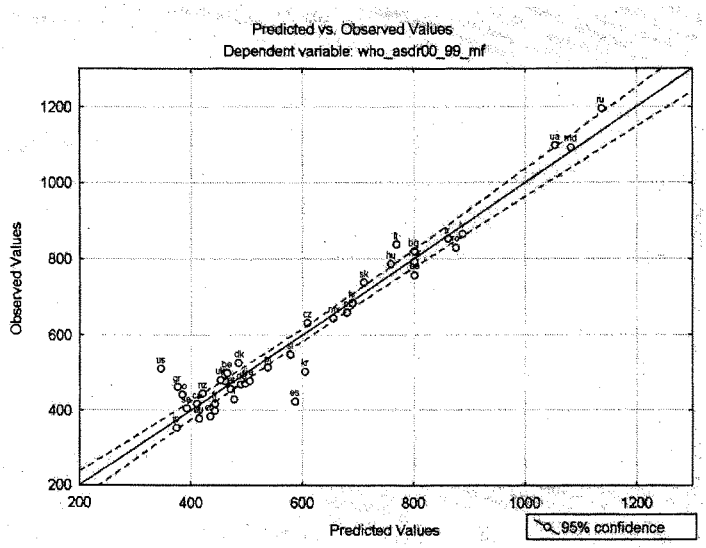
The middle income countries include those of Eastern Europe and, in the Western Hemisphere, Mexico. Eastern European countries in increasing order of mortality include: Slovenia, Czech Republic, Poland, Croatia, Slovakia, Estonia, Hungary, Macedonia, Bulgaria, Romania, Lithuania, Turkey and Latvia. Among the Eastern European countries it is interesting to observe relatively similar age-standardized mortality rates for societies that are geographically proximal and have similar GDP, income and wealth.

The third group of countries with very much higher mortality rates than those of Eastern Europe include: the countries of the Community of Independent States (CIS) including Moldova, Ukraine and the Russian Federation. As a group these countries have a lower GDP per employee than the average in Western or Eastern Europe and have the largest shadow economies among industrialized countries.

**Figure 1**
**Relation of economic variables to age adjusted total mortality 40 European, CIS and OECD Countries, Year 2005**

R= .97027845 $R^2$= .94144027 Adjusted $R^2$= .92863033
F(7,32)=73.493 p<.00000 Std.Error of estimate: 57.996

| N=40 | Beta | Std.Err. | B | Std.Err. | t(32) | p-level |
|---|---|---|---|---|---|---|
| Variables | | | 422.1625 | 113.2121 | 3.72895 | 0.000745 |
| GDP per employee (productivity) | -0.275164 | 0.084246 | -0.0038 | 0.0012 | -3.26819 | 0.002602 |
| Shadow economy as proportion of GDP | 0.442261 | 0.090652 | 7.8362 | 1.6062 | 4.87866 | 0.000028 |
| Public health expenditure as proportion of GDP | -0.218179 | 0.062863 | -29.1464 | 8.3978 | -3.47072 | 0.001507 |
| Self employed as proportion of total employment | -0.223634 | 0.045491 | -4.5745 | 0.9305 | -4.91595 | 0.000025 |
| Unemployment rate, males | 0.117708 | 0.050753 | 6.9623 | 3.0106 | 2.31322 | 0.026924 |
| Alcohol consumption per capita | 0.206031 | 0.046603 | 15.4188 | 3.4876 | 4.42102 | 0.000106 |
| Consumer Price Index (Index Year 2000) | 0.258445 | 0.050777 | 1.3576 | 0.2667 | 5.08979 | 0.000015 |

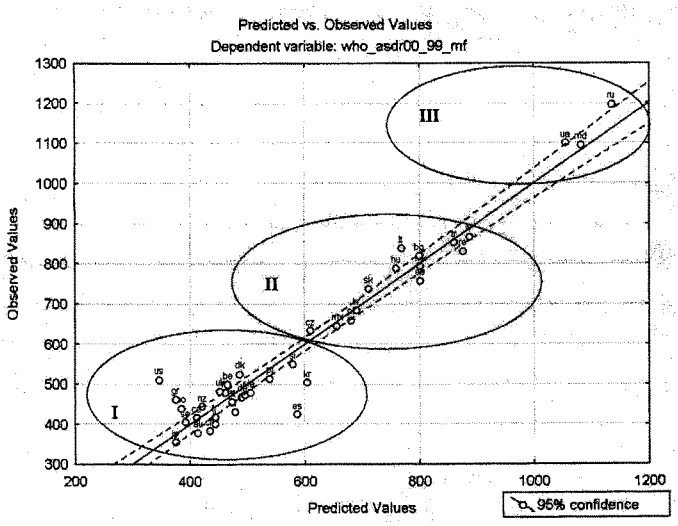


**Importance of National Income to National Mortality Rates**

The model above uses seven factors to account for the levels of age-standardized mortality rates among 40 industrialized countries. However a fundamental distinction among the 40 countries can be seen by distinguishing these countries by region and by average real GDP per employee. Figure 2 below repeats Figure 1 but groups the countries in terms of major regional classification and average GDP per employee. The first region enclosed in circle I, includes Western Europe, North America (except Mexico) and the highly industrialized Pacific countries of Australia, New Zealand, Japan and Korea with average GDP per employee of $ 45, 766. The second group of countries, in circle II, includes Eastern Europe and Mexico, with average GDP per employee of $20,292. The third group of countries, are within the Community of Independent States (CIS) and include Moldova, the Russia Federation and Ukraine, with average GDP per employee of $8,022.

Thus the basic differentiation among the group of countries is by geography and national income/wealth as well as productivity as measured by real GDP per employee. Within each of the three circles, one can see a relatively straight line representing the extent to which the entire set of seven predictors accounts for variation in age-standardized mortality rates among countries within the three regional groups. While the alignment of the three circles in a upward slope is essentially accounted for by GDP per employee, the variation of mortality among countries within the circles is largely accounted for by the remaining six variables in the model (shadow economy, self-employment, inflation rate, pubic health expenditures, male unemployment rate, and alcohol consumption per capita).

**Figure 2**
**Relation of economic factors to age-standardized mortality rates: countries grouped according to average GDP per employee and geographic region.**




| | Region | Real GDP per Employee (Average USD) |
|---|---|---|
| I. | Western Europe<br>North America<br>Pacific | 45,766 |
| II. | Eastern Europe<br>Mexico | 20,292 |
| III. | CIS<br>Moldova<br>Russia Federation<br>Ukraine | 8,022 |

**Suicide, Economic Growth, Unemployment and Government Expenditure**

Suicide is an "external" cause of death which is, at the same time, a principal measure of psychological depression, and is well known to respond to economic crises involving loss and insecurity.

In order to explain (statistically) variation in suicide rates by country, we can investigate several factors which deal with the issue of economic loss and unpredictability. At the individual level, perhaps the most common macroeconomic measure of loss is represented by the unemployment rate. It is also well known that the standard macroeconomic predictor of the unemployment rate is absolute decline and GDP per capita. We would therefore assume that countries with higher levels of GDP per capita, in addition to providing greater income and security, would also show lower suicide rates. Adding to GDP growth as protective against suicide, other major measures of economic development – such as the transformation of economies from domination by agriculture to that of manufacturing and, subsequently, to service industries – should likewise result in greater availability of material goods and services, and thus also reduce the tendency to suicide. However, a direct measure of consumption capacity, especially among the lower income population, is national consumption per capita of food and non-alcoholic beverages. We can compare this variable to expenditures on alcohol and tobacco, where a positive relation to suicide would be expected. Alcohol (and other psychoactive drugs) is known to influence psychological depression. Tobacco, in particular, influences cardiovascular disease and malignancies. The latter two chronic diseases themselves are risk factors to subsequent depression and suicide.

While the suicide rate is relatively strongly correlated (inversely) with real GDP per capita, it is subject to influences that go well beyond trends and fluctuations in national income and wealth (as measured by the GDP). Epidemiologically, suicide, as a marker for both psychological depression, and for poor mental health in general, is strongly associated in much of the literature over the last 40 years with unemployment experienced by individuals. The individual-level relationship between unemployment and psychological depression is so substantial that it is typically found in epidemiological studies to occur within a few months of the onset of unemployment. Nevertheless, the principal relationship between unemployment and the deterioration in mental health is typically observed over a period of several years. This considerable time lag is based on losses and damage to personal relationships (previously) at work, in the family and among friendship networks. Equally important are the longer term losses in income and economic position that frequently occur, especially among middle aged males, when they become reemployed – usually in a different firm, industry or occupation. In those situations reemployment will often involve starting at a considerably lower level of wage/ salary and job status; this will result in long-term losses in cumulative earnings, personnel benefits and retirement income.

In addition there is substantial evidence that the capacity to recover from crisis of cyclical or structural unemployment is, frequently, based on the extent of self-employment in small and medium enterprises (SMEs). Therefore one would assume that countries with a more viable pattern of self-employment would be (1) more highly productive of new employment, (2) able to generate a greater proportion of new cases of self-employment, and (3) able to absorb a larger number of the unemployed. Thus, the extent of self-employment like GDP per capita, should predict lower rates of suicide.

At the same time, one must consider the extent to which the society provides social protection to individuals in periods of economic crisis. One would expect that countries which traditionally offer stronger social safety nets and, in general, more extensive social welfare systems, would be able to create societies with more stable incomes and employment patterns, as well as higher levels of training for those who have lost jobs or need to restructure their careers, as well as unemployment, disability, health insurance and retirement income. A somewhat crude measure of the tendency of a society to provide such a social protection can be found in the magnitude of government consumption (as compared to private consumption) per capita. With such an

indicator, one would assume that greater levels of social protection and economic security provided by government would minimize economic loss due to economic shocks and structural changes; this would in turn predict lower suicide rates.

Social protection is often thought of, by non-specialists, as essentially referring to insurance systems (especially unemployment, disability and frailty, impoverishment and pensions). However, a major aspect of social protection, during working life and after it, involves expenditure on health care. This needs to be distinguished from government expenditure on overall collective consumption, which will also include education, transportation, national defense etc. We are thus especially interested in the proportion of total government expenditure that represents specific expenditure on health. One may say that this is a measure of the extent to which "governments", or the national polity, place a high priority on population health as a key element of social protection.

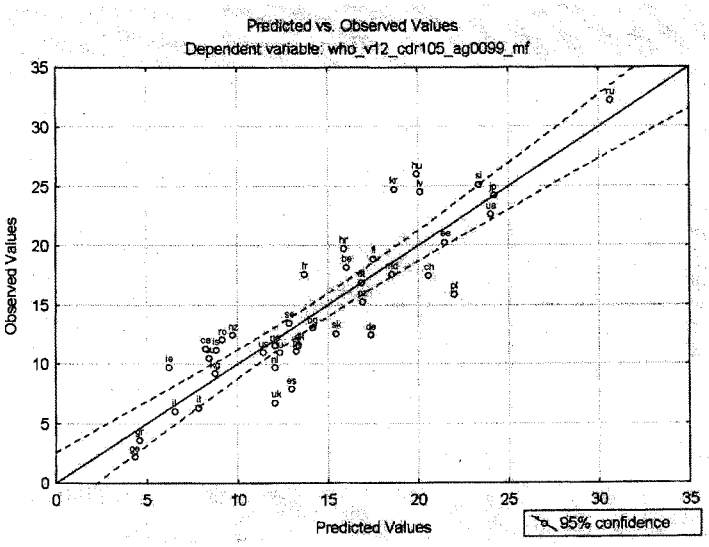
Another position entirely, based on the sociological writings on suicide of Emile Durkheim (1858-1917) puts forward the thesis of social integration as a principal factor militating against high suicide rates. One of Durkheim's key arguments is that a cosmopolitan lifestyle, especially related to urbanization, and incorporating many cultural, religious, political frames of reference and relatively high levels of education, make it difficult for the individual to adopt a coherent system of rational understanding and belief. Such a situation leads to what Durkheim referred to as "anomie" in which the individual becomes relatively "rudderless" and intellectually directionless. This situation, on Durkheim's view, is a primary casual factor in suicide linked to the relative absence of social integration. We could therefore include a measure of such urban cosmopolitanism which would refer to the proportion of the national population that lives in a situation of urban agglomeration. But since Europe is very extensively urbanized, a more penetrating measure of residential agglomeration is the extent of population density among the rural population. Along similar lines of argument, it is also assumed that the divorce rate will predict higher suicide rates.

The above potential causal factors lead us to a model of suicide rate variation among industrialized countries. The model consists (1) economic factors [GDP per capita (inverse), male self-employment (inverse), the unemployment rate (positive)], (2) government expenditures on health care as a proportion of total government expenditures (inverse), (3) social integration [rural population density (positive), divorce rate (positive)], (4) 'life-style' risk factors to suicide directly (e.g., alcohol consumption) and to chronic diseases which themselves are risks to suicide (e.g., tobacco). Figure 3 below presents this model. Nearly all variables are statistically significant and the model accounts for 74% of suicide rate variation among industrialized countries.

**Figure 3**
**Regression summary for total suicide mortality rate (CDR per 100,000 of population)**
**40 European, OECD and CIS countries, year 2005**

R= .89499048 $R^2$= .80100797 Adjusted $R^2$= .74131036
F(9,30)=13.418 p<.00000 Std.Error of estimate: 3.4128

| | Beta | Std.Err. | B | Std.Err. | t(30) | p-level |
|---|---|---|---|---|---|---|
| Intercept | | | 35.73286 | 8.755259 | 4.0813 | 0.000305 |
| GDP per capita, in const. 1990 Geary Khamis $ (Groningen Growth and Development Centre, Total Economy Database, June 2009) | -0.381077 | 0.189844 | -0.00031 | 0.000153 | -2.00732 | 0.053798 |
| Gen. gover. exp. on health - % of total gov. exp. (WHO Statistical Information System) | -0.382798 | 0.133949 | -0.78077 | 0.273208 | -2.85779 | 0.007682 |
| Exp. on food and non-alc. bever. - % of total GDP (World Bank, Global PPP indicators 2005) | -0.436559 | 0.197454 | -0.4198 | 0.189873 | -2.21094 | 0.034806 |
| Exp. on alcohol, bever. and tob- % of total GDP (World Bank, Global PPP indicators 2005) | 0.239833 | 0.139155 | 1.04157 | 0.604341 | 1.72349 | 0.095094 |
| Gover. exp. on collect. consump. - % of total GDP (World Bank, Global PPP indicators 2005) | -0.349901 | 0.095794 | -1.46623 | 0.401415 | -3.65265 | 0.000982 |
| Male self-employment - % of tot. male emplH (ILO, Key Indicators of the Labor Market) | -0.381986 | 0.139958 | -0.28356 | 0.103897 | -2.72929 | 0.010514 |
| Rural pop. density (per sq. km of arable land (World Bank – World Development Indicators) | 0.475674 | 0.089228 | 0.01656 | 0.003106 | 5.33099 | 0.000009 |
| Divorces per 1,000 population (United Nations, Statistic Division) | 0.437951 | 0.110286 | 3.42576 | 0.862683 | 3.97105 | 0.000413 |
| Unemployment rate - % of registered labor force (ILO, Key Indicators of the Labor Market) | 0.319183 | 0.105784 | 0.48069 | 0.159319 | 3.01713 | 0.005162 |



Similar policy issues of national health expenditure as a proportion of GDP, and the unemployment rate can be examined over historical time to observe their implications for population health. In this case a model is required that will include these two variables as predictors of mortality in addition to other factors which help to predict the mortality rate. We begin with the observation that models can be developed which can account for mortality changes over time in industrialized countries, but tend to require at least the two variables of real GDP per capita and the unemployment rate. These models have been published for the United States, the United Kingdom and several other countries (Brenner, 1976, 1985, 1979, 1987). In addition there is cross-national and times series evidence for industrialized countries showing that increased health care expenditure as a proportion of the GDP greatly depends on GDP growth (Hitiris, Posnett, 1992). Therefore, on the grounds of substantial correlation among these predictors (i.e., multi-collinearity), it is unwise to include both GDP per capita and health care expenditures in the same predictive model.

At the same time it would be convenient for policy reasons to include in the model a variable that in some significant way dealt with the fact that the material wellbeing of the non-working segments of the population (youth and elderly) depend on the income and working capacity of the working population. One such variable is a purely demographic version of the 'dependency ratio' (Harwood, Sayer, Hirschfeld, 2004; Cohen, 2003; Crown, 1985), which measures the extent to which the non-working population depends for its income and social benefits on the working population. In this case, the economically dependent population involves the nonworking population under age 15 and (to a very large extent) over 65. The resulting variable of the ratio of the population 15-64 to the population under and over 65 portrays the burden of the working population to support itself as well as the nonworking population. In the micro view, one can see that a family with several offspring and elderly to care for would experience a considerable burden of stress in the need to earn a significant income. Similarly at the national level, a society with a substantial and increasing aging population (typical of wealthy industrialized societies), and/or with a substantial birth rate (characterizing less developed countries) would experience some constraints in investing heavily in health care, pensions, occupational health and safety, education and technological development (Lee, 2002; Masson & Tryon, 1990; Razin, Sadka, Swagel, 2002). Thus a relatively high dependency ratio might theoretically tend to decrease the beneficial health effects and sustainability of economic growth. However, the relation between population aging and economic growth appears to depend on economic and social policies (Fougere & Merette, 1999; Borsch-Supan, 1997. And it could sharply decrease the economic wellbeing of the older population under conditions of economic recession.

It would also be useful in a model like this to include, at least as a control, an important 'lifestyle' variable that represents an important risk to health – in this case, tobacco consumption per capita.

Finally, observation of the United States age-standardized mortally rate (ASDR) over 1970-2005 shows a sharp and continuous decline since 1975. This accelerated mortality decline has been attributed in the United States to the influence of a variety of new cardiovascular drugs which are understood to have been important in the sharp mortality declines in coronary heart disease (Ford, Aljani, Croft, 2007). Since we have limited ability to directly measure such an effect, we instead use a dummy variable to represent the downward shift in mortality since 1975. The same procedure is used to allow us a precisely comparable model for analysis of the United Kingdom ASDR over the same time span.

The models for the U.S. and the U.K. ASDR over 1970-2005 thus includes the following independent variables: (1) health expenditures as proportion of GDP in constant dollars; (2) the unemployment rate as a proportion of the labor force; (3) population 15-64 as a percent of the total population; (5) number of daily smokers in proportion of the population over 15; and (6) a dummy variable for 1975-2005.

The U.S. and U.K. provide acceptable times-series models, with nearly all variables significant (and minimal positive autocorrelation of residuals). For both the U.S. and the U.K. health care expenditures as a proportion of GDP is a highly significant inverse explanatory factor for ASDR. However, the coefficient for U.K. expenditures is higher (minus 30.75) than that for the U.S. (minus 21.70). This would indicate that U.K. expenditures "produce" a greater reduction in mortality than is true for U.S. expenditures. For the unemployment rate, the U.K. impact (8.265) is somewhat larger than that of the U.S. (7.213). This may reflect the higher and more rapidly changing unemployment rates in the U.K., compared to the U.S., during 1970-2005.

**Figure 4**
**Regression Summary for total age adjusted mortality in total population (ASDR per 100,000)**
**Key predictors: health expenditures as percent of GDP, unemployment rate as percent of total labor force**
**UK, years 1970-2005**

R= .99424896 $R^2$= .98853099 Adjusted $R^2$= .98661948
F(5,30)=517.15 p<0.0000 Durbin-Watson d=1.77

| N=36 | Beta | Std.Err. | B | Std.Err. | t(30) | p-level |
|---|---|---|---|---|---|---|
| **Intercept** | | | 1588.874 | 455.8486 | 3.48553 | 0.001535 |
| Total health expend as prop of GDP (OECD Database) | -0.285069 | 0.060696 | -41.793 | 8.8985 | -4.69664 | 0.000055 |
| Total unemploy as prop of labor force (OECD Database) | 0.150331 | 0.033483 | 7.158 | 1.5942 | 4.48978 | 0.000098 |
| Pop 15-64 as proportion of total pop (World Bank Database) | -0.123770 | 0.053324 | -15.134 | 6.5202 | -2.32109 | 0.027263 |
| Tobacco consumption in grams per adult (WHO Database) | 0.677833 | 0.072545 | 77.493 | 8.2937 | 9.34360 | 0.000000 |
| Dummy 1975-2005 | 0.014094 | 0.032453 | 5.603 | 12.9017 | 0.43429 | 0.667184 |

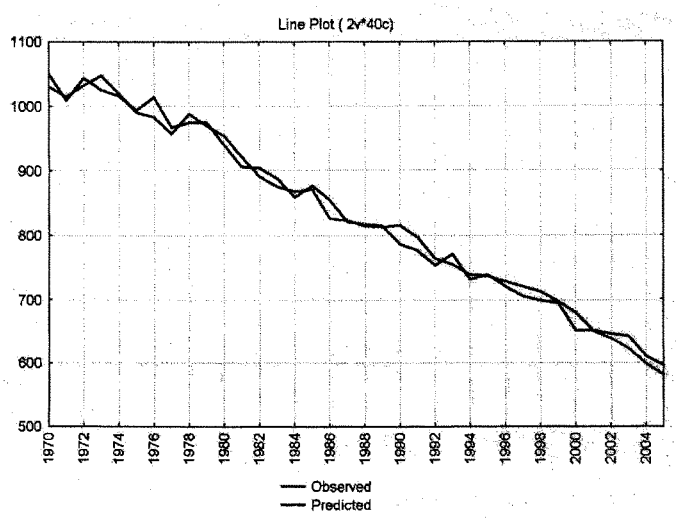


**Figure 5**
**Regression Summary for total age adjusted mortality in total population (ASDR per 100,000)**
**Key predictors: health expenditures as percent of GDP, unemployment rate as percent of total labor force**
**US, years 1970-2005**

R= .99673604 $R^2$= .99348273 Adjusted $R^2$= .99239652
F(5,30)=914.63 p<0.0000 Durbin-Watson d=1.88

| N=36 | Beta | Std.Err. | B | Std.Err. | t(30) | p-level |
|---|---|---|---|---|---|---|
| **Intercept** | | | 1588.874 | 455.8486 | 3.48553 | 0.001535 |
| Total health expend as prop of GDP (OECD Database) | -0.285069 | 0.060696 | -41.793 | 8.8985 | -4.69664 | 0.000055 |
| Total unemploy as prop of labor force (OECD Database) | 0.150331 | 0.033483 | 7.158 | 1.5942 | 4.48978 | 0.000098 |
| Pop 15-64 as proportion of total pop (World Bank Database) | -0.123770 | 0.053324 | -15.134 | 6.5202 | -2.32109 | 0.027263 |
| Tobacco consumption in grams per adult (WHO Database) | 0.677833 | 0.072545 | 77.493 | 8.2937 | 9.34360 | 0.000000 |
| Dummy 1975-2005 | 0.014094 | 0.032453 | 5.603 | 12.9017 | 0.43429 | 0.667184 |

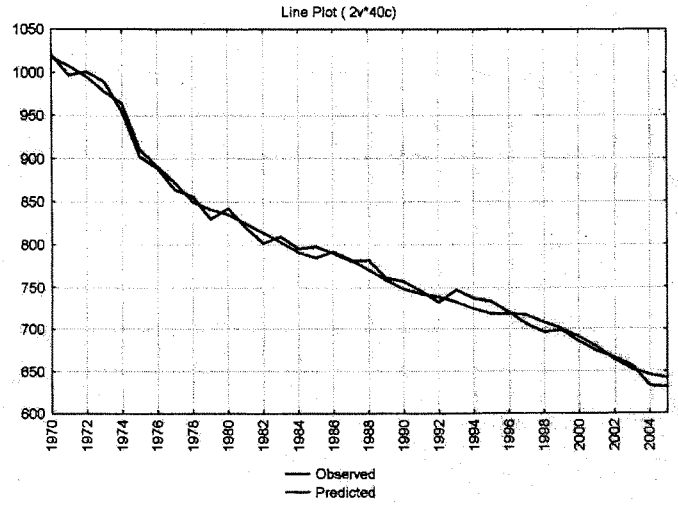


**Figure 6**

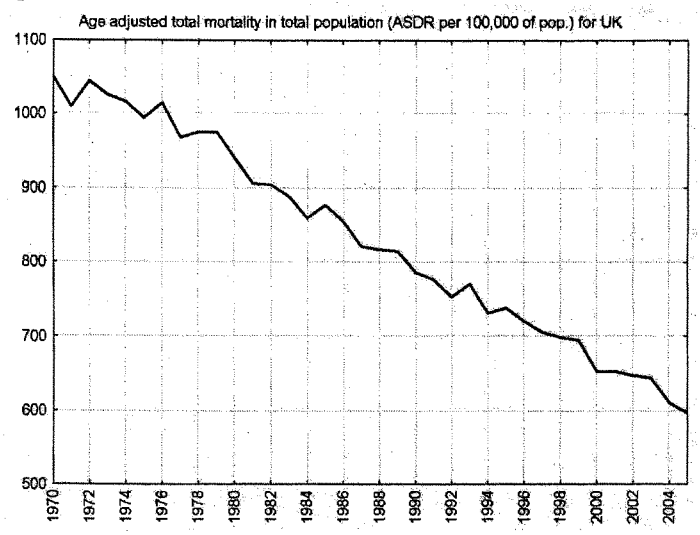

Age adjusted total mortality in total population (ASDR per 100,000 of pop.) for UK
1100
1000
900
800
700
600
500
1970
1972
1974
1976
1978
1980
1982
1984
1986
1988
1990
1992
1994
1996
1998
2000
2002
2004

**Figure 7**

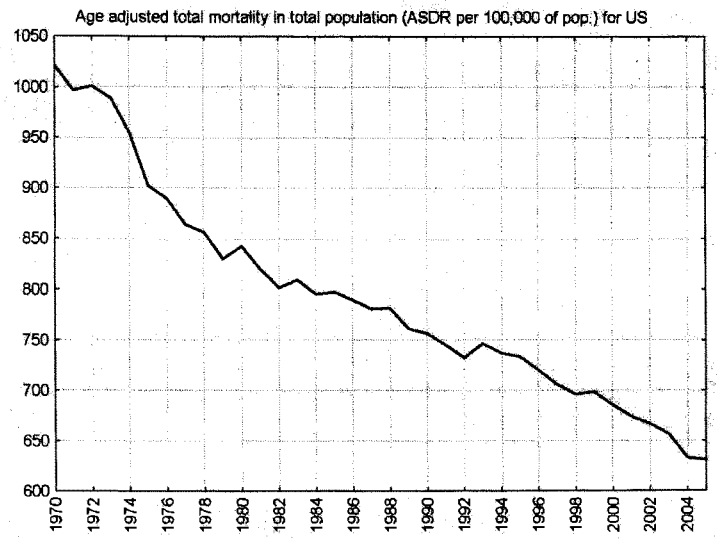

Age adjusted total mortality in total population (ASDR per 100,000 of pop.) for US
1050
1000
950
900
850
800
750
700
650
600
1970
1972
1974
1976
1978
1980
1982
1984
1986
1988
1990
1992
1994
1996
1998
2000
2002
2004

**Figure 8**

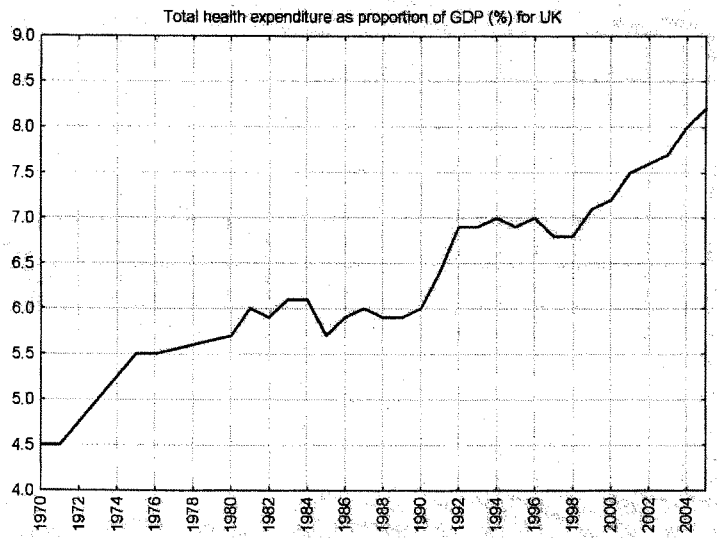

Total health expenditure as proportion of GDP (%) for UK
9.0
8.5
8.0
7.5
7.0
6.5
6.0
5.5
5.0
4.5
4.0
1970
1972
1974
1976
1978
1980
1982
1984
1986
1988
1990
1992
1994
1996
1998
2000
2002
2004

**Figure 9**

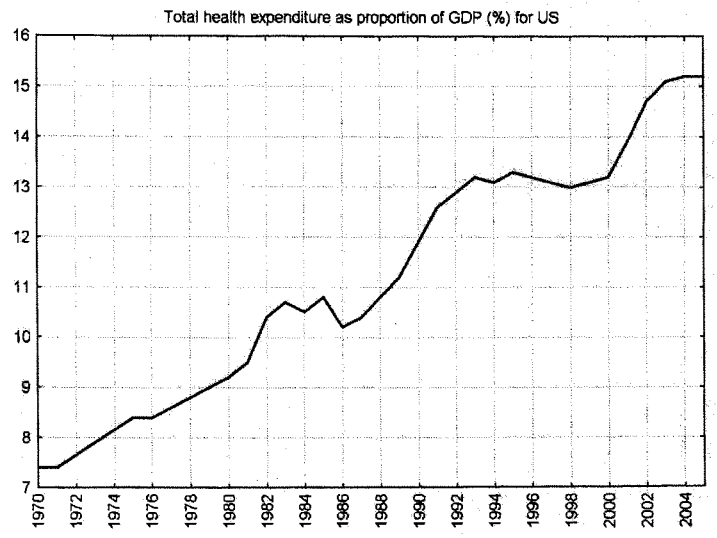

Total health expenditure as proportion of GDP (%) for US
16
15
14
13
12
11
10
9
8
7
1970
1972
1974
1976
1978
1980
1982
1984
1986
1988
1990
1992
1994
1996
1998
2000
2002
2004

Figure 10

Total unemployment rate (% of total labor force) for UK
oecd_hlth_tunem_percenlf
0
2
4
6
8
10
12
14
1970
1972
1974
1976
1978
1980
1982
1984
1986
1988
1990
1992
1994
1996
1998
2000
2002
2004

**Figure 11**

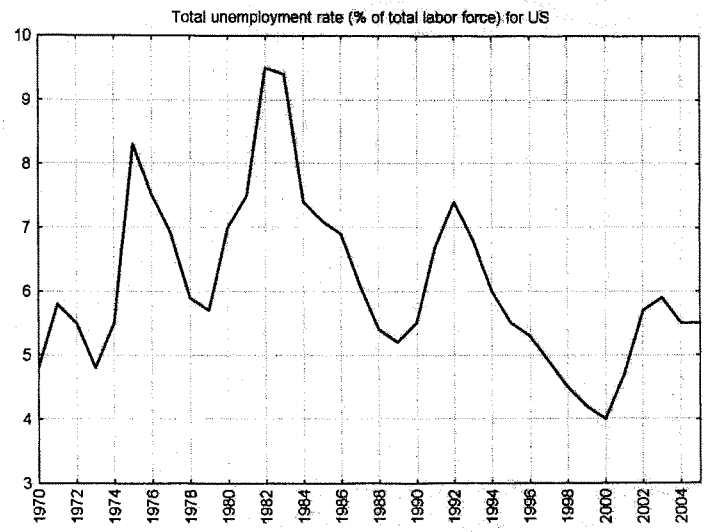

Total unemployment rate (% of total labor force) for US
10
9
8
7
6
5
4
3
1970
1972
1974
1976
1978
1980
1982
1984
1986
1988
1990
1992
1994
1996
1998
2000
2002
2004

**Figure 12**

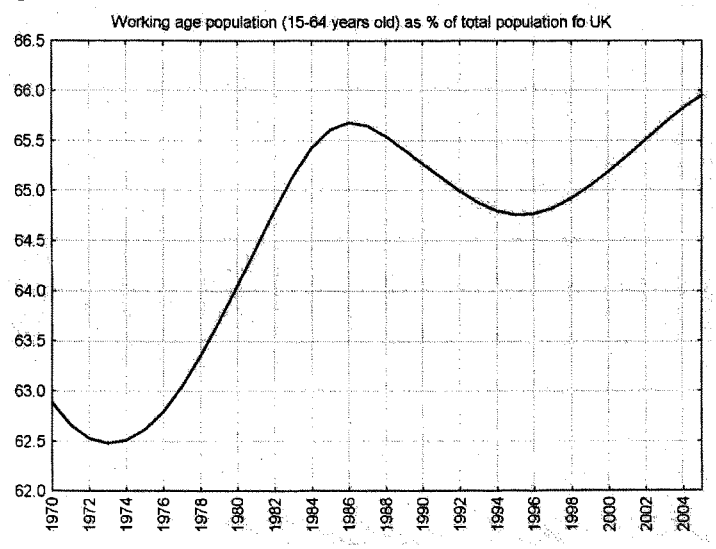

Working age population (15-64 years old) as % of total population fo UK
66.5
66.0
65.5
65.0
64.5
64.0
63.5
63.0
62.5
62.0
1970
1972
1974
1976
1978
1980
1982
1984
1986
1988
1990
1992
1994
1996
1998
2000
2002
2004

**Figure 13**

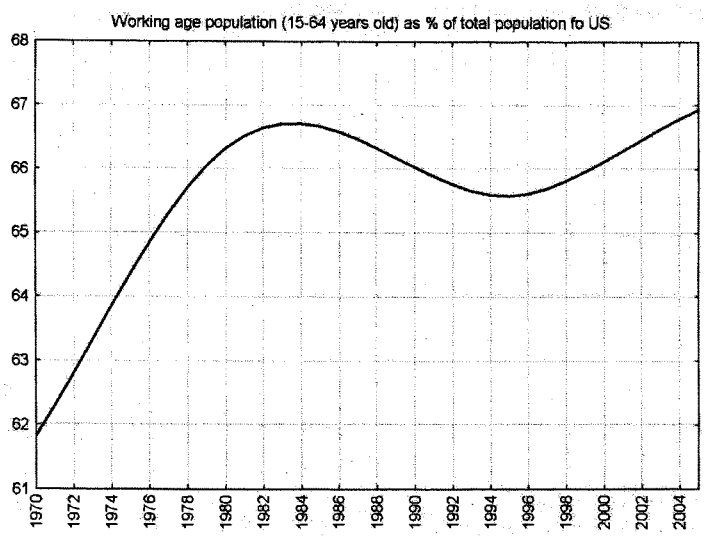

Working age population (15-64 years old) as % of total population fo US
68
67
66
65
64
63
62
61
1970
1972
1974
1976
1978
1980
1982
1984
1986
1988
1990
1992
1994
1996
1998
2000
2002
2004

**Figure 14**

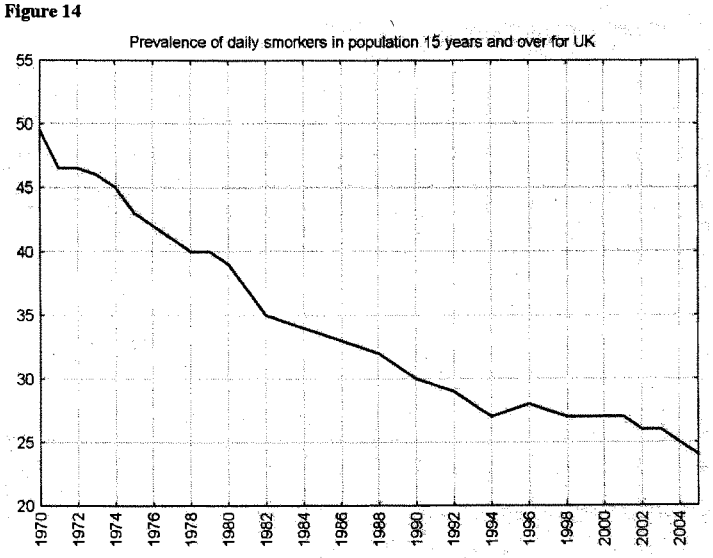
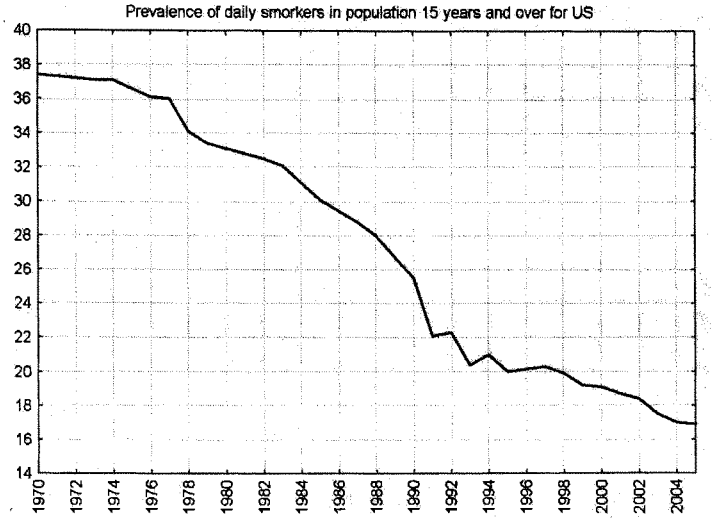

Prevalence of daily smorkers in population 15 years and over for UK
55
50
45
40
35
30
25
20
1970
1972
1974
1976
1978
1980
1982
1984
1986
1988
1990
1992
1994
1996
1998
2000
2002
2004

**Figure 15**


Prevalence of daily smorkers in population 15 years and over for US
40
38
36
34
32
30
28
26
24
22
20
18
16
14
1970
1972
1974
1976
1978
1980
1982
1984
1986
1988
1990
1992
1994
1996
1998
2000
2002
2004

**Projected impact of health care expenditure, and unemployment, on mortality**

In Table 1 below the impact of public health expenditure (as percentage of GDP) is estimated, in relation to changes in mortality under scenarios where the public health expenditure is reduced by 15%, and by 25%. Similarly the impact of decreases in unemployment (male) is increased by 50% and by 100%. A third set of situations is estimated whereby both public health expenditure is decreased and unemployment rates are also increased.

In the scenario where only public health expenditure declines by 15% and 25% the equivalent total change of deaths in the original 40-country sample is approximately 341,000 and 569,000. Using the same model for the 40 countries and making estimates only for 24 of the 27 E.U. countries (without Cyprus, Luxemburg, Malta) is approximately 143,000 and 238,000.

Under the scenario where only unemployment (male) increases by 50%, and by 100%, the equivalent number of deaths in the 40-country sample are approximately 257, 000 and 514,000. For the 24 E.U. countries (based on the 40-country model) the estimates of deaths are approximately 93,000 and 186,000.

Should both public health expenditures (percentage of GDP) decline by 15% and unemployment (male) increases by 50%, the estimated number of deaths in the 40 countries are approximately 599,000 and 236,000 for the 24 E.U. countries. If public health expenditures decrease by 15% and unemployment (male) increases by 100%, mortality increases in the 40 countries by 856,000 and in the 24 E.U. countries by 329,000. if public health expenditures decline by 25% and unemployment (male) increases by 50% total deaths in the 40 countries increase by approximate 826,000 and , in the 24 E.U. countries 331,000. If public health expenditures decline by 25% and unemployment (male) increases 100% then total increases in deaths for the 40 countries are approximately 1,083,600, and in the E.U. 24 countries by 424,000. (All of the above estimates assume that the changes in public health expenditures in unemployment, and the changes in mortality occur within a single year.)

**Table 1**
**Impact of variations of public health expenditures and unemployment on mortality**

| Public Health Expenditure (as percentage of GDP) | | Unemployment (Male) | | Total Change of Deaths (40 countries) | Total Change of Deaths (only EU countries N=24)* |
|---|---|---|---|---|---|
| Factor | % decrease | Factor | % increase | (absolute numbers) | (absolute numbers) |
| 1.00 | 0% | 1.50 | 50% | 257,208 | 92,885 |
| 1.00 | 0% | 2.00 | 100% | 514,416 | 185,770 |
| 0.85 | 15% | 1.00 | 0% | 341,514 | 142,852 |
| 0.75 | 25% | 1.00 | 0% | 569,190 | 238,086 |
| 0.85 | 15% | 1.50 | 50% | 598,722 | 235,737 |
| 0.85 | 15% | 2.00 | 100% | 855,930 | 328,621 |
| 0.75 | 25% | 1.50 | 50% | 826,398 | 330,971 |
| 0.75 | 25% | 2.00 | 100% | 1,083,606 | 423,856 |

***EU 27 without Cypress, Luxembourg, Malta**

**Comment:**
(1) A 25% decrease of public health expenditure as percentage of GDP means that e.g. when public health expenditure as percentage of GDP is 10% it will be reduced to 7.5%

(2) A 50% increase of the unemployment rate means that e.g. when the unemployment rate is at 10% it will go up to 15%

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# Commentary: Economic growth is the basis of mortality rate decline in the 20th century—experience of the United States 1901–2000

M Harvey Brenner[1,2]

**Background** The hypothesis that economic growth has been the principal source of mortality decline during the 20th century in the United States is investigated. This hypothesis is consistent with the large epidemiological literature showing socioeconomic status to be inversely related to health status and unemployment associated with elevated morbidity and mortality rates. Despite evidence over many years showing economic growth, over at least a decade, to be fundamental to mortality rate declines and unemployment rates showing lagged, cumulative effects on mortality rate increases, a recent paper argues that the impact of economic growth is to increase the mortality rate.

**Methods** This study utilizes age-adjusted mortality rates over 1901–2000 in the United States as the outcome measure, while independent variables include real GDP per capita in purchasing power parity, the unemployment rate, and the employment to population ratio. A basic interaction model is constructed whereby (i) real GDP per capita, (ii) the unemployment rate, and (iii) the multiplicative interaction between real GDP per capita and the unemployment rate are analysed in relation to age-adjusted mortality rates. The Shiller procedure is used to estimate the distributed lag relations over at least a decade for variables (i), (ii), and (iii). The error correction method is used to examine these relations for both levels and annual changes in independent and dependent variables.

**Results** While GDP per capita, over the medium- to long-term, is strongly inversely related to mortality rates during 1901–2000, in the very short term—i.e. within the first few months—rapid economic growth is occasionally associated with increased mortality rates estimated in annual changes. With respect to the unemployment rate, the first year (without lag) will frequently be associated with a decrease in mortality, but thereafter, and at least for the following decade, the effect is to increase the mortality rate. Thus, the net effect of increased unemployment is a substantial increase in mortality. This is also reflected in the entirely negative relation between the cumulative effects of the employment to population ratio and mortality rates over a decade.

**Conclusions** Economic growth, cumulatively over at least a decade, has been the central factor in mortality rate decline in the US over the 20th century. The volatility of rapid economic growth as it departs from its major trend, has a very short-term effect (within a year) to increase mortality—partly owing to adaptation to new technology and the adjustment of the formerly unemployed to new jobs, social status, and organizational structures.

**Keywords** Economic growth, per capita income, unemployment, business cycles, economic inequality, mortality

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## Socioeconomic status, unemployment, and health

It is now among the firmest of epidemiological findings, across industrialized societies, that socioeconomic status is inversely related to health status. In particular, higher income has been routinely shown to be a significant inverse predictor of morbidity and mortality.[1–10] Similarly, the large and growing literature on unemployment and health is highly consistent in demonstrating elevated morbidity and mortality associated with unemployment and withdrawal from the labour force.[11–18] It follows that economic growth, the major source of socio-economic status improvement, should lead to lower morbidity and mortality rates, whereas economic decline—especially in conjunction with high unemployment—should increase mortality rates.

## The macro level

At the macro, i.e. national, level Thomas McKeown has demonstrated the fundamental importance of economic development to the decline—and near disappearance—of the classic infectious and childhood diseases as significant causes of death from the second half of the 19th century to the Second World War in England and Wales.[19,20] Over 1860–1950, the importance of economic growth to mortality decline is substantially owing to improvements in nutrition, sanitary engineering, and housing construction. Subsequently, it has been observed since at least the 1970s that the long-term effect of economic growth is a central source of mortality reduction, even after the Second World War in the US, the UK and the other 14 original EU countries, Canada, and Japan.[21–25] It has also been repeatedly shown at the national level that unemployment is a significant predictor of higher mortality rates over a period of at least a decade in many industrialized countries.[21–29]

How then are we to understand findings reported by Tapia Granados[30] that 'economic expansions' are related to higher mortality? Many epidemiologists may find this report incomprehensible on the grounds that the findings are incoherent—i.e. entirely inconsistent with the large epidemiological literature on low socioeconomic status and poor health, on the one hand, and on the relationship of unemployment and diminished health, on the other. The estimates by Tapia Granados are presented in simple correlations, without regard to lag estimation or the usual multivariable controls for confounding and interaction, or the standard econometric tests including those for residual autocorrelation and unit roots, and even without capitation of GDP itself.

Beyond these inconsistencies and methodological omissions, per capita economic growth over the 20th century cannot be positively related to increased mortality rates (age-adjusted), since these two trend-like variables are strongly inversely related to each other as is easily observed (Figure 1). In comparison, economic growth rates on an annual basis, without any lag, show a very weak, but positive relation to age-adjusted mortality rates (Figure 2). Furthermore, economic expansions cannot really be related to mortality increases over the 20th century because, during both expansion and recession years, age-adjusted mortality rates have, on average, fallen. During the 20th century, 72 years, or nearly three-quarters of the century, have been represented by economic growth ('expansions'). If economic growth literally caused mortality to rise, then age-adjusted mortality rates would have shown an increased trend over the 20th century rather than a rapid and massive decline.

## Long-term impact of economic growth on mortality decline

What is the basis for the statement that economic growth is the 'central' precursor of mortality decline in the 20th century?

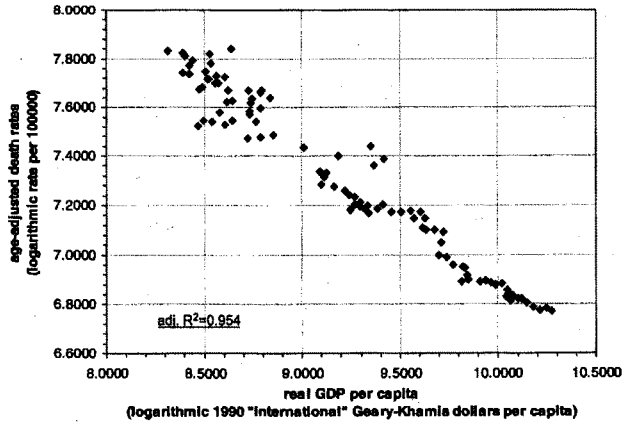


**Figure 1** Relation of real GDP per capita to age-adjusted death rates, US 1900–2000 (natural logarithms)

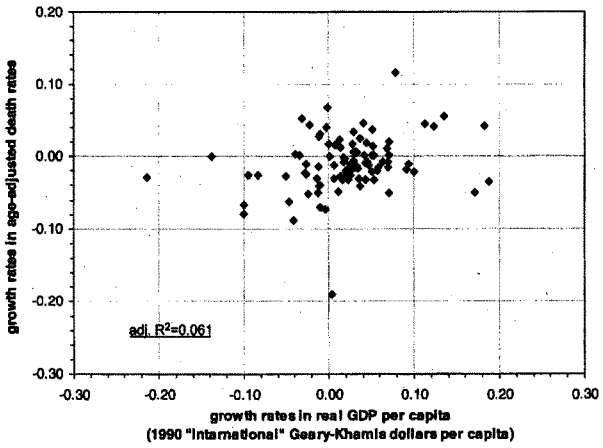


**Figure 2** Relation of growth rates in real GDP per capita to growth rates in age-adjusted death rates, US 1901–2000

Many would immediately turn their attention to the fundamental contributions of economic growth to the reduction of poverty—through the elevation of real incomes via basic earnings and government and employer contributions to the 'social safety net'. For a broader view, it is important to keep in mind investment in the sciences and industrial technologies that directly minimize harm to health, including improved ergonomics, injury control, and reduction of toxic emissions. Of enormous importance is the considerable investment in new medicines, types of surgery and prosthetics, structure of care and hospital facilities and ambulance services.

Additionally, there is the considerable investment, during the last 30 years, in facilities catering to the requirements of the disabled and an older (and in the long-term more frail) population; these include housing, transportation access, and working conditions. More recently, we have had investment in the information produced by epidemiological researchers on the importance of 'lifestyle', including various aspects of consumption (calories, fats, vegetables, and fruits), as well as alcohol and tobacco use and exercise—all involving changes that have become staples of western industrialized culture. In summary, the capacity for investment in new technologies, health sciences, and education have made it possible to create a civilization in which health and life-expectancy outcomes become increasingly predictable.

## Growth in GDP and mortality rates

Despite considerable evidence of the fundamental importance of economic growth to the increased health and life expectancy of industrialized country populations, is it likely that a positive relationship exists between GDP growth rates and mortality growth rates? When answering this question, it is important to bear in mind that the association reported by Tapia Granados refers to an extremely short-term relation—i.e. without lag and without any trends—that connotes a nearly simultaneous occurrence of higher GDP growth rates and higher mortality rates increasing during the same year, but without reference to long-term or even medium-term relations. The epidemiologist would have considerable difficulty interpreting such a relationship, because essential to the inference of causal relations is the time precedence criterion—i.e. the occurrence of the independent variable prior to that of the dependent variable.

Since the long-term relationship (i.e. over at least 10 years) between GDP per capita and declining mortality rates has been observed several times,[21–23,31] and is essential to the long-term trends in mortality reduction, it is clear that economic growth is inversely related to mortality. Under these conditions, is it likely that the zero-lag relation between GDP and mortality rates is actually positive? It is possible that these two observations are consistent with each other and this hypothesis has been published by the present author.[21,23,31] The underlying concept is that while medium- to long-term economic growth is the central source of improvement in life expectancy, the earliest phase of that growth—i.e. within the first year—can actually require increased adaptation.

This phenomenon has been referred to as the distinction between the trends in economic growth vs 'rapid' economic growth.[23,31] These were not the first citations of the positive relation between economic upturns at lag zero and increased mortality. The initial observation was by Dorothy Thomas,[31] utilizing the GDP national accounting method, which had recently been created by her colleague Simon Kuznets. Thomas reported the relationship without attempting an explanation. The original interpretation offered by the present author was based on the idea that while the long-term trend of GDP per capita was the fundamental source of increased life expectation, the volatility of changes in that growth were—in the very short term—a source of increased mortality.[23] In other words, it is

the extent of unpredictable change itself, as compared with sustained growth—or, in classical economic terms 'trend growth'—that contributes to mortality in the very short term. This formulation was built on Durkheim's concept of anomie as related to economic fluctuations, with both rapid economic growth and recession producing mental distress.[32]

Since 1979, the paradox of a positive relationship between GDP per capita and age-adjusted mortality rates in the US has undergone further exploration. Potentially, the most relevant and powerful explanation lies in Schumpeter's identification of the capacity for 'creative destruction' that is the source of economic growth—namely, innovations. Innovations are the basis of improvement in both productivity and the quality of goods and services,[33] but they are also the source of stress in social change. Schumpeter's destructive element lies in the elimination of jobs and termination of businesses that are unable to compete with more up-to-date innovations and procedures. Such innovations are introduced by way of investment, especially during periods of the most rapid economic growth—i.e. economic upturns. Thus, in the very short term, the introduction of new technologies within firms or the establishment of new firms that embody the newer technologies will impose on employees the learning curves or 'growing pains' of organizational adjustment. This will mean adaptation to new ways of working and the acquisition of new skills as well as the threat of loss-of-job status and income in a changing social hierarchy. At the same time, this period of rapid economic growth is the time at which the speed, intensity, and volume of production will be at it's highest since aggregate demand is at a maximum. The issue of work intensity is now prominent in the literature on work stress as pertains to injuries and cardiovascular illness.[34,35]

The intensity and overall workload (productivity per worker) also increases during the economic upturn for another important reason. The unemployment rate is known as a 'lagging' business cycle indicator. This means that it continues to increase or at least remain high after recession is over—i.e. in the upturn phase of the business cycle. Unemployment remains high at this time because employers are still reluctant to hire, or rehire former, employees since they do not yet have an indication that economic growth will be sustainable. The implication is that, despite rising orders for work, new employees will not be brought on very rapidly and the work staff will be assigned a greater volume of work despite potentially increasing stress levels.[36] Tapia Granados[30] also follows Ruhm[37] in proposing that economic upturns lead to elevated consumption of alcohol, tobacco, calories, etc. It is true that such consumption patterns have been shown to influence chronic disease mortality—but they do so over a minimal lag period of 5–10 years and are not specifically related to economic upturns.[38–43]

## Long-term significance of unemployment

In considering the potential impact in the US of unemployment on ill health, attention should be directed to the duration of unemployment. In particular, since the Second World War in the US ~50% of the unemployed remain so for <5 weeks. This means that for a very large proportion of the unemployed, the return to employment—whether or not to the same firm—occurs in little more than a month. It would not seem that these short-term unemployed would be under major stress owing to loss of income, social status, or social relationships as to be at considerably greater risk for poor health or mortality. It is plausible that the stress of job change—i.e. adaptation to the requirements of a new position—could involve additional health risks.

Of substantially greater importance for health is unemployment lasting at least 6 months and certainly more than 1 or 2 years. The presumption is that these longer-term unemployed suffer considerable loss-of-job status, skills, income, social insurance and are at risk for long-term poverty. The evidence indicates that the longer-term unemployed are at major risk for downward social mobility, i.e. a substantial decline in socioeconomic status. The basic epidemiological literature informs us that a considerable reduction in the level of socioeconomic status is a significant risk to health and life expectancy. The literature on the long-term unemployed also shows increased exposure to alcoholism and use of other psychotropic substances such as tobacco and less expensive/nutritious foods. Equally important, the long-term unemployed are especially at risk for damaged family and friendship relations, quite apart from the social isolation induced by the loss of employment itself. Therefore, a time lag of at least a decade for increased health risk among the long-term unemployed is plausible and has been demonstrated for the UK.[23,44,45]

## Interaction between unemployment and economic growth

The economist Okun has formulated a principle (Okun's 'law')[46] which specifies the potential reduction in the unemployment rate that would result from a prior specified increase in economic growth. This intrinsic relationship between economic growth and unemployment means that the experience of recession in a population is a joint function of income and employment loss.

If we are to represent the combined influence of economic growth and unemployment on subsequent mortality, we require a model that will include the (multiplicative) interaction of these two variables. In the unemployment–economic-growth situation, the population is most at risk for health damage when GDP per capita is low and unemployment is simultaneously high. This result is partly owing to the fact that two damaging health risks are interactively more harmful than one and, as indicated above, the first few months of a period of economic growth can carry health risks owing to the introduction of innovations, high work pressure on employees and the reintegration of the formerly unemployed.

## Time-series model

This is the first century-long model of mortality rates based essentially on economic factors. It is nevertheless a preliminary model in that it consists of only three principal independent variables: (i) the long-term effects of economic growth over 0–11 years, (ii) the long-term effects of unemployment over 0–11 years, and (iii) the interactive effect of unemployment and GDP per capita over 0–11 years. For variables (i) and (iii) we

hypothesize a negative sign, and for variable (ii) a positive sign. This model, where all variables are logarithmically transformed, is examined in relation to age-adjusted mortality for the US over the period 1901–2000. Dummy variables are used to deal with potential external shocks to the mortality rate and to the economy owing to the First and Second World Wars, identifying the years 1918 and 1945 as those with the largest numbers of military personnel on active duty. (1918 is also the peak year of the influenza pandemic.) We utilize the error correction method[47] by which are estimated both a set of relationships between the levels of the independent variables and levels of mortality rates, and a first difference (annual change) model for the independent and dependent variables which includes the residual term from the initial level model. While the level model accounts for the fundamental non-linear, trend-like, and large oscillating movements in the age-adjusted mortality rate, the same variables explain nearly 60% of the annual changes in mortality rates (see Table 1 and Figures 3 and 4).

The weighted sums of the lagged variables—estimated by the Shiller procedure[48]—of the three variables distributed over 0–11 years (GDP per capita, unemployment rate, interaction of GDP per capita and the unemployment rate), are taken to represent their cumulated impact. It is found that the 0–11 year cumulative impact of GDP per capita is significantly inversely related to mortality; and the 0–11 year cumulative impact of the unemployment rate is significantly positively related to mortality. Similarly, as hypothesized, the multiplicative interaction of GDP per capita and unemployment cumulated over 0–11 years shows a significant negative sign (see Table 1).

## Conclusions

Economic growth, cumulatively over at least a decade, is the central factor in mortality rate decline in the US over the 20th century. However, in the very short term—i.e. within the first few months of that decade—rapid economic growth is associated with increased mortality, probably owing to the initial stresses of adaptation to new technology in combination with greater work volume, speed, and duration. This very short-term effect disappears within a year and the medium- to long-term lagged effect of economic growth is entirely related to mortality decline.

Similarly, with respect to the unemployment rate in the US, the first year (without lag) will frequently show a negative sign in relation to mortality, but thereafter, and at least for the following decade, the effect is to increase the mortality rate. Thus, the net effect of increased unemployment is a substantial increase in mortality. But even the apparent short-term mortality rate increase related to reemployment is probably owing to the stresses of adaptation to new employment in the face of rapid economic growth. It can be argued that this need to adapt to new work by the formerly unemployed—owing to their having been made unemployed as a result of the previous recession—is an intrinsic part of the health damage attributable to unemployment. Thus, unemployment over a cumulative time period is strongly positively related to mortality increases.

To argue that economic expansions increase mortality is to emphasize peripheral effects to the exclusion of the main health effects of economic growth. It is analogous to pointing out the side-effects of antibiotics or surgery without mentioning their

**Table 1** Multivariable relations between macroeconomic factors and age-adjusted mortality rates in the US, 1901–2000 (all variables in logarithmic form)

| | Constant | Time trend | Age-adjusted mortality (lag 1 year) | Dummy 1918 | Dummy 1945 | Interaction GDP * UR (lags 0–11 years) | Unempl. rate (lags 0–11 years) | GDP per capita (lags 0–11 years) | Residual from level model (lag 1 year) | R bar square | Durbin-Watson |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Model 1 | | | | | | | | | | | |
| Level | | | | | | | | | | | |
| Coefficient | 7.557 | −0.007 | | 0.098 | −0.067 | −0.517 | 0.468 | | | 0.994 | 2.240 |
| (P-value) | (<0.001)*** | (0.776) | | (<0.001)*** | (0.004)** | (<0.001)*** | (<0.001)*** | | | | |
| First difference | | | | | | | | | | | |
| Coefficient | 0.002 | | | 0.093 | −0.057 | −0.604 | 0.547 | | −0.575 | 0.548 | 2.276 |
| (P-value) | (0.524) | | | (<0.001)*** | (0.007)** | (<0.001)*** | (<0.001)*** | | (<0.001)*** | | |
| Model 2 | | | | | | | | | | | |
| Level | | | | | | | | | | | |
| Coefficient | 8.44 | | −0.112 | 0.098 | −0.080 | −0.335 | 0.280 | −0.247 | | 0.994 | 2.262 |
| (P-value) | (<0.001)*** | | (0.118) | (<0.001)*** | (<0.001)*** | (0.004)** | (0.016)* | (0.019)* | | | |
| First difference | | | | | | | | | | | |
| Coefficient | 0.002 | | | 0.097 | −0.068 | −0.311 | 0.251 | −0.277 | −0.566 | 0.571 | 2.270 |
| (P-value) | (0.601) | | | (<0.001)*** | (0.001)** | (0.012)* | (0.038)* | (0.001)** | (<0.001)*** | | |

* $P < 0.05$; ** $P < 0.01$; *** $P < 0.001$.

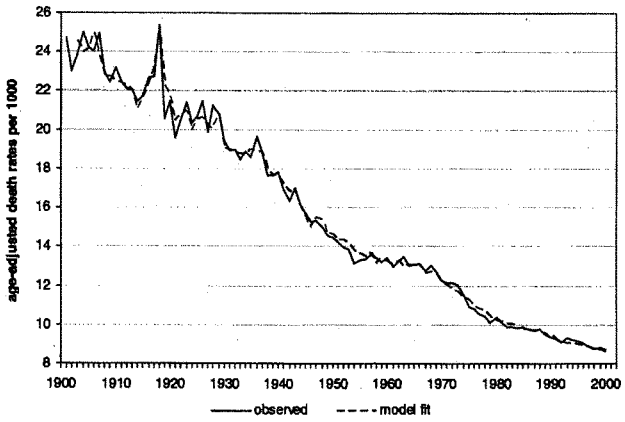


**Figure 3** Multivariate relations between macroeconomic factors and age-adjusted mortality rates in the US, 1901–2000, level model

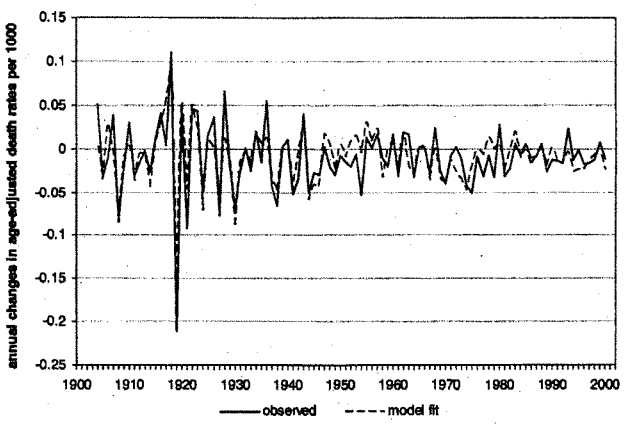


**Figure 4** Multivariate relations between macroeconomic factors and age-adjusted mortality rates in the US, 1904–2000, first difference model

primary life-saving properties. An even closer analogy might be to claim that increased hospital, school, or home construction brings increased death without comprehending the life-sustaining effects of health care, education, or housing. Thus, it is crucial to place the health impact of the small oscillations represented by annual changes in economic growth into the broader context of the principal medium- and long-term trends of economic development.

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# Commentary: The economic business cycle and mortality

Eric Neumayer

There is much evidence that economic recessions can have detrimental health effects for those losing jobs or in fear of losing their jobs. The unemployed in particular are vulnerable as in addition to material losses, they also potentially lose access to social networks, self-esteem, self-confidence, and a structured life schedule—all factors known to affect health.[1,2] Therefore, it is natural to presume that population health as measured by mortality moves counter-cyclically, i.e. one would expect mortality to be up in economic recessions. Yet, there is mounting evidence to the contrary: mortality is up in times of economic expansion and down in recession.[3–7] Importantly, the two pieces of evidence are not necessarily inconsistent with each other. This is because economic upturns can affect the health of many more people or affect health more strongly, for example, via higher working times, job-related stress, increased consumption of health-damaging consumer goods, and an increase in work-related accidents. Therefore, the overall effect of economic expansion on mortality can be negative despite the beneficial health effects of reduced fear of job loss and reduced number of unemployed people.

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Still, given its seemingly counter-intuitive results, it is important that the evidence showing mortality rates to move pro-cyclically is tested in different samples, different time periods, and with different estimation techniques to check its robustness. Tapia Granados[6] has provided a valuable addition to this literature. His time-series analysis of mortality rates in the United States over the period 1900–1996 complements nicely existing evidence based on panel data analysis across the states in the United States,[3] Germany,[7] or OECD countries[4] from shorter time spans as well as other time-series analysis by the same author for Spain and Sweden.[5] Time-series analysis evidence is perhaps particularly welcome since Brenner's contrary results suggesting that recessions raise rather than lower mortality rates are largely based on time-series analysis as well,[8] but note that his research on the issue had started >20 years earlier. I particularly like that Tapia Granados[6] provides estimates both for the entire time period and for selected sub-periods. The fact that the estimated coefficients for the total age-adjusted mortality rate do not differ much across time periods is a striking result, given that most other existent evidence is from much more recent time periods.

However, time-series analysis poses various econometric challenges that are either non-existent or much less prevalent in panel data analysis. Despite space constraints, I would have

## Community Medicine

# MORTALITY AND THE NATIONAL ECONOMY

## A REVIEW, AND THE EXPERIENCE OF ENGLAND AND WALES, 1936–76

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***Summary*** The long-term upward trend in real per-caput incomes is associated with better health, but the smoothed curve disguises cyclic fluctuations, recessions followed by periods of rapid economic growth, which may be stressful to certain groups in the workforce and, by extension, to their families. Especially vulnerable in recessions are those in industries whose goods or services are not essential, the less skilled who are the first to lose their jobs and the last to get their jobs back when the economy improves, and those who find that over one turn in the business cycle their skills are no longer needed. For these groups, most often to be found in the lower socioeconomic classes, this lack of economic security is stressful: social and family structures break down and habits that are harmful to health are adopted. Acutely, if the effect manifests as a psychopathological event (e.g., suicide), or after a time lag of a few years or even one or more turns of the business cycle for chronic diseases, economic recessions and subsequent periods of rapid economic growth are associated with a deceleration in the normally declining curve of mortality against time. This model, tested previously on U.S. data, has now been confirmed on data for England and Wales.

### INTRODUCTION

SINCE at least the mid-19th century England and Wales has seen a secular decline in mortality-rates associated with long-term improvements in economic conditions. The standard of living has improved and economic instability and insecurity have been much reduced. Over the same time period there has emerged a consistent inverse relation between socioeconomic status and mortality: in general, the higher the income, occupational, and educational levels of a population, the lower its mortality-rate.[1–4] This mortality difference is not confined to infectious diseases, attendant upon poor nutrition and sanitation and poverty, but holds for many of the chronic diseases now afflicting modern industrialised nations.

In both the United States and Britain the socioeconomic differentials in mortality-rates may indeed have increased since the second world war[5]—a perplexing trend in Britain where a high-quality health service available to all was introduced in 1948. Even if different socioeconomic groups in Britain do not make equal use of the Health Service,[6] it is unlikely that differential utilisation is solely responsible for the inverse relation between socioeconomic status and mortality.

Factors other than health care which might account for socioeconomic differentials in mortality include intemperate life habits (immoderate use of alcohol, smoking, overeating, lack of exercise)[7] the disruption of basic social patterns involving family and community,[8–12] such as migration, urbanisation, and divorce or widowhood; and the influence on the probability of illness of both stress from specific deleterious events, such as unemployment, retirement or work under conditions of financial and job insecurity,[13–17] and of the cumulative influence of various stressful events over a considerable time span.[18–20] The hypothesis of this paper is that economic instability and insecurity increase the likelihood of immoderate and unstable life habits, disruption of basic social networks, and major life stresses—in other words, the relative lack of financial and employment security of lower socioeconomic groups is a major source of their higher mortality-rates. The hypothesis predicts that indicators of economic instability and insecurity, such as unemployment and unusually rapid economic growth-rates, should be associated, over time, with higher mortality-rates, while the smooth, long-term exponential trend in economic growth should be inversely correlated with mortality-rate trends.

### ECONOMIC FLUCTUATIONS AND LIFE STRESS

Two classic sequences of economic loss associated with life stress and, subsequently, with morbidity and mortality can be identified. In the first the population is exposed to continuous economic instability and insecurity long term, which approach crisis levels during recessions. Particularly at risk are workers in industries whose fortunes depend on cyclic changes in the economy—e.g., in household equipment, cars, clothing, building, and recreation, these being goods and services the purchase of which can be deferred until a recession has passed. Also at risk here are the semi-skilled and unskilled workers. They are among the first to lose their jobs and among the last to be rehired. Populations subject to this "cyclic unemployment" show increased mortality two to three years after the recession which initiated a process of morbidity.

The second classic sequence is associated with changes in the structure of the national economy due to technological innovation within a particular industry through automation, for example, or the replacement of natural fibres by synthetics or because of relocation within or even outside a country where an industry has traditionally flourished. The risk of redundancy rises for workers who represent only a marginal gain to a firm; for them alternative employment in another industry will almost certainly be at a job status and income well below those previously held. Radical change in the individual's social environment can be seen historically too, in the migration of farmworkers to manufacturing centres during the lengthy process of urbanisation and in the post-war decline in manufacturing employment and the concomitant increase in employment in service and communications. In this sequence of "downward social mobility" the illness process begins with recession, and, within two to three years, the likelihood of mortality is greatly increased, particularly if another stress appears. For the downward mobile, the next major source of stress usually occurs during their reintegration into the economy, in the period of rapid economic growth

which follows a recession; for these individuals the probability of mortality increases during rapid economic growth. Some will not be successfully reintegrated, ending up among the intermittently employed or forced into early retirement. In these cases, mortality may be associated with recessions long after the period of initial economic loss. Yet others may find that their work skills are no longer consistent with the pace of industrial development: the potential for job losses here is illustrated by the microprocessor.[21]

## DEVELOPMENT OF BASIC MODEL

The basic model originated with the findings that the rate of first admissions to mental hospitals in New York State was inversely related to the rate of employment during 1914–67 and to an index of business cycles for 1841–1909.[22] Data for the entire United States showed that indices of acute pathological disturbances, including suicide and homicide, rose within a year of increased unemployment-rates.[23] From the psychopathological the research next focused on chronic physical illnesses with a stress element, especially cardiovascular diseases. The earlier study of psychopathology suggested that increases in cardiovascular morbidity would follow increased unemployment within a few months,[24] but that mortality would rise only after a considerable time lag. The lag was found to be two to three years for most age-groups and both sexes.[25] Higher correlations were found at lags of two or three years than at time zero or one year. The same relation, with a nearly identical lag structure, was found by Morris and Titmuss in 1944 for rheumatic heart-disease.[26]

The impact of recession on cardiovascular mortality, which represents 60–70% of total mortality in industrialised societies, raised the question of whether the secular decline in the total mortality-rate might be inversely related to the long-term economic growth trend. Since recession leads to increased mortality, long-term growth should lead to lower mortality. Evidence for this came from findings that the infant-mortality rate, a sensitive index of national economic development, also rose within one or two years of recessions in the U.S.[27]

Initial tests of equations incorporating indices of both long-term economic growth and recession began with mortality related to alcohol consumption, including cirrhosis of the liver.[28] These tests were followed by a large-scale study, prepared for the Joint Economic Committee of the U.S. Congress.[29] A multivariate model incorporated an indicator of economic growth, the rate of unemployment, and the inflation-rate. An additional innovation was the use of the polynomial distributed lag method, which permitted a test of the assumption that there probably was no single discrete lag between economic change and mortality-rates for the entire population. Instead, it seemed realistic to assume that, within a five-year period, the most vulnerable populations (e.g., the aged, previously ill, and lower socioeconomic groups) would respond relatively early to economic trauma, while the least vulnerable would show a longer lag. Thus, a distributed-lag estimate, beginning at year zero and ending at year five, replaced the single optimum discrete lag estimate.

Another significant addition to the model stemmed from the emphasis, in work on the impact of stress on morbidity, of the scale of the adaptation required to meet a group of quite ordinary life changes which accumulate over two or more years.[18,20] Of equal relevance were epidemiological studies which had identified adaptation to urban industrial life, an instance of critical change in the socioeconomic environment, as an important risk factor in cardiovascular disease.[8–10] The implication was that for a population which had endured losses of employment and income during recession, adaptation to new work and living environment during the following period of rapid economic growth would be additionally stressful. This view is strongly supported by evidence from the demographic history of major European cities.[30]

As a result rapid economic growth was included as a predictor of mortality. This model was successfully tested with U.S. data on suicide, homicide, cardiovascular mortality, and age-specific total mortality.[31,32] It then became possible to explain the anomaly, discovered by Thomas,[33] that the early phase of business-cycle upturns tended to be positively correlated with mortality-rates during the late 19th and early 20th centuries in Britain.

Using a graphic analysis, Eyer interpreted the Thomas anomaly differently: high unemployment, which is moderately inversely correlated with business-cycle indices at zero lag, causes lower mortality-rates at zero lag.[34] However, when this interpretation was tested on U.S. data by statistical methods, the unemployment-rate did not consistently show a negative simple correlation with the mortality-rate; usually the relation was positive even at zero lag, and, at lags of two to ten years the relation was consistently positive and significant. With controls for long-term economic growth, the lagged relations between unemployment and mortality (for all causes or for chronic diseases) became stronger, while the unlagged relations became weaker.

With increasingly larger proportions of total mortality being attributed to chronic disease, the lag pattern of heightened mortality behind higher unemployment should be lengthening. Tests based on U.S. data showed that the distributed lag both began at a later time (between three and four years) and extended over a longer period (ten to fifteen years) as the interval of analysis covered increasingly later time spans (e.g., 1950–76, as compared with 1940–76 or 1909–76).

The findings of increased mortality-rates for chronic diseases beginning with a lag of one year, and running as long as fifteen years subsequent to the initial periods of recession, led to the following conclusions:

(1) Recession causes severe economic loss and downward social mobility, which places many of those affected in a long-term state of vulnerability to subsequent recessions and periods of rapid economic growth.

(2) Severe economic loss and downward mobility can initiate long-term processes of chronic illness, which may endure for several years, prior to mortality.

(3) Therefore, in summary, severe economic loss and downward mobility initiate patterns of interaction over several years between chronic disease processes and vulnerability to economic stress.

## ELEMENTS OF EXPLANATORY MODEL

The explanatory model, which permits the prediction of mortality patterns, consists of four main components: (1) the smooth exponential trend of long-term economic growth, measured by real per-caput income; (2) the rate of unemployment; (3) "rapid economic growth", measured by deviations from the long-term exponential trend in real per-caput income and by annual changes in the rate of growth of real per-caput income; and (4) government expenditure on welfare as a percentage of total government expenditure.

The *long-term trend in economic growth*, with major influences on nutrition, sanitation, and education, dominates the secular history of decline in the mortality-rate, up to the time when infectious diseases ceased to be important causes of death (1930–50). Since that time, its main influence has been to reduce the amplitudes of the cycles and fluctuations in national economic behaviour that have been intrinsic to the process of economic growth itself. These cycles and fluctuations ("economic instabilities") remain sources of stress, despite improved

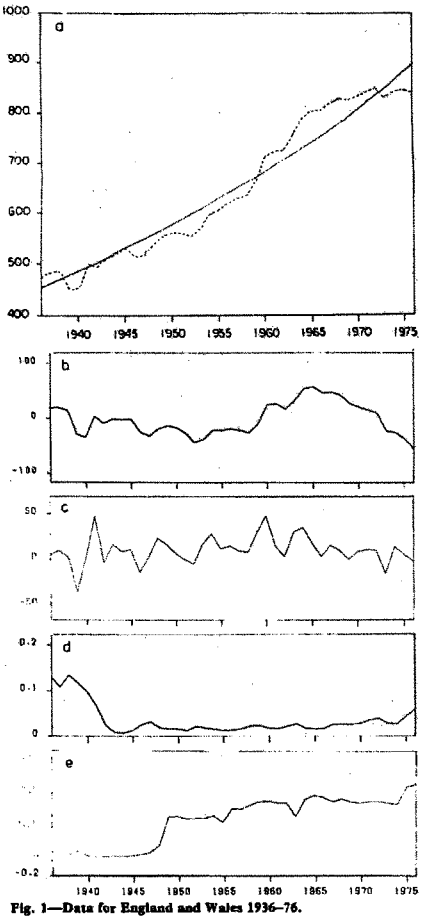


**Fig. 1—Data for England and Wales 1936–76.**

(a) Real per-caput income (broken line) and its smoothed exponential trend (in 1970 £ per person).

(b) Medium-term changes in growth-rate, representing departures from smoothed exponential trend of real per-caput income.

(c) Annual changes in real per-caput income.

(d) Proportion of civilian labour force unemployed.

(e) Proportion of welfare expenditures to total government expenditure, in £ million.

management of the national economy and of individual companies. Accompanying long-term economic growth have come technological developments in medicine. Their significance to the extension of the life span may be controversial, but, to the extent that disability and pain induce stress, health care in the long run may have contributed significantly to the reduction of chronic disease-related mortality.

The *unemployment-rate* reflects loss of income, social status, and close personal attachments for individuals and entire families, but as a national indicator of recession, it becomes an indirect global measure of income loss and work stress in employees of firms experiencing economic difficulty. Since loss of economic and social status is, theoretically, a major source of a series of disturbances, including dangerous life habits, breakdown of family and community social structure, stress-associated physical illnesses, and depression, we examine the association between the unemployment and mortality-rates over a lengthy lag period of zero to ten years.

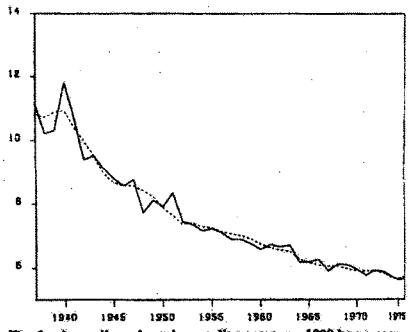


**Fig. 2—Age-adjusted total mortality-rates per 1000 home population.**

Actual (—) and expected (- - - -) values based on fit of composite economic change model including long-term and rapid economic growth variables, unemployment-rates over 0–10 years, and percent of Government welfare expenditures. England and Wales, 1936–76.

*Rapid economic growth* is harmful for specific minorities, particularly those who have suffered economic loss and are attempting to become integrated into the economy, especially during a time when other workers will be gaining significantly in income. It is also a period of rapid introduction of new technologies which produces a higher risk of accidents and the threat of job loss or demotion in the process of industrial reorganisation.

The *government allocation for public welfare* (social security) acts more as a control variable. The size of the allocation is determined by need, and the proportion of the population that requires help will in turn depend on the performance of the national economy. However, in most industrialised nations there is some impoverishment even under the most favourable national economic conditions, so we need to find out whether government transfer payments meant to alleviate economic distress do improve health as well.

## EXPERIENCE IN ENGLAND AND WALES

An attempt was made to test the model by analysing the relations between trends in economic indices and mortality-rates in England and Wales over the years 1936–76. The raw data for this period are illustrated in fig. 1. Table I indicates the impact of each of the independent variables on the mortality-rate. The hypothesis that long-term economic growth is inversely related and unemployment (indicating recession) is positively related to mortality-rate trends is sustained for all age-groups. The rapid-economic-growth variables are weakly related to mortality; the residual from the long-term economic growth-rate shows no statistical significance, while the annual growth-rate shows significance for the population aged 10–44. Finally, Government expenditure on welfare is inversely related to mortality-rates for infants and for children aged 1–4.

TABLE I—COEFFICIENTS FOR MULTIPLE REGRESSION EQUATIONS OF AGE-SPECIFIC MORTALITY-RATES ON NATIONAL ECONOMIC INDICES: ENGLAND AND WALES, 1936–76

| Age | Intercept | Economic growth trend | Growth trend residuals | Annual change in growth-rate | Welfare expenditures | Unemployment over 0–10 year period[2] | $R^2$ | Durbin-Watson statistic | F statistic |
|---|---|---|---|---|---|---|---|---|---|
| Total[1] | 12·57** | −0·099** | −0·033 | 0·022 | −0·33 | 20·68** | 0·97 | 2·30 | 166·66** |
| Infants | 59·76** | −0·05** | −0·004 | 0·033 | −17·79* | 156·57** | 0·99 | 1·73 | 387·98** |
| 1–4 | 4·31* | −0·002** | −0·033 | 0·0005 | −6·57** | 19·59** | 0·95 | 1·69 | 97·50** |
| 5–9 | 1·22 | −0·001 | 0·003† | 0·007 | −0·54 | 9·97** | 0·94 | 1·92 | 67·89** |
| 10–14 | 0·73** | −0·0007† | 0·0001 | 0·002† | −0·14 | 5·26** | 0·98 | 2·00 | 232·37** |
| 15–19 | 0·64† | −0·0003 | 0·0004 | 0·004* | −0·075 | 11·04** | 0·98 | 2·05 | 197·97** |
| 20–24 | 1·24* | −0·0009 | −0·0005 | 0·004* | −0·18 | 13·00** | 0·98 | 1·55 | 223·17** |
| 25–34 | 1·86** | −0·001† | −0·001 | 0·005* | −0·26 | 10·79** | 0·98 | 1·41 | 230·35** |
| 35–44 | 3·91** | −0·003** | 0·0001 | 0·003† | −0·16 | 12·84** | 0·98 | 1·93 | 185·32** |
| 45–54 | 7·59** | −0·003 | −0·002 | −0·002 | −0·70 | 19·53** | 0·95 | 2·09 | 95·84** |
| 55–64 | 21·72** | −0·01 | −0·002 | −0·002 | 0·74 | 27·06** | 0·89 | 2·08 | 38·16** |
| 65–74 | 57·63** | −0·030** | −0·006 | −0·011 | 3·82 | 47·23** | 0·85 | 2·22 | 26·31** |
| 75–84 | 145·48** | −0·079* | −0·055† | −0·025 | 14·09 | 100·28* | 0·82 | 2·12 | 21·09** |
| 85+ | 312·05** | −0·16† | −0·056 | −0·12 | 41·65 | 300·86* | 0·64 | 2·24 | 8·48* |

For t (columns 2–7) and F †p<0·05, *p<0·01, **p<0·001.
For age-group 5–9 Cochrane-Orcutt transformation was used to minimise residual autoregression.
1. Age-adjusted mortality, based on 1940 population age structure.
2. Sum of coefficients for second degree polynomial fit to distributed lag. This degree of polynomial is the best fit for the total age-adjusted mortality-rate, but not necessarily for those of each of the thirteen age-groups. Using the identical lag structure for all of the age-groups serves to test the general applicability of the model to populations of different age.

The combined effect of all four independent variables yields strong prediction for the total age-adjusted mortality-rate (fig. 2) as it does for age-specific mortality rates at nearly all ages (table I). The importance of using the entire explanatory model, rather than a single component such as the unemployment-rate, is illustrated in fig. 3. Here we concentrate only on annual fluctuations in the total (age-adjusted) mortality-rate, in effect, withholding from consideration the long-term trend and all other smooth movements in mortality. In this case, short-term change (i.e., annual change summed over 0–5 years' lag) in the unemployment-rate alone is only a moderately good predictor (table II).

Fig. 3 suggests that short-term changes in unemployment as a measure of economic loss are the most important source of influence on annual fluctuations in mortality when both variables show at least moderate levels of variation. This may indicate a threshold below which the unemployment-rate is not a sufficient predictor of annual changes in total mortality, and other variables are also required. For example, adding annual changes in unemployment in exponential (i.e. squared) form, thus approximating a portion of the threshold effect, adds considerably to the explanation of annual changes in mortality (table II).

Finally, of the six years of lag of unemployment used as predictors, the years of strongest predictive value for total mortality are at lags 1, 2 (particularly), and 5 (table II); this coincides with the United States experience for total and especially chronic disease mortality.[25,29]

The lagged effect of unemployment varies according to the time span and specific causes of death under analysis. Suicide and homicide, for example, show increases within a year of unemployment increasing, while cardiovascular mortality begins to increase two to three years after increased unemployment, the effect persisting for ten to fifteen years. For the period starting in 1950, the lag structure for total and chronic disease mortality following heightened unemployment begins and ends later than when the analysis is started in 1936 or 1940. These findings, which Granada's *World in Action* programme

TABLE II—COEFFICIENTS[1] FOR MULTIPLE REGRESSION EQUATIONS OF ANNUAL CHANGES IN AGE-ADJUSTED TOTAL MORTALITY ON ANNUAL CHANGES IN UNEMPLOYMENT RATES, ENGLAND AND WALES, 1936–76

| Lagged effects of unemployment in years | Constant | Sum of regression coefficients: annual changes | Sum of regression coefficients: annual changes squared | Regression coefficients | Rho | $R^2$ | Durbin-Watson statistic | F statistic |
|---|---|---|---|---|---|---|---|---|
| *Sum of years 0–5*[2]: | | | | | | | | |
| Annual changes | −0·82E-1 | 15·68† | | .. | −0·34† | 0·35 | 2·25 | 4·69* |
| Annual changes and annual changes squared | −0·17† | 70·77† | 1572·13† | .. | −0·41* | 0·53 | 2·14 | 4·30* |
| *Discrete years of lag:* | | | | | | | | |
| Annual changes | | | | | | | | |
| 0 | −0·13† | .. | .. | 4·80 | −0·28† | 0·09 | 2·26 | 3·55 |
| 1 | −0·11† | .. | .. | 8·76† | −0·35† | 0·13 | 2·34 | 5·86† |
| 2 | −0·90E-1 | .. | .. | 12·69* | −0·24 | 0·21 | 2·24 | 9·99* |
| 3 | −0·14† | .. | .. | −1·39 | −0·24 | 0·07 | 2·18 | 2·69 |
| 4 | −0·14† | .. | .. | −0·33 | −0·25 | 0·06 | 2·20 | 2·62 |
| 5 | −0·11† | .. | .. | 6·80 | −0·23 | 0·11 | 2·16 | 5·92† |

For t (columns 2–6) and F †p<0·05, *p<0·01, **p<0·001.
1. Cochrane-Orcutt transformation was used to minimise residual autoregression
2. Distributed lag: third degree polynomial fit

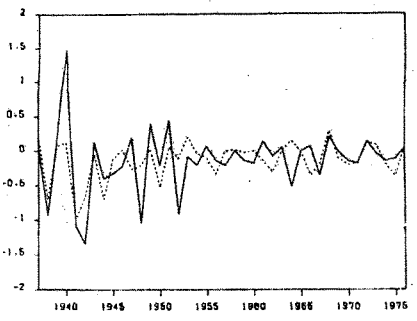


**Fig. 3—Annual changes in age-adjusted total mortality-rates per 1000 home population.**

Actual (—) and expected (- - - -) values based on lagged effect of annual changes in the unemployment-rate over 0–5 years. England and Wales, 1936–76.

reported graphically on British television on Feb. 5, 1979, will be presented in detail elsewhere.

Table III shows a cross-sectional analysis by county for 1971 indicating the association of unemployment and of high income, to mortality-rates, controlling for employment in manual occupations and employment in the chemical industry, a major source of environmental contamination. This analysis tends to confirm the time-series results. Indeed, three major factors account for over 90% of the variance: unemployment (positive), high income (inverse), and the proportion of the population over age 54 (positive). Table II also indicates that, when the cross-sectional relations are specified further by major cause of death, adjusted for age, sex, and the institutional population—i.e., total cardiovascular disease, ischæmic heart-disease, cerebrovascular disease, and malignancies—the model is most appropriate for the total cardiovascular disease and ischæmic heart-disease, largely effective in malignancy, and least appropriate for cerebrovascular disease. These cross-sectional findings based on counties are in general similar to those of Gardner et al.[35] for county boroughs.

## DISCUSSION

A theoretical model of the implications of national economic changes for mortality-rates, developed from epidemiological, demographic, and stress research and incorporating the long-term trend in economic growth, the unemployment-rate, and periods of rapid economic growth, has been refined on the basis of U.S. data and has now been applied to England and Wales for 1936–76 with results similar to analyses of U.S. data for

TABLE III—COEFFICIENTS FOR MULTIPLE REGRESSION EQUATIONS ON COUNTY-SPECIFIC SOCIOECONOMIC INDICES OF COUNTY-SPECIFIC MORTALITY-RATES: ENGLAND AND WALES—1971

| Mortality-rates | Unemployment-rate (1) | High income (2) | Nature of employment: Manual workers (3) | Nature of employment: Self-employed (4) | Nature of employment: Farm employment (5) | Nature of employment: Chemical industry employment (6) | Population over 54 (7) | R (8) | R (9) | F statistic: equation |
|---|---|---|---|---|---|---|---|---|---|---|
| Crude total | 0·20** | −0·21** | 0·04 | −0·05 | 0·02 | 0·10* | 0·79*** | 0·96 | 0·95 | 103·9*** |
| Crude total | 0·35** | −0·34* | 0·21 | 0·51** | 0·19 | 0·19** | .. | 0·73 | 0·69 | 17·9*** |
| Infant | 0·43 | −0·12 | 0·23 | 0·09 | −0·12 | 0·01 | .. | 0·30 | 0·20 | 2·8 |
| Total minus infant | 0·18** | −0·21** | 0·07 | −0·03 | 0·03 | 0·11** | 0·79*** | 0·94 | 0·93 | 72·6*** |
| Standardised Total | 0·52*** | −0·23 | 0·27 | −0·27 | 0·20 | 0·28** | .. | 0·78 | 0·74 | 22·6*** |
| Cardiovascular | 0·25 | −0·41* | 0·34 | −0·21 | 0·27 | 0·17 | .. | 0·63 | 0·57 | 10·73** |
| Ischæmic heart | 0·30* | −0·47* | 0·11 | −0·30 | −0·09 | 0·17 | .. | 0·53 | 0·45 | 7·07* |
| Cerebrovascular | 0·19 | −0·16 | 0·42 | −0·13 | 0·67** | 0·17 | .. | 0·57 | 0·50 | 8·31** |
| Malignancies | 0·45** | −0·23 | −0·30 | −0·26 | −0·60* | 0·26* | .. | 0·47 | 0·39 | 5·63* |

(1) % unemployed of civilian labour force.
(2) % of employed with income greater than £1750.
(3) % of employed with occupation as skilled, semi-skilled, and un - skilled labour.
(4) % of employed with occupation as self-employed professionals, and own-accounts workers.
(5) % of employed with occupation as farm owners, managers, and labourers.
(6) % of employed in chemical industry.
(7) Population over age 54.
(8) R=estimate of variance explained.
(9) R=adjusted estimate of variance explained.
Significance of F statistics: *p≤0·05, **p<0·01, ***p<0·001.

| *Variable* | *Source of data* |
|---|---|
| Unemployment for counties and county boroughs<br>Occupational groups (SEG categories) employment<br>Chemical industry employment | 1971 Census of England and Wales: economic activity, county leaflets. H.M.S.O. (old county designation). |
| Income for counties | Survey of Personal Incomes: 1970–1971. Board of Inland Revenue. H.M.S.O. |
| Population for counties and county boroughs | 1971 Census of England and Wales: county reports, H.M.S.O. (old county designation; 1966 population data replaced 1971 data for counties where data unavailable). |
| Mortality for counties | Registrar General's Statistical Review of England and Wales, 1971. |
| Mortality for county boroughs | O.P.C.S. Mortality Division. Direct communication. |

the same timespan. In addition, a cross-sectional analysis of county-specific mortality-rates for 1971 shows a pattern that is consistent with the over-time predictive equation. These cross-sectional findings obtain when age, sex, the institutional population, and the presence of the chemical industry, for example, were controlled. The validity of the model for two populations (the U.S. and Britain) so different in ethnic groupings, geography, climate, industry, government, and health and welfare policies, is encouraging.

The secular decline in mortality-rate is accounted for by the long-term trend in economic growth, while fluctuations in mortality-rates are largely explained by recessional losses and rapid economic growth (i.e., economic instability). It has been argued that these instabilities in economic growth also account for the socioeconomic differential in mortality. Long-term economic growth will also moderate the problems associated with economic instability: management of the national economy improves, health care gets better in quality and availability, and more substantial income support can be provided for displaced workers and other non-participants in the labour force. Thus the long-term trend in economic growth (or "prosperity") clearly acts to reduce mortality, and certainly not to increase it as has at times been suggested. Rapid economic growth, on the other hand, does contribute to increased mortality within a year.

All three types of major economic change, additively and interactively, affect mortality trends, and the impact of any one of them cannot be estimated without statistical controls for the other two. When unemployment or rapid economic growth act to "increase" mortality, they do so by inhibiting the long-term decline in mortality-rates. Thus high unemployment in Britain in recent years is not expressed as an observable increase in mortality-rate trend, but as a slowing of the decline in mortality that would ordinarily have occurred. The mechanism by which unemployment and rapid economic growth act to slow the secular trend of mortality-rate decline is through a widening of the socioeconomic differentials in mortality. To the extent that one is able to generalise from the U.S. and British experience, the differential mortality-rate across countries depends on the interaction of real per-caput income, especially among the lower socioeconomic strata, and stable rates of economic growth. Countries with the highest real per-caput income in their poorest populations in conjunction with the most stable economic growth-rates should, and typically do, show the lowest mortality-rates at all ages.

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# Society and Health

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# 7

# *Political Economy and Health*

M. HARVEY BRENNER

The political economy—the national economy, in interaction with government policies—influences a nation's health through the mechanisms of production, distribution, and consumption. The main links between the economy and health are economic growth and instability (especially recession), economic inequality (including inequality due to structural changes), production processes and consumption of goods that are harmful to health, high-risk social-interaction patterns disproportionately prevalent in the lower socioeconomic strata, and health-care utilization. This analysis will emphasize three elements of political economy crucial to health: (1) the national economic context of growth, business cycles, and social stratification, (2) the processes of production, distribution, and consumption, and (3) government policies.

Economic growth—the creation of wealth and elevation of the national living standard—has overwhelmingly beneficial effects on health, especially in reduction in acute infectious diseases and occupational injuries as causes of death. The main material benefits of economic growth are better nutrition; better housing; more advanced sanitary, industrial, and traffic engineering; and better health care. The psychological benefits include security from catastrophic economic loss and career damage; decline in the prevalence of physically exhausting and hazardous work; improved quality of life for the ill, disabled, and frail; and a sense of control, confidence, and hope for the future.

Also an outcome of economic growth, however, is the rise of chronic diseases in the industrialized world brought about by increases in consumption of harmful substances, shifts in dietary consumption patterns, sedentary lifestyles, and chemical production. Government policies—for example, regulating or discouraging high-risk consumption and production, providing support for the economically vulnerable, promoting productivity, and cushioning the adverse effects of structural change and recession—are the most effective mechanisms in industrialized societies for moderating the health-damaging effects of economic trends.

Thus the nearly exclusive emphasis in the field of health economics on health policy, and more particularly on health-care financing, ignores those policies that most profoundly influence a nation's health, and shape the overall political economy and its components, including real family income, per capita wage rates, unemployment rates, business-failure rates, consumption patterns (based partly on income availability), and specific sources of industrial toxicity. Thus, a society-and-health perspective should not only be concerned with the regulation of occupational and environmental exposures, food quality, and traffic safety, but it needs to view industrial, economic, and social welfare policies as the essential levers for improving health.

## Political Economy and Health

If we can show that specific macroeconomic indicators and aggregate patterns of consumption and production are the main determinants of trends in population health, then those policies designed and implemented to influence these indicators must be acknowledged as the main policy sources of a nation's health. This chapter will argue that the backbone of a nation's health is its overall wealth production and the productivity of its technology and labor force.

A secondary determinant of population health is the relative stability of economic growth. The quasi-cyclical economic changes that accompany variations in the business cycle, especially as they affect unemployment and business failure, represent profound shocks to the population's economic, physical, and mental health. The damaging effects of these changes persist for at least a decade.

A third determining factor is the extent of economic inequality—that is, the degree of unequal distribution of wealth and of unequal consumption of the commodities and services that represent the products of economic growth. Economic inequality is heavily influenced by the cyclical nature of economic growth, especially the unemployment rate, although such factors as government-financed income supplementation and investment in "human capital," education, and health care play a substantial role. Economic inequality is mitigated to varying degrees by government-based programs, including education, and income supplementation for the elderly, unemployed, and impoverished.

Long-term economic growth has traditionally been assumed to promote increased economic equality (that is, income). In the last 15 years, however, this fundamental assumption has been undermined in the United States by the uncoupling of wage rates from real per capita income, so that economic growth has not lead to less income inequality. Long-term decline in high- to medium-wage manufacturing jobs and a substantial increase during the 1980s in new jobs characterized by substandard wages, benefits, and tenure appears to be largely responsible. This decline has resulted from increasing pressures for the replacement of labor by high-technology machinery, and by heightened investment in overseas plants where wage rates and benefits are substantially lower, unionization is weak, and occupational and environmental regulations are minimal.



It is the overall wealth of a society that enables it to invest in occupationally and environmentally safer production processes and products. Similarly, the extent to which a firm is willing to introduce safer—and more expensive—equipment and products depends on whether such changes will threaten its economic survival. And the extent to which industry and the general public can be persuaded to replace standard but high-risk commodities with safer products partly depends on the magnitude of the financial losses that would be incurred by industry. Such losses are minimized in periods of high economic growth. Finally, the extent of investment in basic research depends on the financial health of government and industry.

This chapter will test an empirical version of this formulation, the economic-change model of population health, using U.S. mortality data for the period 1950–1988.[1] The premises of a national-level, or macro, formulation of this type are considerably strengthened and validated if we can specify the individual-level or micro theoretical components of the model and secure corroborating evidence at the micro level. The fundamental micro-level hypothesis supporting this model views changes in socioeconomic status (SES) as a byproduct of market forces, economic policy, and social-welfare policy. Changes in SES in turn influence virtually all morbidity and mortality patterns, through several mechanisms: alterations in the material standard of living; changes in consumption patterns (which amount to changes in the person-specific biochemical environment); and changes in psychophysiology involving threats to self-esteem, personal security, autonomy or sense of control, achievement and creativity, strength of social relations, and identity with social groups.

It is crucial to demonstrate the key link between national economic change and mortality is SES because the most pervasive and historically important relationship in epidemiology is between SES and morbidity and mortality rates. This relation has traditionally been demonstrated using ranked occupational differences. More recently, education and, especially, income have been used as measures of SES, and both demonstrate an inverse relation to mortality rates. A vast epidemiologic literature has also accumulated on the significant and consistent relationship between unemployment and elevated morbidity and mortality rates.

In sum, the relations between SES and health at the national level show a high degree of explanatory power, statistical significance, and robustness. They also show little tendency to change from one 15-year period to another. This consistency over time makes for a high degree of predictability, and lends considerable support to the enactment of policy interventions, designed to improve economic well-being, that are the principal sources of improvement in the population's health.

After a discussion of the multiple links between SES and health, we will consider

1. This model, which has been under development for many years, has benefited from both methodological and substantive critiques of its earlier versions. A principal innovation has been the use of the Shiller procedure for the estimation of the cumulative relations of economic and epidemiologic risk factors that affect mortality patterns.

SES as a set of intervening variables that act as the link between changes in the national economy and population health. We will then consider the economic-change model of population health, along with empirical data on the capacity of the model to explain changes in mortality rates.

## Mechanisms Linking Economic Position and Health

### Socioeconomic Status as an Intervening Variable

It is widely recognized that the performance of the economy has a profound impact on a nation's health. As the standard of living increases over time, life expectancy normally increases and age-specific illness rates from most causes decline. We also have very clear evidence of the inverse relationship between socioeconomic status and illness and mortality. Indeed, SES is the most powerful and consistent epidemiological risk factor.

Changes in population SES in turn depend almost entirely on national economic changes, which are a product of market forces and public policy, that is, the political economy. Market forces consist of the following: (1) technological changes, dependent on investment in research and development and in new technology; (2) productivity changes, based largely on technological change and investments in "human capital" and infrastructure; (3) structural changes in industry and the labor force, lately involving large-scale decline in manufacturing employment and an upsurge in relatively low-wage service employment; and (4) international competition in manufacturing, finances, and exports. The most influential but routine policy changes are those undertaken to influence the national economy and the welfare of vulnerable or dependent populations: monetary policy; fiscal policy, including defense, education and infrastructural expenditure; employment retraining and compensation; taxation, minimum-wage policy, and social-security and welfare policy. Other policy changes are based on political movements dealing with the rights of specific social groups, such as women, the elderly, and ethnic and racial groups.

Health research has typically treated the role of SES in two ways. First, SES is treated as a proxy for other epidemiological risks, such as excessive consumption of alcohol, tobacco, and fats or exposure to environmental toxins, whose association with measures of SES is taken as incidental. Or, alternatively, SES confounds (or disturbs) estimation of the "pure" statistical impact of such risk factors on health. In other words, SES is not understood as a major variable, with its own specific but profound impact on health. Third, in a more sophisticated fashion, SES is viewed as a causal precursor of a set of epidemiological risks but rarely as a variable that has origins in economic, political, and cultural change.

This chapter proposes a fourth, more dynamic view of the role of socioeconomic status, placing it in an intermediate position between macroeconomics changes and health: that is, SES is a dependent as well as an independent variable. In a technical sense, therefore, SES is an intervening variable between the macro economy and the major risks to health. It is important to note however, that SES is simultaneously an interacting variable. In this case, SES interacts with changes in culture, technology, and government policies in ways that modify, but have tended to reinforce, health inequalities.



### Direct SES-Health Mechanisms

The mechanisms that link SES to health, can be classified as material, psychophysiological, and biochemical risk factors. These mechanisms are both direct and indirect (interactive) in nature. The most direct involve material factors dependent on income and wealth: nutrition, sanitation, housing, industrial engineering, transportation, primary education, health care. They are especially pertinent to infectious diseases, infant and child mortality, and injuries.

Among psychophysiological mechanisms, which influence the chronic diseases (cardiovascular, immune, metabolic) and those that involve mental health (depression, accidents, intentional injury), three broad types can be said to be direct in their effects. The most general involves the self-valuation of the person in terms of the individual's overall status and role (Linton, 1936; Parsons and Shils, 1951), that is, economic position (occupation) and social contribution (content of work and achievement). Individuals are judged against others and against the value standards of their society: Weber (1946) called this "status honor." A person's own judgment of intrinsic self-worth is not idiosyncratic but reflects that of the surrounding society (Cooley, 1902; Mead, 1934). As William James (1890) was the first to point out, public esteem is translated into self-esteem on the part of the individual. Negative self-esteem is closely related to the feelings of shame (Erikson, 1963), stigma (Goffman, 1959) and, most important, deprivation (of social importance). It is thus interpreted as a loss of "what might have been."

A second psychophysiological dimension of socioeconomic status is market position (Weber, 1947), or the ability to obtain income and wealth and thus to consume. Market position is manifested in the use of socially valued goods, services, and symbols that signify comfort, pleasure, intellectual stimulation, and participation in cultural life. From a psychological viewpoint, lack of access to desired consumption generates chronic stress, frustration, and tension, and ultimately profound deprivation.

A third psychophysiological dimension of socioeconomic status is the broad system of incentives and rewards that accompany status and role (occupation and performance) (cf. Davis and Moore, 1945). In addition to income, the rewards of assumed productivity include authority, skill and/or knowledge, access to social networks, and job and income security (cf. Weber 1947; Dahrendorf, 1959; Treiman, 1977), all of which represent basic resources with which the physical and social environment can be influenced. From a psychological standpoint, these resources contribute to a "sense of mastery" of potential life problems, or assurance of lack of vulnerability to stress or threat.

## Interactive Mechanism I: Economy and SES

Let us now look at the interactions between various attributes of SES and changes in the social environment. The most important of these interactions links individual economic circumstances—especially change of job or income and work stress—to the fate of one's employer. It is the firm's capacity to survive and thrive in the competitive economic environment that determines its ability to offer employment, wages, and benefits, not to mention safe and pleasant working conditions.

In recessionary periods, strong firms with significant working capital, whose losses in sales are not substantial, usually retain their employees without adversely altering wages or working conditions. The reverse is true of the weak firm in a poor market position. According to the new ecological school of organizational demography, the environment of such a firm's employees depends largely on how well the firm manages its position in the competitive marketplace (Hannan, 1979; Nielson, 1980). When market competition creates a threat of layoffs or acceptance of adverse working conditions, the question that arises is who is to bear the brunt of those threats. In this situation, status within the firm is paramount. Socioeconomic status within the firm involves bureaucratic authority (Weber, 1947), that is, the authority attached to one's formal work position. It is this source of authority that has been hypothesized as the core of SES, or of social class (Dahrendorf, 1959; Blauner, 1972; Orum, 1978). Authority in the firm determines who is to steer it, who is sufficiently valuable to be retained in difficult times, who will be promoted in times of growth, and who will be harmed or benefited by investments in new technology.

The extent to which an individual will experience economic stress thus depends on the interaction of "demands" and "control" factors (Karasek and Theorell, 1990). Demands on the employer reflect the firm's ability to manage its economic environment, while control depends entirely on the firm's authority structure. Thus, the incidence of significant economic stresses depends largely on the economic conditions affecting one's industry and one's firm, and the responses of the firm's authority structure. Those stresses then filter down to the lower SES strata of the firm, where they stimulate individual coping strategies.

## Interactive Mechanism II: "Lifestyle" and SES

Richard Doll (1987) explains patterns of change in the major causes of death since the early 1900s by applying classic "epidemic" models. According to Doll, the relevant health-risk behaviors have tended toward epidemic rises, peaks, and declines for two separate reasons. First, increased personal disposable income made items that had been relative luxuries (alcohol, tobacco, fat- and protein-rich foods) considerably more accessible to middle- and lower-income groups. Second, the diffusion of these new patterns of consumption throughout society (Hamblin et al., 1973; Burt, 1978) resembles an exponential function that approaches an asymptote. Subsequent decline in epidemic



risk factors is promoted by health messages in the mass media, which report the latest findings on the health risks of various forms of consumption and exposure.

The evidence is strong that such "epidemic" changes in patterns of health-risk behaviors distribute themselves differentially among socioeconomic groups (Morris, 1979). Indeed, the rate of diffusion of common risk factors is so highly related to social class that epidemiologists are often content ot explain the entire SES health relationship by invoking this differential distribution (see Morris, 1979). Diffusion theory (Rogers and Shoemaker 1971) and social-marketing theory (Manoff, 1985) provide relatively clear-cut explanations of how the diffusion of risk factors interacts with socioeconomic level. Initially, the most highly educated individuals (those whose exposure to new information is greatest, and whose social status and wealth also tend to be high) are the first to procure goods newly available on the market. Gradually the rest of society becomes aware of their availability, and (as long as there are continual gains in real disposable income) "catches up" with the innovative leaders (Rogers and Shoemaker, 1971). The retrograde component of the diffusion curve is set in motion only after considerable investment in research on the health implications of the new patterns of consumption and exposure. The time lag between research investment and initial findings is lengthy: because 10–30 years of cumulative exposure is often required for a risk factor to take effect, a generation or more can pass before solid scientific evidence emerges of health-damaging effects.

Thus decades may pass before awareness of the risks to health of given consumption behaviors is diffused throughout the social-economic structure. The retrograde diffusion process may require another generation and may again proceed at different rates depending on social status, education, and income (McQuail, 1988). Income is especially relevant to the capacity to purchase substitutes for risk-laden consumer items. This argument has been used to explain the shift in coronary heart-disease mortality in Britain from an initially higher–SES based mortality rate to the reverse (Marmot et al., 1978, 1987). It can also be applied to any health-risk behavior in which individual choices of consumption items are relevant.

## Interactive Mechanism III: Chemical Toxins and SES

Toxic residues of chemical production are a prime source of carcinogenicity and respiratory disease. Exposure to such residues is of two types: direct occupational exposure of employees in firms that produce or use such chemicals, and exposure of the general population to a contaminated environment.

Interaction with SES is substantial in both cases. Within a high-risk firm, lower-SES employees will experience the most exposure (Registrar General, 1976) because those in authority will leave the handling of dangerous materials and equipment to those who are not in a position to refuse. In general, high-risk firms, with relatively poor security measures and the least-sophisticated equipment, are found in the poorer subgroup of the segmented labor market (Doeringer and Piore, 1971; Edwards, 1975), and their

employees are likely to be those with the least skills and education; these individuals also earn the lowest wages and benefits, and (in the United States) have the least adequate health-care coverage.

The relative lack of authority and, thus, heightened vulnerability of lower-SES employees is compounded by their limited knowledge of occupational health risks and tendency to assume that, in any event, they cannot alter their work situation. These sources of occupational vulnerability are exacerbated by the relative lack of political influence of lower-SES groups on the development of occupational safety and health codes.

Place of residence is also a key risk factor in exposure to chemical carcinogens (Epstein and Swartz, 1981). Here again, the relative lack of political influence of lower-SES groups makes them especially vulnerable, as do the financial and discriminatory components in "choice" of place of residence. Obviously, the families with the fewest resources are not in a position to insist on environmentally healthy neighborhoods.

## Alternative Explanations For Differences In Individual SES?

### Origins of SES for Individuals

Economics and sociology offer four alternative explanations of differences in socioeconomic attainment: these are referred to as (1) institutional determinants, (2) human capital, (3) statistical discrimination and (4) status attainment.

The institutional determinants of individuals' SES are the differential rates of growth (and sometimes decline) of different industries, which therefore offer differential opportunities for advancement. Of particular importance in the literature is the small firm, in the poorly capitalized sector of the "segmented labor market," that offers inferior wages, benefits, and working conditions (Doeringer and Piore, 1971; Edwards, 1975). This segment of the labor market is subject to high failure rates and high unemployment rates, and is obviously highly sensitive to national, regional, and even international business conditions. The literature on institutional determinants makes clear that the basic structure of SES for a nation, and thus the parameters of socioeconomic attainment for the individual, are highly dependent on macroeconomic conditions.

*Human capital* signifies the skill level and productive capacity of the workforce, and thus its occupational abilities and earning capacity. The human-capital school of thought maintains that investment in education and training, by the individual and by society, is crucial to advances in SES (Becker, 1964; Thurow, 1969). Development of human capital requires both institutional structures (e.g., social investments in science and/or knowledge development, educational organizations, and manpower) and, on the part of the individual, sufficient income, leisure, and willingness to forego employment opportunities. Clearly, human-capital investments depend, foremost, on national economic growth and per capita disposable income.



The statistical-discrimination approach posits that, beyond skill and appropriate credentialing, "ascriptive" (Parsons, 1951) aspects of social status (sex, race/ethnicity, age, religion, national origin, region of origin) play a part in determining occupation, job position, and earnings (Coleman, 1974; Thurow, 1987). Over the long term, however, "universalistic" (i.e., objective) and formalized standards increasingly dominate hiring practices, work authority, and incentive and reward systems. This tendency is due to the increasing formalization ("bureaucratization") and professionalization of work, and to increasing requirements for formal training and certification (as suggested by the human-capital school).

The status-attainment approach to differences in SES (e.g., Blau and Duncan, 1967; Sewell and Hauser, 1972; Treiman and Terell, 1975; Featherman and Hauser, 1975) views socialization in childhood as a crucial determinant of future occupation and living standards. This outlook views the family subculture, particularly the occupation of the father (and, increasingly, the mother), as a powerful influence on future socioeconomic status. The SES of family of origin is thus a conservative force, tending to preserve the stability of the social-stratification system.

In sum, leaving aside issues of family and poor socialization, theoretical explanations of differential socioeconomic status focus on economic development and change, emphasizing the mechanisms of industrial development, human-capital formation, and formalization of occupational requirements. One might also add social-welfare payment mechanisms to support the incomes of lower socioeconomic groups, and government policies favoring progressive income taxation and labor-management wage-benefit negotiations.

### Effects of Economic Change on Socioeconomic Status

Changes in the overall socioeconomic level, i.e., the standard of living, and structure (industrial and occupational) of a population are largely dependent on its rate of economic productivity, which in turn largely reflects technological developments (Krugman, 1991; Griliches, 1988; Kendrick, 1980, 1984). The degree of income inequality is related, over time, to several phenomena: the unemployment rate as an indicator of macroeconomic fluctuations (Dunlop, 1938; Menderhausen, 1946; Budd and Whiteman, 1978; Nolan, 1987; Podgursky and Swaim, 1987a, b); differential rates of development (and decline) of specific industries and regions (Kendrick, 1983; Harrison et al., 1986); union activity (Economic Policy Council, 1983; Weisskopf et al., 1983; Freeman and Medoff, 1984; Marshall, 1986); and policies on investments in human capital, infrastructure, and support of vulnerable and dependent groups (Kuttner, 1986; Anderson, 1986). Of lesser significance to income inequality are birth-cohort size (Dooley and Gottschalk, 1984) and such attributes of firms as size, market concentration, and capital to labor ratios (Hodson, 1983). Genetically based ability and aspects of family background are potentially important, but do not appear to influence the SES

structure over time. Income discrimination based on race, ethnicity, sex and age, though subject to political change, can alter the structure of economic inequality.

### Feedback Mechanisms

While relations between measures of SES and health have proven consistent and powerful, causation has not been well delineated, often because its direction is incompletely specified. Reverse causation is logically possible: genetic and biological (that is, intrauterine) factors could account for differing intellectual abilities and functional capacities (thus affecting SES), and for differing morbidity and mortality rates. A substantial research literature stresses the impact of illness, disability, and addictions on reduced functional capacity, including work productivity (Rice, 1966; Luft, 1978; Manning et al., 1982). The possibility of reverse, or lack of, causation even applies to the impact of unemployment on health and mortality. It is plausible, for example, that even in a recession those most likely to be laid off are the least psychologically or physically healthy, who function most poorly. In the short term and certainly in the long term, this group might plausibly have higher mortality and morbidity rates than the employed, apart from any effects of unemployment itself. It is undoubtedly true that illness can lead to declines in economic functioning and thus in occupational level and income.

To the degree that either of these reverse-causation arguments is accurate, economic and social policy intended to improve health would clearly be ineffectual. When the SES-health relation is indirectly measured, however, and given a general ecological expression in which the subjects are unable to influence the economic environment, the relation persists. It thus becomes difficult to argue that the causal direction is reverse. At the macro level, several additional observations make reverse causation unlikely.

First, changes in the overall economy are unlikely to be influenced by the activities of seriously ill individuals. (One could even argue that the death of the very ill contributes to the economy by freeing up resources.) There is a mass of literature on the factors that normally influence economic growth and economic cycles, and mortality patterns (especially in industrialized countries) are not among them. Second, economic changes precede changes in mortality patterns: both short-term and long-term relationships are identifiable between changes in the economy and changes in mortality. Third, relations at the macro level are in accord with similar relations at the micro level, and with theoretical explanations of mortality patterns both in the social sciences and in psychophysiology.

A more plausible explanation is a straightforward feedback mechanism. Thus (1) low SES involves higher incidence of illness and/or disability due to inequalities in the distribution of material, biochemical, and psychosocial benefits and risks. In turn (2) serious illness and/or disability adversely affects employment possibilities, earnings, and productivity. This feedback effect may explain how recessions engender latent increases in mortality rates due to chronic disease: namely, downward social mobility is accelerated and reinforced by chronically compromised health.



## Macroeconomic Determinants of Social Stratification

### Long-Term Growth of the Economy

The distribution of jobs (i.e., the distribution of skilled and semi-skilled manufacturing versus customer-service and sales jobs), which depends on the level of technology prevailing in the economy, and the pay levels associated with the status of those jobs, are widely agreed to be the major determinants of income inequality. As Shorrocks (1987) puts it: "Job distribution, together with customary wage and salary differentials, . . . is the principal determinant of earnings inequality. Personal characteristics appear to be important only because they are used by firms to ration entry into the more attractive jobs."[2]

Long-term income inequality is accounted for by factors of economic growth, demography, and education. Kuznets (1955), whose work addressed the relation between economic growth and income dispersion within countries, found an increase in inequalities at the early stage of industrialization, in conjunction with large-scale movement out of agriculture into the modernizing sector. As the modernizing sector becomes dominant, inequalities decrease. Williamson and Lindert (1980) found evidence of this pattern in the United States: relative wage equality prior to 1816; striking increases in inequality in 1816–1856 and 1899–1916; and secular declines in inequality between 1929 and the Korean War.

### The Impact of Recession and Unemployment

The business cycle, and specifically the unemployment rate, is the second macroeconomic influence on income inequalities. Inequalities widen as the business cycle contracts, specifically as unemployment rates grow. Kuznets (1953) found a tendency in the interwar period (1919–1939), for overall inequality to move inversely with the business cycle, the upper-income group gaining at the expense of the vast majority (probably no less than 85–90 percent) of wage-earners in periods of economic downturn (Kuznets, 1953, pp. 57–58). An earlier study (Menderhausen, 1946), found a similar pattern during the Great Depression (1929–1933).

2. On the issue of wage levels conventionally linked to social status of occupations, Phelps Brown (1987) states: "People insist on the maintenance of customary relations. They require that relative pay conform with status. That the laborer's rate stood at two-thirds of the craftsman's in the building industry of Southern England over more than six centuries . . . can be attributed only to convention. If women's rates had been simply proportioned to productivity, it is hard to account for their relative rise when the rule of 'equal pay for equal work' was enforced in the UK and the Netherlands . . . These observations are all consistent with differences of pay being set to match accepted gradations of status."

The pattern of increasing inequality in recessions and narrowing inequality in subsequent recoveries has persisted in a less extreme form in the postwar period, according to annual data from the U.S. Bureau of the Census.

### Post-1970s Structural and Demographic Shifts

Income inequality in the United States, continued to shrink from the end of World War II until the late 1970s and early 1980s, when inequality began to increase again. This trend continues in the present (Levy, 1987; Maxwell, 1989; Winnick, 1989; U.S. Congress House of Representatives, 1989; Phillips, 1990; Ryscavage and Henle, 1990). For the first time in American history in fact, the economic expansion of the 1980s was accompanied by deterioration in the standard of living for a majority of households (Sweeney and Nussbaum, 1987; Harrison and Bluestone, 1990; Litan et al., 1990).

The existence of increasing inequality and real-wage stagnation in a period of economic expansion has several linked explanations (Maxwell, 1989). First, striking increases in foreign competition and dollar devaluation since the 1970s have forced fundamental changes in the manufacturing and export-oriented industries. These changes may reflect cyclic movements intrinsic to market economies (Thurow, 1980; Feldstein, 1980), as well as a permanent structural shift from manufacturing to service employment (Bluestone and Harrison, 1982). Because the resulting slowdowns in real wages and productivity vary among industries and occupations, changes in income distribution have resulted.

Dooley and Gottschalk (1985) have shown that low-wage workers experienced below-average wage growth. Meanwhile, workers in the rapidly growing high-technology industries, a high proportion of whom are highly paid (Rosenthal, 1985), experienced gains in real income (McMahon and Tschetter, 1986). Polarization of income distribution, and potentially a decline in middle-class income, follows in turn from simultaneous growth of low-wage and high-wage employment (Harrison et al., 1986).

Maxwell's (1989) multivariate statistical analysis of U.S. income inequality in the period 1947–1985 considers these factors as well as demographic shifts and government programs. The results show that income inequality is promoted by increases in the proportion of the nonworking (dependent) population, in service-sector employment, and in the proportion of blue-collar workers. Growth in the dependency ratio and in service-oriented industrial employment increase inequality by increasing the top quintile's income share and decreasing the bottom quintile's. Industrial and demographic forces, such as changes in labor market and immigration, exert the greatest impact on the income share of the lower quintiles, particularly that of the very lowest quintile.

While Maxwell (1989) found government spending on social welfare programs only affects the top and bottom quintiles, cross-national studies do indicate that social-welfare expenditures can have a marked effect on income equality. Of 10 intensively studied Western European and North American countries (Smeeding, 1991), the Scandinavian countries and Germany show the lowest income inequalities and the United States the highest.



### The Cyclical Behavior of Income Inequality

The cyclical nature of earnings distribution is a major generator of income inequality. Even if workers who lost their jobs were drawn proportionately from all wage levels, according to Menderhausen (1946), they would be pushed into zero-income or very low income positions compared to those who retained their jobs; this enlarges the income gap between the unemployed and underemployed on the one hand and those with relatively full-time employment on the other. And, in reality, all workers do not face the same probability of becoming unemployed in a recession; the incidence of unemployment is greater among the less skilled and lower paid. Thus, wage differentials can be expected to widen, partly because unemployed workers are reemployed in lower-wage jobs.

During periods of declining product demand, Oi (1962) argues the employer has an incentive to retain workers with larger investments in human capital (the more skilled and highly paid) and to lay off those with little specific training. The result is larger increases in unemployment among the unskilled, and/or widening of wage differentials.

In the same vein, Reder (1955) argues that, instead of laying off both skilled and unskilled workers in a recession, employers choose to assign their underemployed skilled workers to less skilled jobs and to concentrate layoffs among the less skilled. Employers also tighten hiring standards in recessions and relax them in subsequent expansions.

Among the many studies of the impact of macroeconomic conditions on inequality, the most consistent finding has been a significant disequalizing effect of increases in unemployment, reducing the share of total income earned by lower-SES groups.[3]

## Economic Change and Health: Macro and Micro Evidence

### Stable Economic Growth and Health

Having explored the relationship between SES and health, we can now ask: What, theoretically, is the importance of the economy to the nation's health? To answer this question, let us look first at the health implications of stable economic growth.

The material contribution of economic growth is the basic differentiator among societies in terms of mortality rates. It separates the high-life-expectancy countries from

3. Schultz (1969) initiated the econometric analysis of the topic and estimated an equation relating the inequality in the distribution as measured by the Gini coefficient to variables such as inflation, unemployment, the growth rate, and time trend. Schultz failed to identify any significant influence of macroeconomic variables on the Gini coefficient for the U.S. distribution, while the remaining, disaggregated studies, did find such effects on the distribution time series. Simulation approaches based on micro data (Mirer 1973a,b; Budd and Whiteman, 1978; Nolan, 1987), panel analysis (Gramlich, 1974) and studies specifically of poverty (e.g., Hollister and Palmer, 1972) were also able to estimate the positive relation between recession, or unemployment, and income inequality.

low, and is the prime factor in infant and child survival and infectious diseases rates. Its key elements, as we have seen, are nutrition, housing, sanitary engineering, primary education (of the mother), and primary health care, all of which require societal investments and thus sufficient national wealth. Investments in industrial design and sophisticated equipment are also necessary to prevent disability and mortality due to unintentional injuries.

Stable economic growth is the *sine qua non* of investment in knowledge development, including systematic epidemiological investigation of health-risk factors. Such investment is crucial not only to engineering and the biological and physical sciences but also to the social and economic sciences instrumental in managing the overall economy and individual firms. Joint development of the material economy and of the scientific base provides for predictability, manageability, and comprehensibility in the human and physical environments. Stable economic growth is the prerequisite for fundamental political undertakings designed to promote equality of distribution (labor-management bargaining, taxation, and social-welfare expenditures). These fundamentals contribute in turn to a human psychology of hope and confidence (control, "self-efficacy," and security).

Stable growth is critical to social integration as well. Perhaps the most significant source of social integration is the process of urbanization. The transition of the bulk of the population from rural to urban life may well have caused a basic shift in human relations, as Toennies (1952) and Durkheim (1947) have asserted. In any event, the development and maintenance of urban life has generated the formation of numberless social organizations based on interests and values. It is inaccurate to say that the advent of such formal "secondary" institutions has caused the wellsprings of primary face-to-face relations to "dry up." On the contrary, formal organizations—from workplaces to government—require primary relations *within* the groups that constitute their working parts.

## The Impact of Recession and Unemployment on Health: Descriptive Epidemiology

Studies conducted over the last 20 years on the relationship of economic change to morbidity and mortality in industrialized countries represent two distinct epidemiological traditions in the mental and physical disorders. The earlier work on mental-health problems tended to emphasize the role of economic loss in stress. More recent work on physical health has made it apparent that recession itself plays a causal role. It is now recognized that loss of resources and psychological stress are not easy to isolate causally: the implication is that, in the vast majority of pathologies, including mental and physical illness and criminal aggression, some combination of resource loss and psychological stress is probably involved.

### *Suicide*

Suicide was the first indicator of mental pathology found to increase consistently with adverse changes in the economy (Durkheim, 1951; Henry and Short, 1954; Brenner



1971b, 1980a, 1984a; Vigderhous and Fishman, 1978; Boor, 1980; Marshall and Hodge, 1981). A number of researchers have replicated these findings, attesting to the severe stress brought about by economic recession (Brenner 1976b, 1984a, b; reviewed in Platt, 1986).

### *Mental Health*

Research on the relationship between adverse economic changes and increases in mental-hospital admissions has demonstrated that the relationship can be measured consistently over time (Dayton, 1940; Pugh and MacMahon, 1962; Brenner, 1973a). The first of these studies dealt with Massachusetts during the 1930s, the second with the United States as a whole during the Depression, and the third with New York State in the period 1841–1967. During each recession since 1841, first admissions and readmissions to mental hospitals increased substantially. Cyclical change in the economy was the single most important factor affecting trends in admission. The New York State study has been replicated for the entire United States and for each state in the periods 1936–1970 and 1950–1980, with nearly identical results (Brenner, 1976b, 1984a).

Numerous epidemiological studies on the relation of unemployment to mental health have found symptoms of psychological disorder to be consistently associated with unemployment (Ferman and Gardner, 1979; Dooley and Catalano, 1984; Elder and Caprì, 1988; Forcier, 1988; Kessler et al., 1988; Penkower et al., 1988; Warr et al., 1988; Hamilton et al., 1990).

The relation of criminal aggression—especially homicide, crimes known to the police, arrest rates, and imprisonment, particularly for violent crimes but also for all crimes against persons and property—to economic recession and especially unemployment has been observed for decades (Brenner 1976a, b, 1980a, b, 1984a).

### *Alcohol Abuse*

The findings on alcohol abuse are consistent with a hypothesis of increased mental disorder precipitated by social-psychological stress during economic recession. Increases in mortality rates due to cirrhosis of the liver are positively related, over time, to consumption increases with distilled spirits (rather than wine or beer), and such consumption increases with cyclic declines in the national economy. Cirrhosis mortality itself increases substantially 1–2 years after national economic recession. Because it takes a long time to acquire chronic cirrhosis of the liver, it is clear that the short-term economic trauma had not initiated the cirrhotic condition, but that, once morbidity was present, economic recession tended to hasten mortality (Brenner, 1975).

Other findings underline the relationship between increased consumption of distilled spirits and declines in the national economy. Admissions to mental hospitals for psychosis related to alcoholism and other alcohol-related mental disorders showed substantial and stable increases during economic recessions during the period 1921–1968. Similarly, arrests for drunkenness in Massachusetts increased with adverse changes in the national economy over the period 1915–1968; the arrests lagged 2 years behind

fluctuations in the economy. Finally, arrest rates for driving while intoxicated were found to increase substantially during national economic recessions (Brenner, 1975).

### *Heart Disease*

Early, empirical research on heart-disease incidence and mortality clearly demonstrated that fluctuations in heart-disease mortality rates were inversely related to the employment rate in New York State in 1915–1967. Mortality from coronary-artery disease was found to be related to fluctuations in the unemployment rate for the United States as a whole in the period 1930–1960. Both studies found that mortality peaked at least 2–3 years after economic recessions (Brenner, 1971a, b).

Subsequent studies of the relationship between national economic indicators and cardiovascular-renal disease hypothesized that these illnesses are characterized by significant psychophysiological factors involving hypertension and serum-cholesterol levels. Cardiovascular-renal diseases account for approximately 60 percent of all mortality in many industrialized nations. An examination of U.S. data for 1914–1968, by race, sex, and 10-year age groups, found a consistent relationship between national economic fluctuations, measured by per capita income or employment rates, and mortality rates due to cardiovascular renal disease. For cardiovascular-renal diseases in general, the peak lagged behind economic recessions by 3–6 years, depending on age; the peak for chronic nephritis lagged from 0 to 2 years; for cerebrovascular diseases, the lag ranged from 6 to 9 years (Brenner, 1971a, b).

### *Infant Mortality*

The infant-mortality rate has long been recognized as one of the most sensitive indicators of the general socioeconomic level of a nation. The relationship between the economy, and infant, fetal, and maternal mortality has thus been extensively examined. In all industrialized countries for which data are available, industrial growth is inversely related to the long-term trend in infant-mortality rates (Susser et al., 1985). However, a society's adaptation to economic change is less a matter of the level of economic growth than of whether that growth is relatively smooth or unstable.

An investigation of the relationship between economic instability and mortality in infants under 1 year of age found fetal and infant mortality to increase sharply in response to economic recession, with a peak lag of 0–2 years (Brenner, 1973b). This relation has been demonstrated for the United States in 1936–1974 and 1950–1980 (Brenner 1976a, b, 1984a), the United Kingdom (Brenner, 1979, 1983), and Sweden (Brenner, 1987b). The relationship between economic fluctuations and trends in infant-mortality rates has historically been an important component of the relationship between low socioeconomic status and increased infant mortality; that is, the impact of economic shock, such as on infant mortality, is greater for lower-SES groups. The influence of economic instability, especially recession, on infant mortality trends has grown since 1950, perhaps because of a relative decline in the beneficial impact of secular economic growth in an economy that is already highly developed.



### *Overall Mortality*

The influence of economic change on overall (non-cause) mortality rates has been studied for several decades. The principal long-term declines in overall mortality, as well as age-specific mortality for all age groups, are associated with long-term improvements in the national economy, especially real per capita incomes. The business cycle is heavily influential in the short- to medium-term fluctuations in mortality rates. Such variables as unemployment and business-failure rates are typically associated with increases in mortality two to three years following the lowest point in the business cycle and extending for at least the next 10 to 15 years. The relationships have been most fully explored with data for the United States, United Kingdom, and Sweden (Brenner, 1976a, 1979, 1980b, c, 1984a, 1987b, c, 1991, 1993). Middle-aged mortality rates have also been examined from this viewpoint in at least 10 additional countries (Brenner, 1989).

These types of relationships for overall mortality—with long-term trends inversely related to economic growth and short- to medium-term fluctuations significantly associated with economic cycles—have also been observed for the principal cardiovascular diseases, even when the models included controls for tobacco, fat, and alcohol consumption patterns (Brenner, 1976b, 1984a, 1987a, b, c; Brenner and Mooney, 1982).

## Microepidemiological Research on Unemployment

Unexpected large-scale increases in unemployment rates in European countries that have occurred since the 1973 oil crisis and which continue to the present day have interested epidemiological researchers working at the individual level in prospective studies of morbidity and mortality. A classic study by Moser, Fox, and Jones (1984) examined a nationwide sample of employed and unemployed British men in 1971 to see whether an impact on mortality in 1982 could be discerned. They found not only that the unemployed men had substantially higher standardized mortality ratios (SMRs), after controlling for social-class differences in mortality, but that the wives of these men (who were not themselves unemployed) also showed significantly elevated SMRs. Similar studies in the United States (Sorlie and Rogot, 1990), Denmark (Iversen et al., 1987), Sweden (Stefansson, 1991), and Finland (Martkainen, 1990) found significantly elevated SMRs a decade after the unemployment event; those who were not seeking work or were otherwise outside the labor force tended to show the highest mortality rates.

Studies of psychiatric and somatic morbidity in Germany (reviewed by Schwefel, 1986), the United Kingdom (Jackson and Warr, 1987), Norway (Westin et al., 1989; Westin, 1990), the United States (Linn et al., 1985), and Denmark (Iversen et al., 1989) have repeatedly confirmed the importance of unemployment as a prospective risk factor in physical and mental illness. These studies have taken care to separate out the effects of social selection, which can be especially pernicious in unemployment-health studies because seriously ill and disabled individuals are highly vulnerable to job loss.

While there has been remarkable consistency in the findings of individual-level epidemiological studies, studies of the relation between unemployment and subsequent morbidity and mortality at the national level have not been as consistent. Macro-level suicide and mental-health studies have tended to confirm the generally adverse impact of unemployment, but the results of studies of overall and chronic-disease mortality have been more mixed (Forbes and McGregor, 1987). Whenever controls for traditional risk factors (alcohol, tobacco, fat consumption) have been used, however, the results have uniformly shown elevated mortality rates following recessions, peaking after approximately 2–3 years (Brenner, 1971a, b, 1980a, 1984b, 1987a), and frequently extending as long as 10–15 years (Brenner, 1976a, b, 1984b, 1989). The overall length of the lags is similar to those found in longitudinal epidemiological studies involving traditional risk factors, and may in fact reflect the interaction of recession and downward mobility with those risk factors. If so, the interaction of unemployment with "lifestyle" and toxicological risks may be similar to the well-documented inverse relation of SES with these risk factors.

## Mechanisms Linking Recession and Health

Economic recession engenders damage to health by means of at least six mechanisms: (1) reduced financial access to health care, resulting in underutilization; (2) psychophysiological reactions to stress and loss; (3) damage to social relations and sources of social support; (4) maladaptive coping mechanisms involving high-risk consumption patterns; (5) less thorough and frequent maintenance of manufacturing plants and reduced investment in modernization, with a consequent effect on health and safety; (6) increased work stress during the economic recovery as firms that lost heavily during the recession take on more work but do not yet hire additional workers, due to a capital shortfall and uncertainty about the stability of the recovery.

First, the lack of health insurance and relative poverty of workers in the "secondary" labor market and of people outside the labor force contribute to comparatively low utilization rates of inpatient, ambulatory-curative, and preventive health services, especially among the very young and the elderly (Ford and Marlis, 1990; Rowland, 1990; Whitman et al., 1991; Ahern and McCoy, 1992; Kirkman and Kronenfeld, 1992). Even people who have health insurance are typically required to make copayments so that there is significantly lower utilization of these types of services (Shapiro et al., 1986; Anderson et al., 1991).

Second, psychophysiological coping reactions to stress and loss are known to be highly varied. They include a compromised immune system, which is less able to resist infection and malignancy (Bartrop et al., 1977; Eysenck et al., 1991); effects on the cardiovascular system (Grossarth-Maricek and Eysenck, 1991; Goldstein and Niaura, 1992; Niaura and Goldstein, 1992), including hypertension (Pickering et al., 1991; Schnall et al., 1992), myocardial infarction, angina, and acute cholesterol response (Muldoon et al., 1992); peptic ulcer (Anda, 1992); asthma (Isenberg et al., 1992); disorders of the central nervous system such as migraine, anxiety, and psychotic and adjustment disorders (American Psychiatric Association, 1987); and emotional reactions, especially depression (Paykel et al., 1969; Brown et al, 1973; Brown and Harris, 1978), aggression (Dollard et al., 1939; Miller, 1941; Berkowitz, 1962), and somatization (American Psychiatric Association, 1987).



Third, the ties of family and friendship and peer relations among coworkers have been found to moderate the impact of stress and loss (Brenner and Starrin, 1988; Turner et al., 1990). However, depressive or aggressive reactions to loss and stress can damage social networks by alienating close associates and discouraging them from providing further social support. Indeed, the impact of depression, aggression, or general tension can bring about divorce, and separation or destruction of friendship networks (Liker and Elder, 1983; Coyne et al., 1987; Krantz and Moos, 1987; Rath et al., 1989; Dew and Bromet, 1991; Rook et al., 1991).

Damage to social relations can also result directly from changes in population dynamics during and after economic recessions. According to the push-pull theory of migration, regional (and international) migration is characterized by movement away from areas of meager employment or career prospects to those that offer economic opportunity. This important demographic mechanism comes forcefully into play following nationwide recessions, when people move away from areas (or industries) that have not yet experienced economic recovery and/or expansion to those that have. Such migration therefore peaks at the high point of business cycles. This migration pattern calls for the migrating worker to adapt to a new social setting (Cassel and Tyroler, 1961; Syme et al., 1965; Marmot and Syme, 1976) and overcome social isolation. It also means that the family members and friends left behind will experience loss and long-term deprivation. Furthermore, the communities left behind will suffer a loss of population, and ultimately of economic viability; meanwhile, if migration is substantial, the regions (usually urban) and firms that receive it will also experience problems of adjustment, including weaker social ties among the local (nonmigrant) population.

Relations among different social classes and ethnic groups can suffer considerably under conditions of economic decline (Van Hook, 1990), a phenomenon that lends support to the hypotheses of "frustration-aggression" and scapegoating (Dollard et al., 1939; Miller, 1941; Berkowitz, 1962). This correlation appears to be confirmed by repeated instances of serious ethnic and civil conflict during and after periods of national economic adversity. The related assumption of a strong connection between national economic adversity and changes of government has nearly evolved to the status of a formal theory, in which "political cycles" are a central concept.

Fourth, many social scientists assume that maladaptive responses to chronic stress and adverse life events include adoption of unhealthy consumption patterns. Alcohol (Pearlin and Radabaugh, 1976) in particular has been cited as a maladaptive tool for management of stress and depression, as have tobacco and other addictive substances (Lee et al., 1991; Serxner et al., 1991). Alterations in diet, especially increases in fat and sugar consumption, are also often assumed to be coping devices (Schlundt et al., 1990).

Fifth, minimizing health risks due to occupational and chemical environmental hazards (Susser, 1985) requires considerable investment in equipment maintenance, waste

disposal, and substitution of nontoxic substances for traditional ones. Substantial health risks, therefore, accompany the depletion of investment capital, which can reduce compliance with the regulations of occupational and environmental safety agencies (Leigh, 1989).

Finally, the impact of recession and economic instability on a firm's efforts to survive may be the source of severe work stresses related to serious illness and premature mortality. During a recession, anxieties over potential job loss and threats to career and financial solvency pervade the firm (e.g., Kasl and Cobb, 1982). Recessional stresses are also likely to diminish worker autonomy, due to decreased managerial tolerance for error while the firm struggles for survival. This situation is compounded by damage to social relations (and thus social support) among workers when every worker is worried about job security and no one wants to be linked to those whose jobs are to be terminated (House et al., 1988). More influential, however, in a financially damaged firm is the perpetuation of work stress well into the period of national recovery and expansion. Such a firm will have experienced a shrinkage of working capital and will have an especially difficult time knowing when to hire in the face of growing market demand, a phenomenon known as "the signal extraction problem" (Attfield and Duck, 1985). This difficulty will result in acute and chronic shortages of staff and an extraordinary emphasis on high employee productivity. The result for employees is a situation of "high demands/low control," which has been shown to be related to cardiovascular disease and overall mortality risks (Karasek and Theorell, 1990).

### The Initial 2- to 3-Year Lag of Mortality Following Economic Recessions

The initial elevation of overall mortality rates, including the major causes of death, occurs at approximately two to three years following the recession. This point of elevated mortality is then typically followed by continually heightened mortality rates for at least the next decade. Both of these phenomena are related to the initial impact of the recession.

The basis of the 2- to 3-year lag is as follows. The recession itself is the first phase of loss; the individual's response to unemployment is mental depression and probably the beginnings of other serious physiological disturbances related to chronic diseases. This is a phase of cataclysmic stress, affecting large numbers of people (thus equated with a "disaster") such that the loss of job and income is part of a national or regional phenomenon. These conditions foster social support for the affected individual.

This first phase, however, is not the critical point in the "stressful life event" associated with recession. The most important issue is whether the individual will recover his or her economic and social status, or will undergo a permanent loss. This is decided mainly during the economic recovery. At the peak of the business cycle, occurring about 2–3 years after the recession, a social distance has arisen between individuals who have not recovered and those who have. Since the highest level of employment occurs at this point, the individual who has not economically reintegrated will lose much of the social support received during the recession itself. Also at the peak of the business cycle, the economy is beginning to slow at a time of considerable overoptimism about the economic future. This is a time of great frustration, when it becomes clear that heightened expectations will be unfulfilled—which is especially acute for the individual who has not yet fully recovered from the effects of the preceding recession, but is still desperately hoping to do so.



Thus, at the peak of the business cycle, three states prevail: a maximum economic inequality between those who have recovered from the recession and those who have not; uncertainty about the economic future; and frustration over the failure to achieve the hoped for continuing recovery. All of these are particularly acute in those who suffered loss of employment and income during the preceding recession.

## Macroeconomic Change and Mortality: The Economic-Change Model of Population Health

As we have seen, mortality rates in many Western industrialized societies are typically related inversely to economic growth for the population as a whole and for nearly all age groups. Also, short- to medium-term increases in mortality rates tend to be inversely related to economic recessions, with an average lag of 2–3 years; this early peak heralds the start of a long-term effect of recession, lasting 10–15 years. Epidemiological evidence based on individual-level research, and extrapolation from it to national levels via epidemic models (Doll, 1987) and diffusion theory (Rogers and Shoemaker, 1971), support the view that the major consumption-and-production risk factors (alcohol, tobacco, fats, chemical production) account for much of the hyperbolic shape of mortality trends since the Second World War. Finally, national policies providing for transfer payments (especially those for Old Age, Survivors, Disability and Health Insurance (OASDHI), education and welfare) and health-care expenditures tend to significantly modify mortality trends.

The "economic-change model of population health" helps to organize the empirical data expressing these and other variables in such a way that they can be used jointly to account for changes in mortality patterns. The economic change model (e.g., Brenner 1984a, b) includes measures of the following concepts: economic growth, economic instability (including recession), economic inequality, maladaptive responses to economic growth (excessive consumption of alcohol, tobacco, fat), chemical production, social-isolation measures such as divorce rates, and random "shocks" not predictable by other factors in the model (epidemics, abrupt population movements, military conflict, and high-impact medical technology). The final output of an analysis using this model will bring together, in the same multivariate equation, variables expressing each (or at least several) of these benefit and risk factors; relations for each variable will then cover a distributed-lag period involving at least a decade.

We begin the analysis by identifying the simplest short-term relationships for a single variable; we then examine the cumulative impact of the same variable over multiple years (distributed lag), and finally show the relations of multiple variables in a "full" time-series multiple-regression model.

The Box-Jenkins technique (Box and Jenkins, 1982) of time-series analysis, using autoregressive and moving-average terms to fit (and thereby forecast) basic trends and cycles in mortality, is useful for analyzing short-term relations. Our analysis asks, for example, whether changes in the unemployment rate, as a basic cyclic economic indicator, will help explain changes in mortality trends after the autoregressive and moving-average components of these trends have been accounted for. Previous research indicates that mortality from all causes and from major chronic diseases reaches a first peak of increase approximately 2–3 years following the bottom of a recession, as measured by the highest point in the unemployment rate (e.g., Brenner 1971a, b, 1980a, 1984b, 1987a). This is apparent in our analysis of age-adjusted mortality, both total mortality and mortality for specific sex-race groupings (see Table 7–1). For white males, a significant positive relationship between the unemployment rate and mortality is observed after a 2-year lag. For white females and nonwhite males and females, the positive relations for unemployment can be seen at 2 and 3 years.

Because, on average, economic cycles tend to be 4–5 years in length (Mitchell, 1951), this classic 2- to 3-year lag in mortality after the peak in the unemployment rate means that the first peak in mortality following recession approximately coincides with the subsequent peak in the business cycle—that is, the peak of "recovery" or "expansion." Given this observation, one should also note that the zero-lag relationship between unemployment and mortality rates is actually inverse. The *first* peak in the lagged mortality rate at 2–3 years after recession is not accidental: the delayed impact of economic distress interacts with chronic-disease mortality in such a way that the first wave of increased mortality peaks at about the same time as growth in the economic cycle. The explanation for this phenomenon involves three different populations that experience considerable loss due to recession.

The first population will have experienced loss of employment and income during the recession, and these losses may have been compounded by illness. Illness, in turn, reduces the likelihood of rapid reentry into the labor force, and substantially decreases productivity if reemployed. Over time, therefore, this population will at least remain at a lower economic level than prior to the recession, and may have a permanently decreased economic status. Meanwhile, with the subsequent expansion of employment and income, the bulk of the population will have found its economic position significantly advanced. Between the bottom of the recession and the peak of the upturn, therefore, the differences in economic position between the majority and this minority (as a specific cohort) will reach a maximum of inequality. The minority population's ensuing relative deprivation and social isolation will then expose it to its highest risk of psychological distress during the entire economic cycle.

A second population seriously harmed by recession consists of employees of firms in vulnerable industries. As we have seen, these firms frequently have difficulty adjusting to the subsequent economic upturn, due to a severe shortage of capital and the "signal-extraction problem." These difficulties result in minimal hiring despite increased market demand. Understaffing then calls for high productivity from existing employ-

**Table 7-1** Box-Jenkins Model of Short-Term Time-Series Relations Between Unemployment Rate and Age-Adjusted Mortality Rate, by Race, United States 1947–1988

*(Second Differences, 2- and 3-Year Lags)*[a]

| Variable | Lag (Years) | Coefficient | Standard Error | T Statistic |
|---|---|---|---|---|
| *White Males* | | | | |
| Unemployment Rate | 2 | .443E-01 | .151E-01 | 2.935 |
| AR | 1 | −.525 | .148 | −3.542 |
| MA | 1 | −.514 | .163 | −3.156 |
| RBAR Sq. .592; Q(18) = 4.714 | | | | |
| *White Females* | | | | |
| Unemployment Rate | 2 | .171E-01 | .929 | 1.836 |
| AR | 1 | −.915 | .139 | −6.563 |
| AR | 2 | −.491 | .139 | −3.529 |
| RBAR Sq. .480; Q(18) = 13.353 | | | | |
| Unemployment Rate | 3 | .165E-01 | .933E-02 | 1.778 |
| AR | 1 | −.824 | .133 | −6.154 |
| AR | 2 | −.535 | .139 | −3.841 |
| RBAR Sq. .485; Q(18) = 15.489 | | | | |
| *Nonwhite Males* | | | | |
| Unemployment Rate | 2 | .733E-01 | .387E-01 | 1.896 |
| AR | 1 | −.734 | .143 | −5.139 |
| AR | 2 | −.398 | .149 | −2.673 |
| RBAR Sq. .387; Q(18) = 17.051 | | | | |
| Unemployment Rate | 3 | .980E-01 | .326E-01 | 3.004 |
| AR | 1 | −.774 | .130 | −5.957 |
| AR | 2 | −.548 | .130 | −4.215 |
| RBAR Sq. .447; Q(18) = 12.386 | | | | |
| *Nonwhite Females* | | | | |
| Unemployment Rate | 2 | .593E-01 | .259E-01 | 2.291 |
| AR | 1 | −.751 | .150 | −5.012 |
| AR | 2 | −.357 | .151 | −2.365 |
| RBAR Sq. .322; Q(18) = 15.328 | | | | |
| Unemployment Rate | 3 | .706E-01 | .243E-01 | 2.906 |
| AR | 1 | −.744 | .146 | −5.102 |
| AR | 2 | −.449 | .149 | −3.011 |
| REAR Sq. .370; Q(18) = 10.771 | | | | |

a. For white males, only the 2-year lag model.

Abbreviations: AR, autoregression term; MA, moving average; E−01, exponent to the power −.01 (e.g., .443 E−01 = .0443); RBAR Sq., adjusted coefficient of determination (i.e. adjusted explanation of variance); Q, measure of autocorrelation of residuals used in Box-Jenkins model.

*Sources:* Mortality data from the National Center for Health Statistics; employment data from the U.S. Bureau of Labor Statistics.

sees—a classic case of the "high-demand/low-control" situation that is gaining attention in the literature on work stress and cardiovascular disease (Karasek and Theorell, 1990). This situation would also lead to higher accident rates and, in some groups (especially the ill and impaired), feelings of hopelessness-helplessness prompted by inability to cope with severe work demands.

A third population combines features of the first two. This population loses employment and income during a recession, and is rehired possibly at a lower socioeconomic level only after economic recovery and often by firms that themselves suffered serious financial reverses during the recession. This population too may carry an additional burden of illness. That illness may have been further exacerbated in the case of the United States by loss of access to health care due to loss of income or insurance during the recession. When this ill population finds new employment during a recovery, it probably enters the economy at a time when demand for labor is high and work pressures are therefore extreme. This group, grateful to have found employment, is desperate to retain that employment despite the conflict between work pressure and illness. But if work pressure exacerbates the illness (such as cardiovascular symptoms), the individual will either be forced to quit or to work at a less intensive pace despite the requirements of the firm. In either case, inability to function "adequately" in the face of such pressure could lead to a sense of dejection and ultimately hopelessness. There is evidence that a psychological state of hopelessness-helplessness is an important factor in fatality due to chronic disease (Karasek and Theorell, 1990).

It is only the first peak in mortality, however, that occurs 2–3 years after recession. Mortality rates lag behind such economic indices as unemployment and business-failure rates by 10–15 years. To demonstrate this relationship, let us look again at the unemployment rate in its distributed-lag relation to mortality for the total population (see Tables 7–2 and 7–3). As these distributed-lag equations show, the basic cumulative temporal pattern can be measured over 2–13 years. The Shiller distributed-lag technique (Shiller, 1973) is used because it eliminates the need for a mathematically rigid functional form (as compared to the polynomial distributed lag), and because the curve-fitting method for the full distributed lag requires the expenditure of only one degree of freedom. The resulting relations, modeled in second differences (rate of change), can also be transformed to first differences (annual changes) and levels, with all variables retaining statistical significance (see Table 7–3). The statistical relationships originally modeled with both independent and dependent variables in second difference form indicate that the level of mortality rates is influenced by the level of cyclical and structural changes in the national economy.

The addition to this equation of the unemployment rate at zero-lag results in a significant distributed-lag relationship, but no longer a significant zero-lag relationship. This finding further confirms the view that, in chronic-disease mortality and in mortality from all causes, the basic short-term relation between unemployment and mortality rates peaks at a 2- to 3-year lag.

Now let us look at whether the relationship between unemployment and mortality-rate changes is still apparent after we control for the influences of other economic variables (such as per capita disposable income) and high-risk consumption and production factors.



Table 7-2 Time-Series Regression Equation Showing Relations Between Economic and Consumption Variables and Age-Adjusted Mortality Rates for the United States, 1950–1988

*(Second Differences, Shiller Distributed Lag)*

| | | 1950–1988 | | | |
|---|---|---|---|---|---|
| Order | Economic Change | Lag (Years | Coefficient | Standard Error | T Statistic |
| 1 | Unemployment rate | 2–13 | .290 | .569E-01 | 5.094 |
| 2 | Per capita real disposable income | 2–14 | −.294E-02 | .475E-03 | −6.183 |
| 3 | Per capita fat consumption | 0–14 | .152E-02 | .255E-03 | 5.979 |
| 4 | RHO | | −.628 | .131 | −4.784 |
| RBAR Sq. .885 | | | | | |
| Durbin-Watson 1.941 | | | | | |
| F Chow (3, 31) = .111 | | | | | |
| *1950–1968* | | | | | |
| 1 | Unemployment rate | 2–13 | .240 | .793E-01 | 3.031 |
| 2 | Per capita real disposable income | 2–14 | −.327E-02 | .662E-03 | −4.941 |
| 3 | Per capita fat consumption | 0–14 | .209E-02 | .414E-03 | 5.044 |
| 4 | RHO | | −.497 | .270 | −1.842 |
| *1969–1988* | | | | | |
| 1 | Unemployment rate | 2–13 | .263 | .121E-01 | 2.168 |
| 2 | Per capita real disposable income | 2–14 | −.305E-02 | .642E-03 | −4.749 |
| 3 | Per capita fat consumption | 0–14 | .106E-02 | .246E-03 | 3.052 |
| 4 | RHO | | −.822 | .138 | −5.965 |

Abbreviations: RHO, autocorrelation term; RBAR Sq., adjusted coefficient of determination (adjusted explanation of variance); Durbin-Watson, measure of autocorrelation among regression residuals; F Chow, F statistic for the Chow test of lack of equivalence of regression coefficients between the first (1950–1968) and second (1969–1988) halves of the period over which the regression equation is calculated; E−01, E−02, etc, exponents to the power −.01, −.001, etc (see footnote to Table 7-1).

*Sources:* U.S. Government data: unemployment rates, *Handbook of Labor Statistics*; per capita real disposable income, Bureau of Economic Analysis; fat consumption, Agricultural Statistics.

First, we can observe the relation between unemployment and mortality rates, in two- or three-variable distributed lag models, including the long-term cumulative relation between per capita disposable income and a single biochemical risk factor such as fat consumption per capita (see Table 7–4).

Second, the Shiller distributed-lag procedure enables us to estimate the simultaneous impact of several predictors, including unemployment and wage rates, social-welfare and health-care expenditures, and consumption and production risk factors. These variables are entered into a step-wise multiple-regression time-series equation, again with

**Table 7-3** Time-Series Regression Equation Showing Relations Between Economic and Consumption Variables and Age-Adjusted Mortality Rates[a] United States, 1950–1988

| Order | Economic Change | Lag (Years) | Coefficient | Standard Error | T Statistic |
|---|---|---|---|---|---|
| *(First Differences, Shiller Distributed Lag)* | | | | | |
| 1 | Trend | 0 | −.539 | .194E-02 | −2.877 |
| 2 | Unemployment rate | 2–13 | .294 | .797E-01 | 3.687 |
| 3 | Per capita real disposable income | 2–14 | −.295E-02 | .485E-03 | −6.078 |
| 4 | Per capita fat consumption | 0–14 | .149E-02 | .343E-03 | 4.343 |
| 5 | RHO | | .548 | .150 | 3.668 |
| RBAR Sq. .650 | | | | | |
| Durbin-Watson 2.553 | | | | | |
| F(4, 34) = 38.800 | | | | | |
| Level Equation (Shiller Distributed Lag). | | | | | |
| 1 | Trend | 0 | −.250 | .726E-01 | −3.440 |
| 2 | Trend square | 0 | .354E-02 | .124E-02 | 2.832 |
| 3 | Unemployment rate | 2–13 | .273 | .790E-01 | 3.463 |
| 2 | Per capita real disposable income | 2–14 | −.159E-02 | .387E-03 | −4.098 |
| 3 | Per capita fat consumption | 0–14 | .130E-02 | .127E-03 | 10.225 |
| 4 | RHO | | −.914 | .104 | −8.795 |
| RBAR Sq. .998 | | | | | |
| Durbin-Watson 1.889 | | | | | |
| F (5, 33) = 701.490 | | | | | |

a. These models are algebraically transformed from the second-difference model in Table 7-2.

Abbreviations: See Tables 7-1 and 7-2.

*Sources:* As in Table 7-2.

a hypothesized lag of approximately 0–14 years. For total mortality rates and for the sex-race breakdown, the basic relationship can be initially estimated in second differences. (The reason for the initial second-difference modeling is that it permits necessary controls for multicollinearity, long-term linear, and quadratic trends.) It is also feasible to observe each of these sets of multivariate relations in first-difference and in level (undifferenced) form.

In the case of the level relationships, we hypothesize that the principal long-term linear trend is central both to the rate of productivity that gives rise to the standard of living and to the production of scientific knowledge, which ultimately leads to the diminution in consumption and production of factors found to be health risks. We suggest that the "factor" behind this trend is long-term investment in research and development, financed by both private sources and government. We do not yet understand, however, the empirical basis of the (relatively weak) quadratic trend that appears to increase the mortality rate. Apart from these two long-term trends, the remainder of the model remains intact, with its full set of benefit and risk factors, each variable showing statistical significance.



**Table 7-4** Time-Series Regression Equation Showing Relations Between National Economic Changes and Age-Adjusted Mortality Rates[a] United States, 1950–1988

| Order | Economic Changes | Lag (Years) | Coefficient | Standard Error | T Statistic |
|---|---|---|---|---|---|
| *Economy* | | | | | |
| 4 | Per capita real disposable income | 1–14 | −.841E-02 | .346E-03 | −24.303 |
| 7 | Annual change in wage rate | 1–12 | −.361E-01 | .593E-02 | −6.090 |
| 9 | Unemployment rate | 0–10 | .982E-01 | .234E-01 | 4.193 |
| 11 | Business-failure rate | 1–7 | .102E-01 | .193 | 5.293 |
| *Policy* | | | | | |
| 14 | Health Expenditures as a proportion of GNP | 0–8 | −24.298 | 11.660 | −2.083 |
| *Consumption* | | | | | |
| 10 | Per capita fat consumption | 0–14 | .203E-02 | .252E-03 | 8.075 |
| 12 | Per capita cigarette consumption | 2–10 | .778E-03 | .240E-03 | 3.244 |
| 5 | Per capita spirits consumption | 0–13 | 7.648 | .391 | 19.585 |
| 6 | Per capita energy consumption | 0–8 | .120E-01 | .575E-02 | 4.651 |
| *Production* | | | | | |
| 8 | Per capita chemical production | 0–11 | .796E-01 | 120E-01 | 6.614 |
| 1 | Constant | | 19.182 | 3.917 | 4.897 |
| 2 | Linear trend | | 429.776 | 35.290 | −12.178 |
| 3 | Trend sq. | | .306E-01 | .158E-02 | −13.022 |
| 13 | Marriage rate | 0–9 | −.350 | .329E-01 | −10.621 |
| RBAR Sq. .99947 | | | | | |
| Durbin-Watson 1.840 | | | | | |
| F(14, 25) = 33914.5 | | | | | |

a. These relations between *levels* of mortality (rates) and levels of economic and social variables were originally estimated in second differences, and are easily transformable algebraically into first differences (annual changes) as well.

Abbreviations: See Tables 7-1 and 7-2.

*Sources:* U.S. Government data: per capita disposable income, Bureau of Economic Analysis; unemployment rates, *Handbook of Labour Statistics*; business-failure rates and health expenditures, Historical Statistics of the U.S.—Statistical Abstracts; cigarette and spirits consumption, Statistical Abstracts of the U.S.

When this method of applying (1) Box-Jenkins, (2) single-variable distributed-lag, and (3) multivariate distributed-lag approaches was used to analyze overall mortality by age, sex, and major cause of death (total cardiovascular disease, coronary heart disease, malignancies, cirrhosis, suicide, and homicide) the overall findings were as follows:

1. Economic growth, as measured by real per capita disposable income (and/or by real wage rates), is inversely related to overall (and chronic-disease) mortality rates over at least 1–14 years.
2. Economic recession, as measured by the unemployment rate, and/or by the business-failure rate, i.e., bankruptcy, is positively related to mortality over 0–10 and 1–7 years, respectively. The initial peak of this relation is an elevated mortality rate 2–3 years after the recession's peak.

3. During the recessional year itself, however, overall mortality declines, followed by a sharp increase (with no lag) during the initial year of recovery. Important exceptions include suicide, homicide, and other mental-health indices and infant mortality, whose positive relation to unemployment rates *begins* at the zero year.
4. Rates of consumption of fats, cigarettes, and alcohol are positively related to total cardiovascular and cancer mortality-rate increases over at least 0–14 years.
5. Chemical production is related to increased overall mortality, and specifically to that due to malignancies, over at least 0–14 years.
6. Social-welfare and health-care expenditures per capita are inversely related to overall mortality rates over at least 0–8 years. These relations are statistically significant only after the variables representing economic change and high-risk consumption patterns are held constant.

These findings have been replicated in analyses in other countries and over different time periods.

## Conclusion

The mechanisms that link SES to health also link changes in SES to changes in health. Thus, stable and equitably distributed economic growth brings about material gains (improved nutrition, sanitation, injury control, health-care technology, and access to health care), and increased potential for control of biochemical risks as a result of investments in health sciences and public education. Psychologically, stable economic growth increases self-esteem (via achievement), security, mastery, and social integration. Recession brings about the opposite effects—notably psychophysiological reactions to economic threats and losses and increased inequality—and tends to increase work stress in firms that have experienced severe economic loss.

During the recovery phase of the business cycle, illness induced by the stresses of recession may prevent reintegration of recession-displaced workers. This lack of economic recovery may be the greatest source of recession-induced health problems in some populations, combining as it does absolute loss, downward mobility, relative deprivation in relation to the majority, and probable loss of social support from peers. In combination with family instability, this set of circumstances serves to elevate the mortality rate over at least a decade following recession.

While the economy is instrumental in advancing the population's health, it is clear from the findings of this study that it does not do so through market factors alone. Market forces, in fact, often generate considerable morbidity and mortality by promoting high-risk consumption and production. Investment in the health sciences, public-health knowledge, and regulation are crucial to counterbalance these tendencies.

Trends in economic productivity and inequality have been adverse for at least the last decade and a half. Action is obviously needed to remedy the short- and long-term problems of the U.S. economy—especially relatively low investment, wage stagnation, and poverty. Perhaps debate on economic and social-welfare policy would become more pointed if it were clearly understood that the health and life expectancy of the nation are at stake.



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# Class, Work, and Health

JEFFREY V. JOHNSON and ELLEN M. HALL

The inquiry into the interconnections of work, social class, and human well-being h been a basic theme in social science since the advent of the industrial revolution in nineteenth century. Interpreting these complex interrelationships remains a challe however.

The association between lower social class position and adverse physical and me health (Hollingshead and Redlich, 1958; Dohrenwend and Dohrenwend, 1969) been reported in the United States (Antonovsky, 1967, 1968; Kitagawa and Hau 1973; Haan et al., 1987, 1989; Williams, 1990), in Great Britain (Marmot et al., 19 1987, 1991; Marmot and McDowall, 1986; Carr-Hill, 1989, Smith, 1990) and in Sc dinavia (Vagero and Lundberg, 1989; Vagero, 1991).

Social class is a powerful determinant of a multitude of factors that affect health: cess to social resources, such as medical care and adequate housing; the nature of physical and urban environment; and individual resources, such as income and edu tion, that reflect differential opportunities. Exposure to hazards and stresses of d life are also differentially distributed along social-class lines. Those at the lower en the social-class hierarchy are more likely to be exposed to chemical and physical h ards in their work, to be threatened with unemployment, and to have to contend wit deteriorating urban physical and social environment. Indeed, it has been suggested t lower social-class position is characterized by meager social and individual resour in combination with high levels of daily stress, and that it is this imbalance, or str that ultimately explains the higher morbidity and mortality rates of less-advantaged cial-class groups (Haan et al., 1989).

It can be argued that social class is the primary determinant of exposure to adve factors; however, the mechanisms by which class might influence health remain unc specified. Biomedical researchers commonly employ three measures of social sta that have been found to be predictive of adverse health outcomes: income, educati

Senator BOXER. Thank you. I think this was terrific, and I feel better about what you said before.

Ms. Cathy Woollums, please go ahead.

**STATEMENT OF CATHY S. WOOLLUMS, SENIOR VICE PRESIDENT AND CHIEF ENVIRONMENTAL COUNSEL, MIDAMERICAN ENERGY HOLDINGS COMPANY**

Ms. WOOLLUMS. Thank you, Madam Chair. I am Cathy Woollums, Senior Vice President and Chief Environmental Counsel of MidAmerican Energy Holdings Company.

We have five U.S. energy platforms, including two utilities, MidAmerican Energy Company in the Midwest and PacifiCorp in the West and Northwest, which serve retail electric and natural gas customers in 10 States.

Our Midwest utility, MidAmerican Energy, has a resource base that is about 52 percent coal, 21 percent natural gas, 7 percent nuclear and 20 percent wind, hydro and biomass. PacifiCorp, which operates 78 power plants across the West, has a resource base slightly higher in coal, but also 21 percent wind, hydro and geothermal. Indeed, our two utilities are No. 1 and No. 2 respectively in the U.S. in ownership of wind-power generation among regulated utilities. We have built over 2,300 megawatts of wind and are building nearly 600 this year. So by the end of this year, about 26 percent of MidAmerican Energy's generation capacity will come from wind.

Our other three U.S. energy platforms are two interState natural gas pipelines and CalEnergy, which operates 10 geothermal plants in California.

You have heard from witnesses this morning about the health costs related to the new EPA regulations. I am going to discuss briefly the compliance costs of these regulations. Every utility is implementing its own unique compliance strategy based on numerous factors that include its resource base, impact on reliability, capital costs, operation and maintenance costs, age of its existing power plants, cost of replacement power and projected load growth. Section two of my written testimony contains a rule by rule overview and brief explanation of our compliance strategy, including EPA's regional haze rule, which is aimed at visibility improvement, not health.

Many of these regulations are not new. Indeed, we have made substantial investments in emissions control equipment over the past decade, and have budgeted for additional projects in the next 10 to 12 years. Through 2010, our two utilities have spent nearly $1.6 billion in capital expenditures for required emission control equipment under these EPA rules, including mercury. We estimate total compliance costs will be about $5.3 billion.

It is very hard to translate these projected costs into specific percentage rate increases to our customers in all 10 States in which our utilities operate. But let me give you two metrics to demonstrate the magnitude of these costs. PacifiCorp' fossil plants have a net value today, after depreciation, of about $3.38 billion. Compare that number to the estimated $1.3 billion that PacifiCorp expects to spend on additional environmental controls between now and 2022, and that gives you a relative sense of the cost of these

pollution control devices to our customers. Our Midwest utility, MidAmerican Energy, those figures are $1.1 billion net value today after deprecation, compared to an estimated $510 million in expenditures between now and 2020.

What does all this mean to our customers, the utility industry and the economy? First, we are concerned about the cost and timetables for implementation of the rules. These compliance costs will increase rates to our customers, just as they are faced with increased rates for other major capital expenditures, including new power plants to meet increasing load growth and to further diversify our resource mix, as well as transmission issues.

Indeed, our PacifiCorp customers are already seeing double digit annual rate increases. It is therefore critical to minimize the cost impact of these rules. Second, if the implementation time tables remain unchanged, these compliance costs will be shouldered by our customers in the form of higher rates and a very narrow window from 2013 to 2015. Third, we are concerned about the costs, that compliance costs will have a domino effect and may dramatically increase production costs for industrial plants and could result in job losses. Fourth, coal units premature retired in response to these EPA rules will have remaining book value issues to address in the form of recovery.

Last, we are concerned that forcing all U.S. coal plants to comply with these rules during such a short timeframe will make it very hard to find and train skilled domestic craft labor. We are also concerned that a compressed timeframe will cause a dramatic rise in the cost of labor and materials for both retrofits and new generation as demand for skilled labor and pats will greatly outstrip supply. We are already seeing this in the marketplace. For example, we just finished negotiating a contract for the installation of scrubbers, bag houses and selective non-catalytic reduction at two of our facilities in 2013 and 2014. The costs are about 20 percent higher than we anticipated.

Emission reduction projects are complex, they take years to execute, and we have to work with our State regulators to define the technical requirements and then address the rate recovery issues. We can't wait for just in time compliance. Thank you.

[The prepared statement of Ms. Woollums follows:]

**Testimony of Cathy S. Woollums**
**Senior Vice President and Chief Environmental Counsel**
**MidAmerican Energy Holdings Company**
**Committee on Environment and Public Works**
**United States Senate**
**June 15, 2011**

Thank you for the opportunity to testify today to provide you with one electric utility's perspective on the costs to comply with new Environmental Protection Agency ("EPA") regulations. My name is Cathy Woollums, and I am the senior vice president and chief environmental counsel of MidAmerican Energy Holdings Company. My comments today are not meant to represent the industry as a whole, although I believe our experiences are largely consistent with those of other U.S. electric utilities, almost all of which have spent – and continue to spend – considerable dollars and resources in planning to comply with these EPA regulations. Every utility, of course, is implementing its own unique compliance strategy based on myriad factors, including its resource base, system impacts, reliability, capital costs, operating and maintenance costs, age of its existing generation units, cost of replacement generation, and projected load growth. What I hope to do this morning is to give you a sense of how these factors translate into our utility operations' overall compliance costs.

## Background on MidAmerican

MidAmerican Energy Holdings Company ("MidAmerican") is a global energy services provider serving almost 6.9 million customers worldwide. MidAmerican's five U.S. energy business platforms consist of two electric utilities, two natural gas pipelines and an independent power producer. The two regulated utilities are MidAmerican Energy Company, an Iowa-based utility providing regulated electric and natural gas service to customers in Iowa, Illinois, South Dakota, and Nebraska; and PacifiCorp, which operates as Pacific Power in Northern California, Oregon, and Washington, and as Rocky Mountain Power in Idaho, Utah, and Wyoming. The two interstate pipelines are Kern River Gas Transmission Company, providing natural gas transportation from Wyoming to Southern California; and Northern Natural Gas, which operates from Texas to the Upper Midwest. The fifth platform is CalEnergy, an independent power producer with geothermal facilities in California and cogeneration plants in New York, Arizona, Texas, and Illinois.

At the end of 2010, MidAmerican Energy Company had 7,048 megawatts of owned and contracted generating capacity. Approximately 52 percent was fueled by coal; 21 percent by natural gas and oil; 20 percent by wind, hydroelectric and biomass; and 7 percent by nuclear. PacifiCorp's generating plants have a net owned capacity of 10,623 megawatts. The company operates 78 generating facilities across the West. Approximately 58 percent was fueled by coal; 21 percent by natural gas; and 21 percent by wind, hydroelectric, geothermal, or other.

MidAmerican Energy Company and PacifiCorp are number one and number two, respectively, in the U.S. in ownership of wind-powered generation among rate-regulated utilities. As of December 31, 2010, nearly 20 percent of MidAmerican Energy Company's total owned and contracted generation capacity and nearly 12 percent of PacifiCorp's total owned and contracted

generation capacity was powered by wind. When MidAmerican Energy Company's 593 megawatts of wind capacity expansion in Iowa is complete by year-end 2011, approximately 26 percent of its total owned and contracted generation capacity will come from wind.

CalEnergy operates 10 geothermal plants with a cumulative generation capacity of 327 megawatts in California's Imperial Valley. Expansion plans call for six new plants with a total of 470 megawatts of additional geothermal capacity.

# *SECTION I*

## I. MidAmerican's Environmental Control Investments

MidAmerican has undertaken significant efforts with our permitting and regulatory agencies to ensure that our environmental control investments are timely in order to ensure compliance with existing environmental requirements, that they proceed in a reasoned fashion, and that they are coordinated with existing outage schedules to avoid additional outage time associated with equipment tie-in. These coordinated efforts reduce costs associated with replacement power and maintain system reliability.

MidAmerican has made substantial investments in pollution control equipment over the past 10 years and has budgeted for additional pollution control projects in the next 10-12 years. We began planning emission control projects targeting sulfur dioxide ("$SO_2$"), nitrogen oxide ("NOx"), and mercury emissions prior to 2005, when the EPA was developing its Clean Air Interstate Rule ("CAIR") and Clean Air Mercury Rule ("CAMR"). Both rules were ultimately vacated by the D.C. Circuit Court of Appeals, which directed the Agency to rework the regulatory framework underpinning both rules. Ultimately the CAIR was replaced by the Clean Air Transport Rule ("CATR") and the CAMR by the Utility Hazardous Air Pollutants ("HAPS") Maximum Achievable Control Technology ("MACT") rule. While the EPA was reworking these rules, MidAmerican continued planning various emissions control projects. Section II of this document contains a rule-by-rule overview and brief explanation of MidAmerican's compliance strategy.

Through 2010, our Midwest utility, MidAmerican Energy Company, has spent more than $370 million in capital expenditures for required pollution control equipment under these EPA rules. We estimate that the total costs for all pollution control projects (defined as capital, operations and maintenance and other costs) will exceed $1.1 billion by the end of 2020. These total costs are expected to increase annual costs to customers by $130 million per year by 2020.

Our other utility, PacifiCorp, has spent more than $1.2 billion in capital expenditures from 2005 through 2010 to comply with these EPA rules, and we estimate that total capital expenditures will exceed $2.7 billion by the end of 2022. Total costs that will have been incurred by our customers to pay for these pollution control projects during the period 2005 through 2023 are expected to exceed $4.2 billion, and by 2023 the annual costs to customers for these projects will have reached $360 million per year.

It is very difficult at this point to translate these projected costs to comply with the new EPA rules into specific percentage rate increases to our customers in all ten states in which we are subject to state public utility commission regulation, but let me give you one metric to demonstrate the magnitude of these costs. PacifiCorp's fossil steam generation units currently have a cumulative net value (after depreciation) of approximately $3.38 billion. Just compare that current value – $3.38 billion – to the estimated $1.3 billion in additional environmental control project capital costs PacifiCorp will spend between now and 2022, and that gives you a relative sense of the cost of these emissions control devices to our customers.

Due to the large number of our generating units that will be potentially affected by these new EPA regulations, deferring the installation of compliance projects places MidAmerican and our customers at risk of not having access to necessary capital, material, and labor in a compressed time frame concurrent with other utilities. For example, in the eastern United States, utilities are required to install controls under the CATR during the same 2012-2014 time frame within which they are required to comply with the HAPS MACT rule. We have already seen a dramatic rise in these pollution control costs in anticipation of the increased demand for labor and equipment. For example, MidAmerican Energy Company has just negotiated a contract for the installation of scrubbers and baghouses at two of our facilities in 2013 and 2014, and the costs are approximately 20% higher than anticipated. We have no choice, however, but to move forward, in order to ensure that we are in compliance and not subject to penalties for noncompliance or third party lawsuits.

The Department of Energy[1] estimates that between 35-70 gigawatts will shut down nationwide as a result of EPA's new rules. Similarly, a recent study by National Economic Research Associates ("NERA") estimates that 47.8 gigawatts of coal-fueled electricity capacity will likely become uneconomic and retire by 2015. Some of those facilities are also located in key transmission grid areas that provide voltage support that cannot be addressed by the fall of 2014 in order to comply with the anticipated January 1, 2015 implementation date. According to four other independent studies conducted last fall, with which I am sure the Committee is familiar (North American Electricity Reliability Council, Brattle, Credit Suisse, and Sanford Bernstein), this aggressive schedule for implementation of these and other EPA rules will likely result in closures of up to 60 gigawatts of existing U.S. coal capacity by January 2015.

MidAmerican, like many utilities, is concerned about the costs and timetables for the implementation of these EPA rules. These compliance costs will increase rates to our customers at the same time as they see increased rates for other major capital expenditures for new generation to meet increasing demands for electric service and to further diversify our generation portfolios, as well as construct billions of dollars of transmission to be able to deliver energy where it is needed. These rate increases are already occurring at PacifiCorp, with customers seeing annual rate increases, some in double-digit percentages.

Especially in this economic climate, it is critical to minimize the cost impact of these rules, which ultimately will be borne by our customers. If the timetable of the rules remains unchanged, compliance costs will be shouldered by our customers in the form of higher rates in a

[1] "EPA regulations for coal-fired power plants could force shut downs", *Bristol Herald Courier* (May 27, 2011); quoting James Wood, deputy assistant secretary for the U.S. Department of Energy.

very narrow window from 2013-2015. These increases will dramatically increase production costs for industrial plants and could result in job losses. Also, units prematurely retired in response to these EPA rules will have remaining book value issues to address.

Moreover, forcing all U.S. coal plants to comply with these EPA rules during such a short time frame will cause the costs of labor and materials for both retrofits and new generation to rise dramatically as demand for skilled labor and parts will greatly outstrip supply. A boom and bust cycle of craft labor employment created by these proposed EPA deadlines will make it challenging for firms to find, train, and retain skilled domestic craft labor.

## II. MidAmerican's Environmental Compliance Planning Process

First and foremost in the decision to invest in environmental controls is our compliance obligation. If a permit or regulation requires one of our plants to reduce emissions or achieve emission limits that cannot be met with existing equipment, we examine compliance options to ascertain what equipment can be installed to achieve the emission requirements. MidAmerican also monitors state and federal rulemaking activities and legislative proposals that would have an impact on the facilities' operations. Monitoring these future requirements gives us a longer term view of the potential investments that may be required to lawfully continue operation of the facilities.

To assess the potential impacts of new environmental regulatory initiatives, the environmental groups in our business units review proposed and final regulatory requirements and actively engage in the regulatory processes at both the state and at the federal levels. We seek feedback from our environmental regulators to assess their concerns, read and analyze legislation and regulations proposed at the state and federal levels, provide feedback on legislation, and review and comment on proposed regulations. We submit written comments in regulatory proceedings and participate in public hearings on the proposals, ensuring that our concerns or support, as appropriate, are considered in these public forums. We are both well informed and engaged on these issues.

## III. Compliance and Project Timing Considerations

We, like virtually all other electric utilities, examine a multitude of factors to determine the appropriate mitigation measures. For example, if a regulation prescribes a specific emissions limit, our teams review what types of controls may be available to achieve the requisite emissions limit, given the specific characteristics of each unit. We consider system impacts, reliability, capital costs, operating and maintenance costs, the life of the controls, the life of the unit itself, cost of replacement generation, and many other factors. If an emissions trading mechanism is available to achieve compliance, we compare the costs of obtaining the emissions allowances to the costs of installing and operating new equipment, considering the factors noted above.

We also examine the actual and potential compliance time frames and how those time frames may be coordinated with planned plant outage schedules. Coordinating major environmental control projects with existing outage schedules allows MidAmerican to avoid additional outage

time, thus reducing the need for replacement power, minimizing costs, and maintaining system reliability.

Pollution control projects are extremely complex and require a significant amount of evaluation and planning to bring to fruition. Moreover, state environmental agency permitting processes are required to define the technical requirements needed in order to seek competitive bidding and pricing for the work and ultimately executing the projects. The timeline for securing contracts for this type of work through project completion often has a multi-year duration.

## IV. Managing Project Execution and Compliance Risk

The full and final scope of environmental regulations is not easily determined, particularly when rulemakings are often lengthy in their own right and just as often followed by extensive and lengthy litigation before the rule is finalized. Perfect foresight is not possible; the EPA has recently begun to acknowledge that its approach to regulation makes it difficult for companies with compliance obligations to make long-term decisions on compliance. In EPA Administrator Lisa Jackson's remarks prepared on the release of the HAPS MACT standards on March 16, 2011, she stated:

> The proposal and implementation of these standards will also have benefits for American utilities. For the first time in twenty years, they will have certainty about the standards they must meet. And setting national standards for mercury and air toxics will level the competitive playing field and close loopholes for big polluters. Utilities that have already put pollution control technology in place will no longer have to compete with those who have delayed those investments – a group that includes almost half of the nation's coal-fired plants, which lack advanced pollution control equipment. In fact, facilities that have already taken responsible steps to reduce the release of toxins into our air will be at a competitive advantage over their heavy-polluting counterparts. And to ensure cost-effectiveness, we have proposed flexibility in meeting the standards. The technologies being required already exist in abundance, and under the proposal, power providers have four years to comply.[2]

MidAmerican believes it would be imprudent to wait until all the regulations are considered, finalized, and quantified to install controls. Doing so would put the facilities at substantial risk of noncompliance and does not reflect the reality of the multistate operations and planning process for large utilities. Moreover, it would be imprudent to assume a large utility can install all required controls under a "just-in-time" plan. This approach to compliance poses a significant risk to MidAmerican and our stakeholders; as a practical matter, it cannot be economically achieved on a system the size of MidAmerican's utility platforms. Emission reduction projects are complex, multi-year projects. Trying to install multiple controls within the same short time frames poses a significant risk of noncompliance, with penalties that can be substantial. Even if a regulatory agency did not impose penalties for failing to achieve emission reduction deadlines,

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[2] Remarks available at:
http://yosemite.epa.gov/opa/admpress.nsf/12a744ff56dbff8585257590004750b6/b7e570d651cadc038525785500570 11c!OpenDocument

third parties have not hesitated to bring lawsuits against the operators of those facilities that miss deadlines or are otherwise not in compliance with permit and emission limits. Indeed, the federal Clean Air Act specifically allows for private citizen enforcement of air quality requirements.

## V. Other Factors to Consider

Finally, environmental regulations and the cost of implementation are only one factor that influences whether or not to make investments in environmental projects; MidAmerican also must consider the cost of alternative generation, such as small modular nuclear reactors. Future natural gas prices, construction costs for renewable generation, and associated transmission availability and costs are also among the factors we evaluate in determining whether it is economic to install controls at coal-fueled plants.

## VI. The Role of State Regulators and Stakeholder Feedback

Our state regulators are the consumers' watchdogs, and they apply standards to ensure that only those costs that are prudently incurred and useful in providing service are recovered in rates. This structure does not encourage utilities to become early movers or emission control technology developers. Those responsibilities lie with the vendor community, where the market provides greater potential rewards for successful innovation. Shareholders of these unregulated companies, not utility customers, earn the rewards of success or bear the costs of failure.

Neither utilities nor regulators have perfect foresight regarding the development of future technologies, future market conditions, or changes in environmental laws, but we make the best projections possible in our resource development decisions. We also appreciate that the American public is concerned with environmental issues, including global climate change. The significant concern for electric utilities is carbon dioxide, the byproduct of the combustion of fossil fuels. Although the primary focus has been on coal-based generation, since it produces more carbon dioxide per unit of electric energy than other fossil fuels, natural gas-fired generation also produces carbon dioxide emissions and is at risk as a continuing source of fuel due to uncertainties around climate change and carbon dioxide regulations.

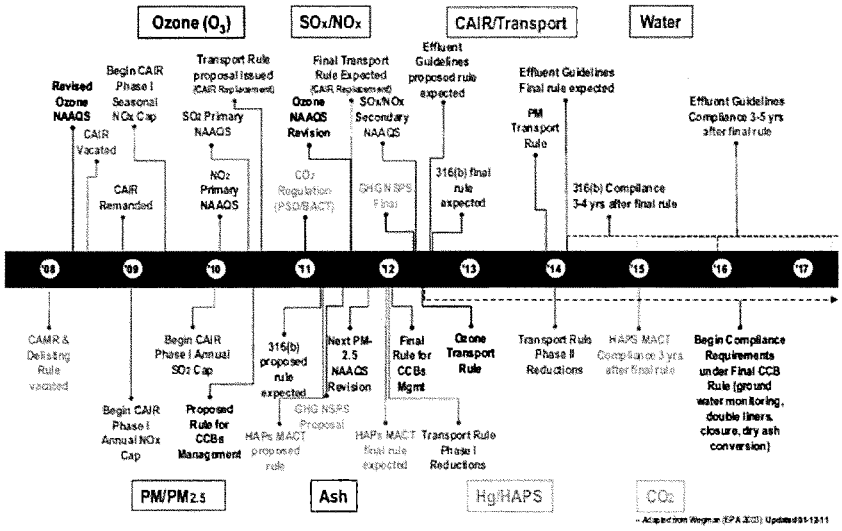
There are many different viewpoints regarding whether MidAmerican should make investments in our existing coal-fueled facilities. Our challenge is to work with these stakeholders and our regulators to come up with solutions that balance state and federal policies, ensure system reliability, maintain 100% compliance with all laws, keep the lights on, meet increasing customer loads, ensure the safety of our employees and customers, and satisfy the obligation to serve, all while maintaining reasonable rates.

# *SECTION II*

## *The So-Called "EPA Regulatory Train Wreck"*

Both MidAmerican Energy Company and PacifiCorp continue to pursue proactive environmental control strategies that are protective of the environment while minimizing cost impacts to our customers. There are a multitude of environmental requirements the electric industry faces over the next several years driving these investments. Figure 1 provides a timeline, referenced colloquially as the so-called "EPA regulatory train wreck" slide. It identifies some of the requirements that are currently underway or in development. There is a great deal of uncertainty associated with future environmental requirements; however, MidAmerican must comply with the requirements that exist today and prepare for the regulations that will be adopted in the future.

**Figure 1 - EPA's "Regulatory Train Wreck"**




The areas of regulation listed below reflect the color-coded "categories" of regulations identified within Figure 1.

1. **PM/PM2.5**
2. **Ozone ($O_3$)**
3. **SOx/NOx**
4. **CAIR/Transport Rule**

These first four categories are grouped together because under the Clean Air Act each of these categories is linked to one or more National Ambient Air Quality Standards ("NAAQS"). These "criteria pollutants" – particulate matter ("PM"), sulfur dioxide ("$SO_2$"), ozone ("$O_3$"), nitrogen oxides ("NOx"), carbon monoxide ("CO"), and hydrocarbons – while undesirable, are not toxic in typical concentrations in the ambient air. Under the Clean Air Act, they are regulated differently from other types of emissions, such as hazardous air pollutants and greenhouse gases.

A NAAQS by itself does not require emissions reductions from specific sources, such as power plants. Rather, the EPA and/or a state will identify various control measures that once implemented, are meant to achieve the NAAQS. A particular control measure may require emissions reductions from certain types of sources. An example of such a control measure would be the EPA's proposed Clean Air Transport Rule, discussed further below.

The Clean Air Act, which was last amended in 1990, requires the EPA to set NAAQS (40 CFR part 50) for pollutants considered harmful to public health and the environment. The Clean Air Act established two types of national air quality standards. ***Primary standards*** set limits to protect public health, including the health of "sensitive" populations such as asthmatics, children, and the elderly. ***Secondary standards*** set limits to protect public welfare, including protection against decreased visibility, damage to animals, crops, vegetation, and buildings. The Clean Air Act requires the EPA to review the latest scientific information and standards every five years. Before new standards are established, policy decisions undergo rigorous review by the scientific community, industry, public interest groups, the general public and the Clean Air Scientific Advisory Committee (CASAC).

**Particulate Matter (PM) and Fine Particulates ($PM_{2.5}$):** The Clean Air Act established NAAQS for particle pollution (i.e., particulate matter or "PM"). The EPA last revised the air quality standards for particle pollution in 2006. The next review is expected in 2011.

**Ozone ($O_3$):** Ozone is a gas composed of three oxygen atoms. It is not usually emitted directly into the air, but at ground-level is created by a chemical reaction between NOx and volatile organic compounds ("VOC") in the presence of sunlight. EPA last revised the NAAQS for ozone pollution in 2008 (at 75 micrograms per cubic meter), putting some counties into non-attainment and requiring states to take steps to reduce emissions to improve the ambient air concentrations. However, EPA is now reconsidering its 2008 decision and may lower the limit (to between 60 and 70 micrograms). EPA expects to make its decision by the end of July 2011.

**Sulfur Dioxide ($SO_2$) and Nitrogen Oxide (NOx):** In 2010, the EPA promulgated new "primary" one-hour NAAQS for $SO_2$ and nitrogen dioxide ("$NO_2$") concentrations, which add a temporal nature to emissions reductions necessary to improve the ambient air concentrations. New "secondary" $SO_2$ and NOx NAAQS are expected in 2012.

**Clean Air Transport Rule ("CATR"):** EPA's proposed CATR would require new reductions in $SO_2$ and NOx emissions from large stationary sources, including power plants, located in 31 states and the District of Columbia beginning in 2012. It is meant to help states attain NAAQS set in 1997 for ozone and fine particulate matter. This rule would replace the Bush

administration's CAIR, which was vacated in July 2008 and rescinded by a federal court because it failed to effectively address pollution from upwind states that is hampering efforts by downwind states to comply with ozone and PM NAAQS.

The EPA has been discussing the possibility of additional emissions reductions via a "PM Transport" rule (2013) or a "Transport II" rule (2014). Justification for such a rule or set of rules would be triggered by the setting of more stringent ozone or PM NAAQS. For example, a more stringent ozone NAAQS may result in an expansion of NOx emissions reduction requirements to stationary sources operating in the non-CATR states.

***MidAmerican's Compliance Strategy:*** The Clean Air Transport Rule only impacts MidAmerican Energy Company's coal units in Iowa and CalEnergy's natural gas facilities in Texas, Illinois and New York. MidAmerican Energy Company has already completed a low NOx burner and overfire air program across its entire coal-fueled fleet. As a result, NOx emissions have dropped from approximately 40,000 tons per year to slightly over 20,000 tons per year – or nearly 50%. In addition, dry scrubbers have been installed at its Louisa and Walter Scott Energy Center unit 4 in 2007, and Walter Scott Energy Center unit 3 in 2009. Additional scrubber projects are being planned for Neal South in 2013, and Neal North units 2-3 and the Ottumwa Generating Station in 2014. Once these projects are complete, MidAmerican Energy Company's $SO_2$ emissions will be reduced from a baseline of over 60,000 tons per year to slightly less than 25,000 tons per year – or nearly 60%.

The EPA intends for this Rule to evolve as additional changes are made to the National Ambient Air Quality Standards for $SO_2$ and NOx. This could lead to significant stranded investments and cause the affected states to also expand to the western coast; if modeling shows those states ultimately contributing to a downwind attainment problem.

**Regional Haze Rule**: While not depicted within the EPA regulatory train wreck slide, an EPA rule meant to address visibility concerns will drive additional NOx reductions particularly from facilities operating in the Western United States. On June 15, 2005, EPA issued final amendments to its July 1999 regional haze rule. These amendments apply to the provisions of the regional haze rule that require emission controls known as Best Available Retrofit Technology ("BART"), for industrial facilities emitting air pollutants that reduce visibility. These pollutants include $PM_{2.5}$, and compounds which contribute to $PM_{2.5}$ formation, such as NOx, $SO_2$, certain volatile organic compounds, and ammonia. The 2005 amendments included final guidelines, known as BART guidelines, for states to use in determining which facilities must install controls and the type of controls the facilities must use. States had until December 2007 to develop their implementation plans. States were responsible for identifying the facilities that would have to reduce emissions under BART and then set BART emissions limits for those facilities. Those facilities are expected to install additional emissions controls usually within five years after the EPA approves a state's regional haze plan (2014-2017).

***MidAmerican's Compliance Strategy:*** PacifiCorp operates 19 coal-fueled generating units; 14 of these units are BART or BART-eligible units. Between 1999 and 2014, PacifiCorp will have installed low-NOx burners at 15 units, reducing NOx emissions by 36,800 tons per year. The capital cost of these projects is $125 million; annual operating and maintenance expenses

associated with the equipment are $1.6 million. Beginning in 2014, PacifiCorp will install selective catalytic reduction ("SCR") to achieve additional NOx emission reductions. Between 2014 and 2022, five units will have SCR installed, reducing NOx emissions by 21,000 tons at a cost of $951 million; operating and maintenance costs will increase by $25.8 million annually.

Unfortunately, recent discussions with the Utah and Wyoming Departments of Environmental Quality suggest that EPA Region 8 believes it may be necessary, for purposes of Regional Haze BART requirements, to install another five SCR in Wyoming and four SCR in Utah, combined with the five planned installations, within a five-year time period—potentially requiring 14 SCR by 2017 and an additional $1.7 billion to $2 billion in costs. PacifiCorp maintains its outage schedule on a four-year cycle; major projects such as the addition of emission control require a significant outage. Installing controls during times outside of the normal outage schedule creates significant electric reliability and availability concerns and imposes significant additional costs for replacement power. The costs of controls, replacement power, and other project-related costs are reflected in increased costs to customers.

The Regional Haze program does not require that emission reductions occur on a date certain; to the contrary, the Regional Haze program is a long-term program designed to improve visibility in Class I areas with the national goal of achieving natural visibility conditions by 2064. States are required to establish reasonable progress goals to achieve the required visibility improvements. States are required, under Section 169A(b) of the Clean Air Act to consider the following when making their BART determinations:

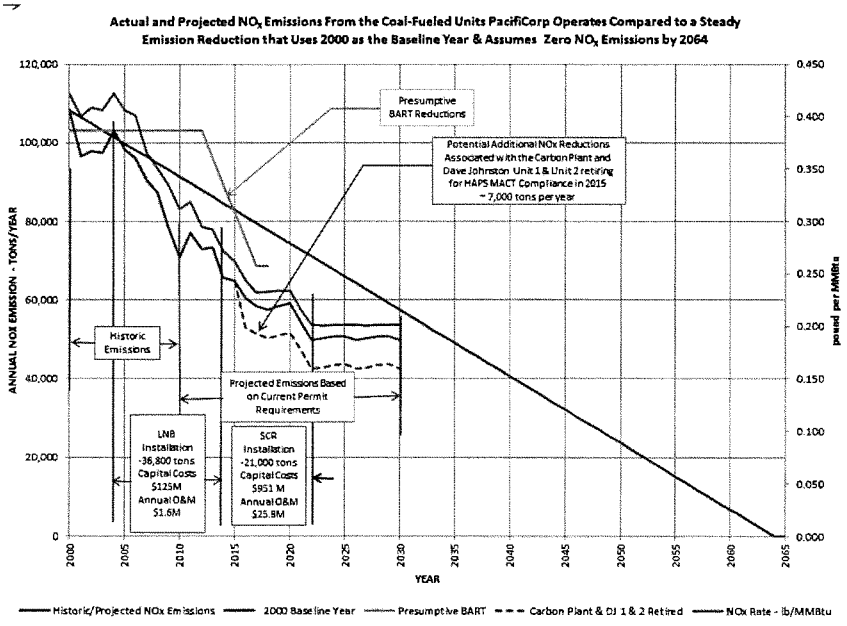
- The costs of compliance;
- The energy and non-air quality environmental impacts of compliance;
- Any existing pollution control technology in use at the source;
- The remaining useful life of the source; and
- The degree of visibility improvement which may reasonably be anticipated from the use of BART.

In considering whether the states' implementation plans are sufficient for approval, EPA appears to be focused, at best, on two criteria – the costs of compliance and the degree of visibility improvement. Effectively, EPA has indicated that any emission reductions that can be accomplished for $5,000 or less per ton at facilities that have more than a 0.50 deciview impact on a Class I area should be controlled. EPA's analysis fails to take into consideration the more robust criteria considered by the states in making their determinations, opting for more reductions sooner.

As a result of EPA's failure to take into consideration factors such as existing pollution control technology in use at the source, its cost per ton of emissions reduced is inaccurate. For example, at PacifiCorp's Jim Bridger Unit 1, low-NOx burners were installed in 2010. Rather than calculating the incremental costs associated with installation of SCR from the reduced baseline that reflects the emission reductions from low-NOx burners, EPA spreads the cost of both low-NOx burners and SCR to achieve a cost per ton removed more than $2,000 per ton lower than the incremental difference between low-NOx burners and SCR.

EPA's suggestions that it will require more emission controls in a shorter period of time is akin to jumping off a cliff, rather than achieving emission reductions in a reasonable period of time through 2064. (See Figure 2.)

**Figure 2 – PacifiCorp's Regional Haze/BART Compliance Strategy**




**5. Hg/HAPS**

In March 2005, EPA issued the Clean Air Mercury Rule ("CAMR") to permanently limit and reduce mercury emissions from coal-fired power plants under a market-based cap-and-trade program; this rule would effectively remove coal-fired power plants from the Clean Air Act list of sources of hazardous air pollutants. However, CAMR was vacated in February 2008, with the circuit court finding EPA's removal of coal-fired power plants from the list of generating sources regulated under Clean Air Act Section 112 out of statutory compliance.

On March 16, 2011, the EPA signed the proposed Utility Hazardous Air Pollutants ("HAPS") Maximum Achievable Control Technology ("MACT") rule, which sets standards for 10 non-mercury HAPS metals, mercury and acid gases. It also establishes work practices to ensure the minimization of organic HAPS such as furans and dioxins emitted by coal and oil-fueled electric generating units. The rule is standard-drive, not technology-driven and, as such, there are

multiple pathways to comply with the rule; however, it appears the EPA is encouraging utilities to: install baghouses with particulate matter continuous emission monitors for non-mercury metallic HAPS control, install sulfur dioxide scrubbers to control acid gases, and install activated carbon/reagent injection to remove mercury.

***MidAmerican's Compliance Strategy:*** In order to meet emissions projections, MidAmerican Energy Company must complete scrubber projects planned for Neal 4 in 2013, and Neal units 2 and 3 and Ottumwa Generating Station in 2014 and add sorbent injection to Neal 1, Walter Scott Energy Center unit 1, Walter Scott Energy Center unit 2, and Riverside Generating Station. Walter Scott Energy Center unit 4 already employs an activated carbon injection system to control mercury and the remaining units with existing or planned baghouses are expected to install activated carbon injection by fall 2014. The cost of most of these projects is approximately $485 million (MidAmerican Energy Company's share). Additional activated carbon injection and sorbent injection projects at the four small coal-fueled units would require an estimated $30 million (MidAmerican Energy Company's share).

MidAmerican Energy Company's smaller coal-fueled units (Walter Scott Energy Center 1, Walter Scott Energy Center 2, Neal 1, and Riverside) may not be able to comply with the proposed HAPS MACT rule without making significant investments in control technology (unless the units are converted exclusively to fire natural gas).

For PacifiCorp, in order to meet the emission reductions anticipated by the new regulations, PacifiCorp must complete scrubber, baghouse, and mercury emissions controls projects no later than fall of 2014 in order to comply with the anticipated January 1, 2015 implementation date at a cost of approximately $1.26 billion (PacifiCorp's share). This capital cost includes installation of mercury control at all PacifiCorp units, including Carbon Unit 1 and 2 and Dave Johnston Unit 1 and Unit 2 at an estimated $12 million (PacifiCorp's share).

The units most at risk from the new HAPS MACT regulations are unscrubbed units that do not have baghouses. These units (Carbon Units 1 and 2 and Dave Johnston Units 1 and 2) may need to be idled or converted to natural gas (assuming it is available onsite) if the non-mercury metallic HAPS and acid gas HAPS limits cannot be met through dry sorbent injection, or other emergent low-cost technology solutions.

Due to the non-emission-trading nature of the proposed rule, units not meeting the unit-based HAPS MACT emission standards would be required to cease operation on or about January 1, 2015, should that date become the compliance deadline. Some of those facilities are also located in key transmission grid areas that provide voltage support that cannot be addressed by the fall of 2014 in order to comply with the anticipated January 1, 2015 implementation date. As such, we urge EPA to carefully consider potential options to develop a mechanism that avoids significant impacts to the availability, reliability and cost of electricity while balancing the need to reduce emissions.

**6. Water**

**Cooling Water Intake Structure Rule:** EPA recently released it proposed cooling water intake structure ("CWIS") rule pursuant to Clean Water Act (CWA) section 316(b) for existing steam-electric power plants. In November 2010, EPA entered into a settlement agreement with the environmental community that sets a binding timetable for a proposed rule by March 2011 and a final rule by July 2012.

***MidAmerican's Compliance Strategy:*** All of MidAmerican Energy's coal-fueled generating facilities, except Louisa, Ottumwa and Walter Scott Unit 4, which have water cooling towers, are regulated facilities under 316(b) of the Clean Water Act and may be impacted by the outcome of the expected rulemaking. Neal 1-4, Walter Scott Energy Center 1-3, and Riverside Generating Station have once through cooling on the Missouri and Mississippi Rivers. At PacifiCorp, only the Dave Johnston plant withdraws enough cooling water to be covered by the 316(b) rule. Every other PacifiCorp facility that is potentially affected by this rule has a recirculating cooling system in place thereby meeting the likely technology requirements of the rule.

**Steam Electric Effluent Guidelines:** EPA announced in September 2009 that it intends to revise the existing steam electric guidelines, last updated in 1982, that set the technology-based effluent limitations for the steam electric industry. The new effluent guidelines rulemaking is likely to set strict performance standards that will force technological and operational changes at existing coal-fueled, nuclear, gas-fueled, and combined cycle facilities. The most significant impact, however, will likely be to coal-fueled facilities. The proposed rule is due in July 2012 with a final rule expected in January 2014.

***MidAmerican's Compliance Strategy:*** MidAmerican Energy Company does not have any wet scrubbers installed in its coal-fueled fleet, and none are planned. The dry scrubbing process does not produce a significant waste water stream, as the approximate 600 gallons per minute of lime slurry water is evaporated in the process and emitted out the stack as vapor. MidAmerican, however, may face a greater challenge concerning the discharge of process water from its coal ash surface impoundments.

PacifiCorp has a number of wet scrubbers in its coal-fueled fleet which produce waste water streams. In most cases, water from these waste streams is collected and evaporated in waste water ponds. The wet scrubbers are currently installed at Hunter 1-3, Huntington 1-2, Naughton 3, Bridger 1-4, Cholla 4, Craig 1-2, and Colstrip 3-4. New wet scrubbers are planned to be placed in service at Naughton 1-2 in 2012 and 2011, respectively. In addition, the PacifiCorp coal-fueled facilities have a number of coal ash surface impoundments.

Unfortunately, there is no definitive method to ascertain the potential financial impacts of new effluent guidelines on the MidAmerican and PacifiCorp coal-fueled fleets until the actual rule requirements are proposed in mid-2012; and there are no projects budgeted to specifically address these issues. However, as the effluent discharge requirements become more and more stringent, the facilities which have discharges to waterways will likely be required to either add wastewater treatment facilities or redesign their process if possible to be a zero discharge facility. The costs to comply with such a rule are expected to be high. Wastewater treatment systems

generally range from tens of millions of dollars for a small facility, to a hundred million or more for a large facility.

**7. Ash**

In June 2010, EPA proposed two primary regulatory options for coal combustion residuals ("CCR") disposed of in landfills and/or surface impoundments: (1) regulation of the materials as hazardous wastes under Subtitle C of the Resource Conservation and Recovery Act ("RCRA"); or (2) regulation of the materials as non-hazardous wastes under Subtitle D of RCRA. Under both options, the proposed regulatory requirements likely would lead to the accelerated closure of all existing unlined landfills and unlined wet surface impoundments, although the agency's "D Prime" option would allow for the continued use of existing landfills and surface impoundments through their useful life as long as certain environmental and safety standards were met. Under each option, CCRs that are beneficially used would be excluded from regulation; however, the stigma associated with a hazardous waste determination would have a devastating impact on continued beneficial uses. Under the two primary options under consideration by EPA, CCR disposal practices will be impacted significantly and result in significant compliance costs, may lead to the closure of existing disposal facilities, and may threaten continued CCR beneficial use.

***MidAmerican's Compliance Strategy:*** The regulation of CCR under either of the EPA's primary options would have a significant impact on the methods that MidAmerican Energy Company typically employs to manage its ash. With the exception of Walter Scott Unit 4 and Neal Unit 4 which handle all the coal ash dry, all of MidAmerican Energy Company's coal-fueled units sluice the boiler bottom ash to on-site surface impoundments. In addition, if CCR is ultimately designated as a hazardous waste, the beneficial use market could evaporate and eliminate the over $3 million MidAmerican Energy Company receives each year for this commodity. The loss of the beneficial use market would also increase disposal costs and dramatically increase the rate at which the monofills are filled.

Similar to MidAmerican Energy Company, the regulation of CCR under either of the EPA's primary options would have a significant impact on the methods that PacifiCorp typically employs to manage its ash. Currently, Carbon, Hunter, and Huntington do not have any wet surface impoundments at the facilities. The remaining coal-fueled units, however, sluice ash and scrubber waste to on-site surface impoundments. In addition, if CCR is ultimately designated as a hazardous waste, the beneficial use market could evaporate and eliminate the over $3.5 million PacifiCorp receives each year on average from this commodity. The loss of the beneficial use market would also increase disposal costs and dramatically increase the rate at which monofills are filled.

**8. $CO_2$**

**Best Available Control Technology ("BACT") Guidelines:** On November 10, 2010, the EPA published a set of guidance documents to assist state permitting authorities and industry permitting applicants with the Clean Air Act PSD and title V permitting for sources of greenhouse gases ("GHGs"). The guidance consists of a number of different documents. EPA provided a general guidance document entitled "PSD and Title V Permitting Guidance For

Greenhouse Gases," which includes a set of appendices with illustrative examples of BACT determinations for different types of facilities. There also remains ongoing concern about the application of New Source Review ("NSR") rules to GHGs. It is unclear whether owners of fossil power plants should proactively undertake efficiency improvements, lest those efficiency improvements be treated as a modification that triggers the application of NSR rules.

***MidAmerican's Compliance Strategy:*** With respect to the GHG BACT permitting, PacifiCorp recently completed permitting for its Utah Lake Side 2 natural gas combined-cycle power plant, where the additional resources and costs required to complete the permitting effort were estimated to be between $25,000 and $50,000 for GHG-related modeling costs, consultant costs, and internal labor.

MidAmerican Energy Company recently completed its GHG BACT permitting for its George Neal South emission control project located in Iowa, but the additional work was completed internally. However, to comply with the newly proposed GHG limit, MidAmerican Energy Company demonstrated that replacing the existing turbine with a more efficient design is technically feasible and would cost approximately $20 million. We also have to test several boiler injection chemicals to determine if they improve plant efficiency. If it is determined that the chemicals are technically and economically feasible, the unit will be required to utilize them going forward.

It should also be noted, that despite claims to the contrary, there are no post-combustion technologies commercially available to control greenhouse gas emissions. Carbon capture and sequestration is likely at least 5-10 years away from becoming commercially available, and only if certain technical, legal, and liability challenges can be overcome. Additionally, the use of biomass is generally limited to certain boiler types for potential retrofit, and only a small percentage can replace the primary boiler fuel. As a result, facilities undergoing GHG BACT permitting are only left with potential efficiency upgrades / heat rate improvement projects to pursue. Since these types of projects typically result in relatively small improvements in efficiency (i.e. less than 1%-3%), an aggressive GHG BACT permit limit may not be achievable on existing units.

**New Source Performance Standards:** On December 23, 2010, in a settlement reached with several states and environmental groups in *New York v. EPA*, the EPA agreed to promulgate emissions standards covering GHGs from both new and existing electric generating units under Section 111 of the Clean Air Act by July 26, 2011 and issue final regulations by May 26, 2012.[3] New source performance standards are established under the Clean Air Act for certain industrial sources of emissions determined to endanger public health and welfare and must be reviewed every eight years. New source performance standards apply to new and modified sources and effectively establish the floor for determining what constitutes BACT.

In addition, emission guidelines will apply to existing sources. The emissions guidelines, issued by EPA, are used by states to develop plans for reducing emissions and include targets based on demonstrated controls, emission reductions, costs and expected time frames for installation and

[3] EPA also entered into a similar settlement the same day to address greenhouse gas emissions from refineries with proposed regulations by December 15, 2011 and final regulations by November 15, 2012.

compliance and may be less stringent than the requirements imposed on new sources. States must submit their plans to EPA within nine months after the guidelines' publication unless EPA sets a different schedule. States have the ability to apply less stringent standards or longer compliance schedules if they demonstrate that following the federal guidelines is unreasonably cost-prohibitive, physically impossible, or that there are other factors that reasonably preclude meeting the guidelines. States may also impose more stringent standards or shorter compliance schedules. Lastly, under Section 111, EPA may establish standards that rely upon market mechanisms rather than technology-specific emissions rates.

***MidAmerican's Compliance Strategy:*** It is unclear what approach EPA will take when establishing new source performance standards covering GHGs from both new and existing electric generating units or what the guidelines will be for existing sources. The proposed settlement agreement indicates that EPA's initial evaluation of available GHG control strategies indicates that there are cost-effective control strategies for reducing GHGs from electric generating units and that it would be appropriate for EPA to concurrently propose performance standards from new and modified electric generating units, and emissions guidelines for GHG emissions from existing affected electric generating units. As noted above (p. 15), MidAmerican disagrees that there are cost-effective post-combustion control strategies for reducing greenhouse gas emissions, and only limited efficiency improvements are commercially available at this time. EPA indicated that the GHG standards are likely to apply to existing facilities starting in 2015 or 2016.

## Figure 3 - Overview of MidAmerican's Environmental Control Projects

| | | | | NOx Emission Controls | | | | | $SO_2$ Emission Controls | | Particulate Controls | | | Mercury (Hg) Control | CCB Compliance | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Unit | Year Installed | Regulatory Depreciation Life (non-OR) | Accredited Net MW Rating (100% Share) | Neural Network System | Low NOx Burners | Overfire Air | Selective Non-Catalytic Reduction | Selective Catalytic Reduction | Dry Scrubber | Wet Scrubber | Electrostatic Precipitator | Wet Scrubber | Baghouse | Activated Carbon Injection | (Dates shown are initial compliance projects in-service) Pond closure, wet-to-dry conversion, new facilities | Potential to Operate on Full Load Natural Gas | MEC/PAC Ownership |
| Neal 1 | 1964 | | 135 | Y | N/A | Y | Not Planned | Not Planned | Not Planned | Not Planned | Y - Hot | N/A | Not Planned | 2014 | 2015 | Y | 100.00% |
| Neal 2 | 1972 | | 295 | Y | Y | Y | 2014 | Not Planned | 2014 | Not Planned | Y - Cold | N/A | 2014 | 2014 | 2015 | N/A | 100.00% |
| Neal 3 | 1975 | | 515 | Y | Y | Y | 2014 | Not Planned | 2014 | N/A | Y - Cold | N/A | 2014 | 2014 | 2015 | N/A | 72.00% |
| Neal 4 | 1979 | | 644 | Y | Y | Y | 2013 | Not Planned | 2013 | N/A | Y - Cold | N/A | 2013 | 2014 | Not Planned | N/A | 40.57% |
| WSEC 1 | 1954 | | 45 | Not Planned | Y | Not Planned | Not Planned | Not Planned | Not Planned | Not Planned | Y - Hot | N/A | Not Planned | 2014 | 2015 | N/A | 100.00% |
| WSEC 2 | 1958 | | 88 | Not Planned | Y | Y | Not Planned | Not Planned | Not Planned | Not Planned | Y - Hot | N/A | Not Planned | 2014 | 2015 | Y | 100.00% |
| WSEC 3 | 1978 | | 680 | Y | Y | Y | Not Planned | Not Planned | Y | N/A | Y - Cold | N/A | Y | 2014 | 2015 | N/A | 79.10% |
| WSEC 4 | 2007 | | 800 | Y | Y | Y | Not Planned | Y | Y | N/A | N/A | N/A | Y | Y | Not Planned | N/A | 59.66% |
| Louisa | 1983 | | 745 | Y | Y | Y | Not Planned | Not Planned | Y | N/A | Y - Hot | N/A | Y | 2014 | 2014 | N/A | 88.90% |
| Riverside | 1925/1961 | | 130 | Y | Y | Y | Not Planned | Not Planned | Not Planned | Not Planned | Y - Cold | N/A | Not Planned | 2014 | 2015 | Y | 100.00% |
| Ottumwa | 1981 | | 710 | Y | Y | Y | Not Planned | Not Planned | 2014 | N/A | Y - Hot | N/A | 2014 | 2014 | Not Planned | N/A | 52.00% |
| | | | | | | | | | | | | | | | | | |
| Carbon 1 | 1954 | 2020 | 67 | Not Planned | Not Planned | Not Planned | Not Planned | Not Planned | Not Planned | Not Planned | Y - Cold Side | - | Not Planned | Sorb Inj + Oxidizer | 2015 | Under Review | 100.00% |
| Carbon 2 | 1957 | 2020 | 105 | Not Planned | Not Planned | Not Planned | Not Planned | Not Planned | Not Planned | Not Planned | Y - Cold Side | - | Not Planned | Sorb Inj + Oxidizer | 2015 | Under Review | 100.00% |
| Cholla 4 | 1981 | 2042 | 395 | Not Planned | Y | Y | Not Planned | Not Planned | N/A | Y | N/A | - | Y | Coal Oxidizer | 2015 | Not Planned | 100.00% |
| Colstrip 3 | 1984 | 2046 | 740 | Not Planned | Y | Y | Not Planned | Not Planned | N/A | Y | N/A | Y | N/A | Y - Installed | 2015 | Not Planned | 100.00% |
| Colstrip 4 | 1986 | 2046 | 740 | Not Planned | Y | Y | Not Planned | Not Planned | N/A | Y | N/A | Y | N/A | Y - Installed | 2015 | Not Planned | 100.00% |
| Craig 1 | 1980 | 2034 | 428 | Not Planned | Y | Y | 2014 | Not Planned | N/A | Y | N/A | - | Y | Coal Oxidizer | 2015 | Not Planned | 19.28% |
| Craig 2 | 1979 | 2034 | 428 | Not Planned | Y | Y | 2013 | Not Planned | N/A | Y | N/A | - | Y | Coal Oxidizer | 2015 | Not Planned | 19.28% |
| Dave Johnston 1 | 1958 | 2027 | 106 | Not Planned | N | N | Not Planned | Not Planned | Not Planned | Not Planned | Y - Cold Side | - | Not Planned | Sorbent Injection | 2015 | Under Review | 100.00% |
| Dave Johnston 2 | 1960 | 2027 | 106 | Not Planned | N | N | Not Planned | Not Planned | Not Planned | Not Planned | Y - Cold Side | - | Not Planned | Sorbent Injection | 2015 | Under Review | 100.00% |
| Dave Johnston 3 | 1964 | 2027 | 220 | Not Planned | Y | Y | Not Planned | Not Planned | Y | N/A | Y - Cold Side | - | Y | Sorbent Injection | 2015 | Not Planned | 100.00% |
| Dave Johnston 4 | 1972 | 2027 | 330 | Not Planned | Y | Y | Not Planned | Not Planned | 2012 | N/A | Y - Cold Side | - | 2012 | Sorbent Injection | 2015 | Not Planned | 100.00% |
| Hayden 1 | 1965 | 2030 | 184 | Not Planned | Y | Y | Not Planned | 2015 | Y | N/A | N/A | - | Y | Sorbent Injection | 2015 | Not Planned | 24.46% |
| Hayden 2 | 1976 | 2030 | 262 | Not Planned | Y | Y | Not Planned | 2016 | Y | N/A | N/A | - | Y | Sorbent Injection | 2015 | Not Planned | 12.80% |
| Hunter 1 | 1978 | 2042 | 430 | Not Planned | 2014 | 2014 | Not Planned | Not Planned | N/A | Y | Y - Cold Side | - | 2014 | Coal Oxidizer | 2015 | Not Planned | 93.75% |
| Hunter 2 | 1980 | 2042 | 430 | Not Planned | 2011 | 2011 | Not Planned | 2023 | N/A | Y | Y - Cold Side | - | 2011 | Coal Oxidizer | 2015 | Not Planned | 60.31% |
| Hunter 3 | 1983 | 2042 | 460 | Not Planned | Y | Y | Not Planned | 2024 | N/A | Y | N/A | - | Y | Coal Oxidizer | 2015 | Not Planned | 100.00% |
| Huntington 1 | 1977 | 2036 | 445 | Not Planned | Y | Y | Not Planned | 2023 | N/A | Y | Y - Cold Side | - | Y | Coal Oxidizer | 2015 | Not Planned | 100.00% |
| Huntington 2 | 1974 | 2036 | 450 | Not Planned | Y | Y | Not Planned | Not Planned | N/A | Y | N/A | - | Y | Coal Oxidizer | 2015 | Not Planned | 100.00% |
| Jim Bridger 1 | 1974 | 2037 | 530 | Not Planned | Y | Y | Not Planned | 2022 | N/A | Y | Y - Cold Side | - | Not Planned | Sorb Inj + Oxidizer | 2015 | Not Planned | 66.67% |
| Jim Bridger 2 | 1975 | 2037 | 527 | Not Planned | Y | Y | Not Planned | 2021 | N/A | Y | Y - Cold Side | - | Not Planned | Sorb Inj + Oxidizer | 2015 | Not Planned | 66.67% |
| Jim Bridger 3 | 1976 | 2037 | 530 | Not Planned | Y | Y | Not Planned | 2015 | N/A | Y | Y - Cold Side | - | Not Planned | Sorb Inj + Oxidizer | 2015 | Not Planned | 66.67% |
| Jim Bridger 4 | 1979 | 2037 | 530 | Not Planned | Y | Y | Not Planned | 2016 | N/A | Y | Y - Cold Side | - | Not Planned | Sorb Inj + Oxidizer | 2015 | Not Planned | 66.67% |
| Naughton 1 | 1963 | 2029 | 160 | Not Planned | 2012 | 2012 | Not Planned | Not Planned | N/A | 2012 | Y - Cold Side | - | Not Planned | Sorb Inj + Oxidizer | 2015 | Not Planned | 100.00% |
| Naughton 2 | 1968 | 2029 | 210 | Not Planned | 2011 | 2011 | Not Planned | Not Planned | N/A | 2011 | Y - Cold Side | - | Not Planned | Sorb Inj + Oxidizer | 2015 | Not Planned | 100.00% |
| Naughton 3 | 1971 | 2029 | 330 | Not Planned | Y | Y | Not Planned | 2014 | N/A | Y | Y - Cold Side | - | 2014 | Sorb Inj + Oxidizer | 2015 | Not Planned | 100.00% |
| Wyodak | 1978 | 2039 | 335 | Not Planned | 2011 | 2011 | Not Planned | Not Planned | Y | N/A | Y - Cold Side | - | 2011 | Sorbent Injection | 2015 | Not Planned | 80.00% |

Senator BOXER. Thank you.
Dr. Munzer.

**STATEMENT OF ALFRED MUNZER, M.D., PULMONARY AND CRITICAL CARE, WASHINGTON ADVENTIST HOSPITAL**

Dr. MUNZER. Thank you, Madam Chair.

I am Dr. Alfred Munzer, and I am a physician specializing in lung disease and practicing at Washington Adventist Hospital in Takoma Park, Maryland. I am delighted to appear before the Committee on behalf of the American Thoracic Society.

I spend my days treating people with serious conditions like asthma, chronic obstructive pulmonary disease, sarcoidosis, lung cancer, and any number of serious respiratory diseases, many of which are unknown to the general public. Through a combination of medications, interventional procedures and lifestyle modifications, I work with my patients to help control the respiratory diseases.

There is one thing neither I nor my patients can control, and that is air pollution. Air pollution plays a major role in causing and exacerbating respiratory illness. From years of clinical experience, I know that when the D.C. area has a Code Orange or Code Red day, patients will suffer the effects. Those with asthma will experience acute exacerbations of their condition, making every breath they take more labored. The emergency room at our hospital will be filled with patients with serious respiratory distress. In most of these cases, these patients didn't do anything wrong or different. They just happened to be unlucky enough to breathe highly polluted air.

While I am not an air pollution researcher, my clinical experience of the impact of air pollution on respiratory health is backed up by countless peer-reviewed studies in the United States and abroad. The science documenting the adverse effects of air pollution on human heath is comprehensive, consistent and compelling. Unfortunately, that science is also under attack.

Industry regulated by the Environmental Protection Agency has started a campaign to discredit the research that is used to support EPA's regulations under the Clean Air Act. Some Members of Congress appear to be taking up the mantra of discrediting or openly discounting the validity of EPA-sponsored research. This is a mistake and is a distraction from what we all should be focusing on: reducing air pollution to improve everyone's health.

The EPA's science is sound, and its methodology is strong in its conclusions. But the EPA is not the only source of credible science that shows that air pollution matters. Respected scientific agencies in the United States and around the globe have documented the adverse effects of air pollution. The NIH has supported a number of studies that found that air pollution, particularly ozone and particulate matter, is bad for everyone's health. And this is especially true for children.

Silverman and colleagues demonstrated warm weather patterns of ozone and fine particulate matter that disproportionately affects children with asthma and appears responsible for severe attacks that could have been avoided. More and colleagues in California conducted a study that showed that current levels experienced in

Southern California, ozone contributes to an increased risk of hospitalization for children with asthma.

In another study by the National Institutes of Heath, Dr. Balmes and colleagues demonstrated that traffic-related air pollution lead to measurable decrease in lung function. Even the American Petroleum Institute has contributed to the scientific literature. In an API-funded study, Dr. Schelegle and his colleagues demonstrated that in chamber studies, ozone concentrations below 75 parts per billion decreases a key measure of lung function in young, heathy adults.

For the record, I will include a brief list of other important studies that demonstrate that air pollution continues to be an important health issue in the United States. In conclusion, the science is consistent and comprehensive and comes from multiple credible sources, including the EPA. I hope Congress and the EPA can put the questions about the scientific validity of the air pollution studies to rest and start focusing on the real problem: how best to move forward with eliminating the threat posed by air pollution. The control of air pollution is part and parcel of our national defense.

[The prepared statement of Dr. Munzer follows:]

**American Thoracic Society**

*We help the world breathe*

**Statement of the American Thoracic Society**
**Before the Senate Environment and Public Works Committee**
**Presented by Alfred Munzer MD**
**On Wednesday, June 15, 2011**

I am Dr. Alfred Munzer and I am a physician specializing in lung disease and practicing at Washington Adventist Hospital in Takoma Park, MD. I spend my days treating people with serious conditions like asthma; chronic obstructive pulmonary disease, or COPD; sarcoidosis; and a number of other serious respiratory diseases, many of which are unknown by the general public.

Through a combination of medications, interventional procedures and lifestyle modifications, I work with my patients to try to help control their respiratory disease. But there is one thing, neither I nor my patients can control and that is air pollution. Air pollution plays a major role in causing and exacerbating respiratory illnesses. From years of clinical experience, I know that when the DC area has a code orange or code red air pollution day, patients will suffer the effects. Those with asthma will experience acute exacerabations of their condition, making every breath they take more labored. And the emergency room at the hospital will be filled with patients in serious respiratory distress. In most these cases, my patients didn't do anything wrong or different: they just happened to be unlucky enough to breathe highly polluted air.

While I am not an air pollution researcher, my clinical experience of the impact air pollution on respiratory health is backed up by a countless peer reviewed studies in the United States. and abroad. The science documenting the adverse health effects air pollution has on human health is comprehensive, consistent, and compelling.

Unfortunately, that science is also under attack.

Industry regulated by the Environmental Protection Agency has started a campaign to discredit the research that is used to support EPA's regulations under the Clean Air Act. Some members of Congress appear to be taking up the mantra of discrediting or openly discounting the validity of EPA-sponsored research. This is a mistake and is a distraction from what we all should be focusing on:reducing air pollution to improve everyone's health.

The EPA's science is sound in its methodology and strong in its conclusions. But the EPA is not the only source of credible science that shows air pollution matters. Respected scientific agencies in the United States and around the globe have documented the adverse effects of air pollution.

The NIH has supported a number of studies that found that air pollution – particularly ozone and particulate matter – is bad for everyone's health. This is especially true for children.

Silverman and colleagues demonstrated warm weather patterns of ozone and $PM_{2.5}$ disproportionately affect children with asthma and appear responsible for severe attacks that could have been avoided.

Moore and colleagues in a California Air Resources Board funded study showed that current levels experienced in Southern California, ozone contributes to an increased risk of hospitalization for children with asthma.

In another study funded by the National Institutes of Health, Dr. Balmes and colleagues demonstrated that traffic related air pollution lead to measurable decreased in the lung function of adults.

The American Petroleum Institute has even contributed to the scientific literature. In an API funded study, Dr. Schelegle and colleagues demonstrated that in chamber studies exposures, ozone concentrations below 75 ppb decreases FEV1, a key measure of lung function, in healthy young adults.

I could go on about many studies supported by respected scientific agencies other than the EPA, but I hope my point is clear: air pollution impacts in a significant and negative way the health of Americans. This is not an opinion, it is a fact.

For the record, I have included a brief list of other important studies that all demonstrate that air pollution continues to be an important health issue in the United States. The most comprehensive listing of relevant studies can be found in the EPA Integrated Scientific Assessment document or the relevant the EPA criteria document.

In conclusion, the science is consistent and comprehensive and comes from multiple creditable sources, including the EPA. I hope Congress and the EPA can put to rest questions about the scientific validity of air pollution studies and start focusing our attention at the real problem: how best to move forward with eliminating the threat posed by air pollution.

I would be happy to answer any questions.

**Selected References**

**TOPIC: Air pollution makes asthma worse, especially in children**

**Ambient ozone concentrations cause increased hospitalizations for asthma in children**: an 18-year study in Southern California. Environ Health Perspect. 2008 Aug;116(8):1063-70. Moore K, Neugebauer R, Lurmann F, Hall J, Brajer V, Alcorn S, Tager I.

Key Finding: Ozone contributes to an increased risk of hospitalization for children with asthma living in California.

**Respiratory disease associated with community air pollution and a Steel Mill**, Utah Valley. Pope, CA. Am J of Public Health 1989 79 (5):623

Key Finding: Pediatric hospital emissions were two to three times higher during the winters when the mill was open compared to when it was closed

**Exposure to traffic: lung function and health status in adults with asthma.** J Allergy Clin Immunol. 2009 Mar;123(3):626-31. Epub 2009 Jan 18.Balmes JR, Earnest G, Katz PP, Yelin EH, Eisner MD, Chen H, Trupin L, Lurmann F, Blanc PD.

Key Finding: Traffic-related air pollution lead to measurable decreased in the lung function of adults

**TOPIC: Air pollution can kill you**

**Long-term ambient multipollutant exposures and mortality.** Am J Respir Crit Care Med. 2011 Jan 1;183(1):73-8. Epub 2010 Jul 23. Hart JE, Garshick E, Dockery DW, Smith TJ, Ryan L, Laden F.

Key Finding: Residential ambient air pollution exposures were associated with mortality.

**Long-term ozone exposure and mortality**. N Engl J Med. 2009 Mar 12;360(11):1085-95. Jerrett M, Burnett RT, Pope CA 3rd, Ito K, Thurston G, Krewski D, Shi Y, Calle E, Thun M.

Key Finding: Demonstrates a significant increase in the risk of death from respiratory causes in association with an increase in ozone concentration.

**Susceptibility factors to ozone-related mortality: a population-based case-crossover analysis**. Am J Respir Crit Care Med. 2010 Aug 1;182(3):376-84. Epub 2010 Mar 25. Stafoggia M, Forastiere F, Faustini A, Biggeri A, Bisanti L,

Cadum E, Cernigliaro A, Mallone S, Pandolfi P, Serinelli M, Tessari R, Vigotti MA, Perucci CA; EpiAir Group.

Key Finding: A greater vulnerability of elderly people and women was indicated; subjects who died at home and had diabetes emerged as especially affected.

**TOPIC: Ozone adversely impacts lung function**

**The effect of air pollution on lung development from 10 to 18 years of age.** N Engl J Med. 2004 Sep 9;351(11):1057-67. Gauderman WJ, Avol E, Gilliland F, Vora H, Thomas D, Berhane K, McConnell R, Kuenzli N, Lurmann F, Rappaport E, Margolis H, Bates D, Peters J.

Key Finding: Air pollution alters lung function in children.

**Chronic exposure to ambient ozone and lung function in young adults. Epidemiology.** 2005 Nov;16(6):751-9. Tager IB, Balmes J, Lurmann F, Ngo L, Alcorn S, Künzli N.

Key Finding: Air pollution alters lung function in you adults who are near peak lifetime lung function.

**6.6-hour inhalation of ozone concentrations from 60 to 87 parts per billion in healthy humans**. Am J Respir Crit Care Med. 2009 Aug 1;180(3):265-72. Epub 2009 May 15. Schelegle ES, Morales CA, Walby WF, Marion S, Allen RP.

Key Finding: Ozone concentrations below ~75 ppb decreases FEV1 in health young adults.

Senator BOXER. Thank you very much.

I am going to open up the question time and then I am going to turn the gavel over to Senator Carper to conclude.

Thank you all. You are all very straightforward. I appreciate it.

Dr. Paulson, talk to me about exposure to mercury, either during pregnancy, what the impact is on the fetus, and what is the impact on a little child who is exposed to mercury? Ms. Woollums complained a lot about the mercury rule. And I am going to get to her. Yes, you did, and I am going to ask you some questions.

Talk to me about what happens when there is too much mercury.

Dr. PAULSON. Mercury is a neurotoxin. It damages the brain and results in decrease in i.q. of children who are exposed.

The change is particularly important when looked at on a population scale. A shift in i.q. of as little as five points in the population as a whole means a radical decrease in the number of gifted and talented individuals in the population, and a marked increase in the number of people with intellectual disabilities. So small changes in i.q. at the individual level have a major impact at the public level. It is very important to decrease the amount of mercury that comes out of power plants.

Senator BOXER. And as you know, there is a rule currently to do that. I assume you are supportive of that rule?

Dr. PAULSON. Yes, ma'am.

Senator BOXER. OK. And the nurses are as well? The rule on mercury?

Ms. BUCIC. Yes.

Senator BOXER. OK. Is that true for you, Dr. Munzer.

Dr. MUNZER. Yes, it is.

Senator BOXER. OK. So I am going to talk to the person here who is representing the people who, when they supply us with electricity, have a problem because there is a lot of mercury emissions. As I listened to you over and over again, for your entire discussion, you mostly talked about this rule and what a problem it is. And I need to talk to you about this, because you are the environmental counsel. So I am thinking that you would want to see them make progress here. And you are asking for delays and all the things, and you are saying that there is, this was one thing you said. It is hard to find labor? You have got to be kidding. I thought you said in your testimony that if we do this, it is hard to find the labor.

Ms. WOOLLUMS. I am sorry, it is hard to find what?

Senator BOXER. It is hard to find the labor. Yes. You said in your testimony it was hard to find labor to do the work.

Ms. WOOLLUMS. Yes, and with all due respect, I disagree with the characterization relative to my statements on mercury.

Senator BOXER. OK. It is just my subjective listening to it, it seemed like a lot of complaining about the mercury rule. But we will go back to the statement, see how much of your time you took about that. It was a heck of a lot of it. But talk to me. Why would you say it is hard to find labor?

Ms. WOOLLUMS. Because we are talking about, and let me go back to the mercury rule, I actually——

Senator BOXER. I am asking you, why is it hard to find labor? That is my question.

Ms. WOOLLUMS. Because we are talking about installing a great number of pieces of equipment within very short periods of time.

Senator BOXER. OK. Well, let me make your life better. We have the AFL–CIO telling us there is sufficient labor to cover the needed work on the power plant. People want jobs. So I would be glad to, there is a high unemployment, we are talking, my Republican friends are talking about that. We are saying, yes, we have to do more about jobs. So that is just not happening.

Now, do you feel, just Ms. Woollums, if you saw somebody throw a dart and it was meant for the dartboard, but it went over the other way and it hit a child, I am assuming you would hold that person responsible, would you not, for throwing that dart in an unsafe manner? Yes or no?

Ms. WOOLLUMS. It depends on the circumstances.

Senator BOXER. I will say it again. A child is out there, say, 17 years old, and playing darts, and doesn't look around, doesn't check to see who is there. There is a bunch of kids standing on either side. There is no protection. Throws the dart and it hits somebody else. Would you suppose that child has some culpability in what happened, or the parent who allowed that to take place?

Ms. WOOLLUMS. You have changed the dynamic slight, but what——

Senator BOXER. Yes or no? Yes or no? If someone, let me put it this way, if someone hurts someone else, do you think they ought to be held responsible?

Ms. WOOLLUMS. It depends on the cir——

Senator BOXER. Oh, really? OK. Well, how about this. Somebody, OK, decides to do something in their yard without taking all the proper precautions that are listed by the manufacturer of this product. They go out there and they just don't do anything right, there is people nearby and they get hurt. Are they responsible, if they knew about this?

Ms. WOOLLUMS. In that circumstance, I would say yes.

Senator BOXER. OK. Well, my belief is, if you know that your plant is spewing out this poison, poison that doctors say unequivocally causes brain damage in children, and you complain about this or that and the other, and guess what, your poison from the Midwest where you are is going to his State, is going to his State, is going to his State. And they are doing everything right. And they are just standing by. And their people are going to the emergency room.

So I guess what I want to say to you, after finally getting an answer to my I thought was a simple question of responsibility, is that we all have responsibility for what we do, especially if our byproduct of what we do is producing one of the most dangerous toxins. And that is not the only toxin.

So I would just hope that you would go back to your people and tell them, just for me, I don't speak for a soul else, that I think it is time to step up to the plate. The fact is, I have a chart here, I ask unanimous consent to put it in the record, of the power plants in the Untied States, many of them are super old. They have either got to be brought up to code, fixed, with the best available technology or close them down. You can't keep on going.

As I said, when I went to China, I never saw the sun. And I want to tell you, Ms. Woollums, you ought to go to China. Because you see the impacts of people, a government who could are less about the health of, they don't give a darn about the people there. All they want is, getting to Dr. Brenner's point, is they should work, work, work, work, work, work, work. But they don't care. And the people are suffering because of it.

So this issue of the mercury rule, today we are talking about the Clean Air Act, the mercury rule, the mercury that goes in the air. I think as Environmental counsel, I hope you will tell them that I hope they will see this as a win-win as they, yes, their consumers have to breathe clean air as well as pay their electric bills.

And if you ask them, because we asked people, 69 percent of them want us to do tougher, tougher rules on air. All over the Country, I don't care what State, from Wyoming to California, anywhere. This is a Republican and Democratic poll just done a couple of months ago. And I believe it is time for good stewardship here. And you are the environmental counsel. And I hope and pray that instead of fighting these rules, you will work with us, you will work with the EPA. And let's get some rules out there that work.

Because I will tell you, I have been hearing Senator Carper for more years than I can tell you talking to me about mercury. I am in a different position. We don't have that kind of problem in our State. But this is serious stuff. And so I hope you will take that message back for me, doesn't come from anybody else. It is just my message, step up to the plate, corporate responsibility, caring about people's health and understanding that if you can't breathe, you can't work. If your child is brain damaged, your life changes. You can't have a life that is normal. And I hope you will take that back.

And I thank my colleagues, and I would ask Senator Barrasso to take his time, and turn the gavel over to Senator Carper.

Ms. WOOLLUMS. Madam Chairman, I will take that message back to my company.

Senator BOXER. Thank you.

Ms. WOOLLUMS. One thing I would like to add is MidAmerican has already begun the process of being a leader in the mercury charge. And as a matter of fact, we were one of the very first companies, back when our plant became operational in 2007, to install activated carbon injection for mercury control.

Senator BOXER. Excellent. Well, it is time to help us with this rule and do even more. Because if the technology is there, it helps us. Thank you very much.

Senator BARRASSO. Thank you very much, Madam Chairman.

Dr. Brenner, you said in your testimony that the unemployment rate is a well-established risk factor for elevated illness and mortality rates in epidemiological studies performed in the last 30 years or so. You said the unemployment, which is now 9.1 percent, was at 10 percent in spite of all the promises that the President made that if we passed his so-called stimulus plan that it wouldn't go above 8 percent, you said that the unemployment rate is also an important risk factor in heart disease, overall decreases in life expectancy. Could you elaborate a little bit on what the impact to children is with regard to parents who are unemployed, and how

unemployment affects a child's health in terms of a household with unemployment?

Mr. BRENNER. The most thorough studies that we have indicate that the employment status of the breadwinner is crucial for the entire family. So one interesting study published in 1982, I believe, in the Journal of the Lancet, the major international medical journal, demonstrated that when the head of household is unemployed, within 10 years there is an increase in the mortality rate of the spouse, even though the spouse will not have experienced any employment changes.

There are numerous studies on the effect of unemployment on the socio-economic status of the family. When the effect of lowering the status of the family occurs to pregnant women, to children, to families where there are children in the one to 4 years of age, the studies indicate that as long as 40 to 50 years later, there are elevated levels of mortality, particularly cardiovascular mortality.

So it is a phenomenon that sweeps through time, even though we think of it normally as occurring in a very discrete way, here it is and it is gone tomorrow. In our current economy, for instance, which is just before us, obviously, we not only have relatively high unemployment rate, we have one that is very long. We have one of the longest periods of lengthy unemployment again in our history, since the Second World War. Those effects are much, much larger, because they have effects into the next period of employment.

The reason for that is that once people lose work, for a long period of time, they tend to lose their skills. And if they are employed again at all, it is a much lower wage level typically. They lose seniority, they lose retirement rights and the rest of it, we are familiar with. So this is a lifelong situation that goes on that characterize the unemployment rate.

Senator BARRASSO. So then your opinion would be that the more we could do to actually get people working again, in terms of actually being things for the general overall health of all these very skilled physicians and their patients, one of the best things we could do is actually improve the economy, get people back to work, raise the gross domestic product, raise that, lower the unemployment rate, and we ought to be focusing on the economy.

Mr. BRENNER. It is the very best thing we can do, without any question.

Senator BARRASSO. All right. Ms. Woollums, going through your testimony, if it does seem that all these additional rules and regulations and red tape coming out of Washington, and specifically the Environmental Protection Agency, and we did hear testimony that there have been incredible improvements in air quality in this Country over the last 40 years, but that these additional costs are going to be borne by families who are already having a hard time making ends meet, and that these rules and regulations are going to make things worse. Is that your impression of what you are seeing across the Country?

Ms. WOOLLUMS. Yes, and as a matter of fact, Senator, in your home State, our most recent rate case asked for approximately a 20 percent increase, part of which reflects the increasing regulation, primarily driven by the regional haze regulations.

Senator BARRASSO. And I am sorry that Senator Boxer has left, Mr. Chairman, as she kind of ran over a while. I would like to use a little bit of additional time. I know I have a couple of minutes left, maybe if I can go another two or three beyond that?

Senator CARPER.

[Presiding] No way. The Chair will be generous but not foolish. I am supposed to be somewhere else right now, but just go ahead.

Senator BARRASSO. If you could just talk a little about the mercury rule, I think there were some things you were trying to get out and weren't able to. I would be happy to continue as Chairman if you need to leave in an expeditious manner.

Senator CARPER. I have got all day.

[Laughter.]

Senator BARRASSO. Please. There were some things you didn't get a chance to say.

Ms. WOOLLUMS. Certainly. We support moving forward with the mercury rule. That is not the primary piece of our objection and concern. It is, as a general proposition, fairly straightforward to control mercury. The issue is largely attributable to the hydrochloric gas and other non-mercury metals that are the basis of the rule that we have concerns about. As I referenced, our newest facility that already controls mercury, we have actual operating experience. And that operating experience also suggests that the stringency of the standard will be extremely challenged on a brand new facility with a full suite of controls.

Senator BARRASSO. The Chairman had mentioned the AFL–CIO and some of the apparent people that are available to work. But I understand that some unions have actually come out opposing a number of the regulations from the Environmental Protection Agency, saying if you shut down coal-fired coal plants, that a number of additional jobs, union and non-union, will be lost. I don't know that that applies specifically to your company, but I think you have a general overview of what is happening nationally. Could you comment on that, please?

Ms. WOOLLUMS. As a general proposition, any time that there is a loss in an industry such as ours, where you have highly skilled individuals, but they are not necessarily highly educated individuals, it is very difficult to retrain them to go into other types of industries. This is what they have done their entire lives. And as Dr. Brenner referenced, employed individuals tend to contribute greatly to society.

Senator BARRASSO. Dr. Brenner, yes, sir?

Mr. BRENNER. Forgive me, I think there is an essential point that somehow I wasn't able to make clearly. If we want to be very stringent with regulations, let us say we all agree that that is a great thing to do, even if we wish to do that, without the investment capital from industry, it cannot happen.

As the Chairman pointed out, with the best available technology. The point is, to have the best available technology or even moderately good technology, you need investment. If the GDP is harmed, if firms are harmed, they cannot make the investment. Therefore, the primary focus needs to be on sustaining the firms before they can take action that could actually support that kind of legislation.

Senator BARRASSO. Thank you, Mr. Chairman.

Senator CARPER. You are quite welcome.

To our witnesses, I just thank you so much for joining us today. Some of you have been with us before, and it is great to see you again. I am especially grateful to Ms. Bucic. Has anybody ever mispronounced your name? Has anybody ever pronounced it correctly?

Senator Whitehouse, why don't you go ahead and ask your questions.

Senator WHITEHOUSE. Thank you very much.

I am interested in the, I don't know, what you might call kind of the misallocation problem and where we go with that. There are two issues. One is that you have polluting industries, let's say, the power industries. And the cost of compliance is 100 percent on them. But the benefit is societal. It is in the health care system, it is in the education system, it is in other people's salaries and jobs. It is in, and it is hard to put the number together.

I could see the argument, let me go back to the AEP case that Rhode Island and other States filed many years ago. When that was resolved, my recollection is that AEP had to spend $4.6 billion to clean up its act. But that the societal savings, the benefit of that cleanup, was $30 billion, not just that year, but going forward.

So if I were a private investor, and somebody said, if you invest $4.6 billion in this project, it will pay you $30 billion a year, that is a no-brainer. And we have this battle because there is a dislocation between the utility that has to pay the $4.6 billion and the Country at large, or the State at large or the region at large that gets the benefit of the cleaner air.

I am wondering, and clearly if it was $4.6 billion in and $4.6 billion out, I think there would be a pretty good case to be made, why undertake the effort? It turns out into a net wash.

But let me ask Ms. Woollums first. Isn't there a point at which the societal benefit justifies the emitter having to spend money in order to protect, in order to be able to take advantage of that benefit? And I am wondering at what point you think it begins to make sense? Is it one to one, is it four to one, is it five to one? We have some information that on the Transport rule, it might be as much as 145 to 1, which is clearly a payback anybody in their right mind would leap at. At what point do you think it makes sense for the industry to be a little bit more cooperative about accepting that this is an important responsibility for the Country? Again, one to one, two to one, five to one, ten to one? Where do you think that falls?

Ms. WOOLLUMS. Senator, with all due respect, I am not an economist. And I don't know that I can approach the question from the perspective you have asked me to. My role frankly is very akin to Lisa Jackson's. My role is to follow the law. My role is to ensure compliance with the regulations. And whatever regulation is passed, my company will comply with.

Senator WHITEHOUSE. But clearly, there are two roles you have. You have a role to comply with the law, you also have a role to advocate as to what the law should be. You are here representing this company in that role, you are not here in your compliance role, you are here in your advocacy rule. It is a legitimate role, this is the United States of America, you get to do that. My point is, in

your advocacy role, is there a point where the payback becomes enough that the company, instead of sending people to challenge the rule says, you know what, that is sensible, we should do that, it is good for the community, it is good for the State it is good for the Country, the payback is huge, we get it. We collect our revenues through rates that are approved and we can ordinarily collect these costs any way. We will just go for it and not kick up a fuss.

Ms. WOOLLUMS. And I am probably not going to answer your question, but I don't view my role as being an advocate. I view my role as being an educator to tell you what the costs of compliance are going to be.

Senator WHITEHOUSE. And so you just, if it were 50 to 1, you would still be here educating us in favor of not going forward with these?

Ms. WOOLLUMS. I am not educating you in terms of not going forward with the regulations. I have not said that we should not move forward with the regulations.

Senator WHITEHOUSE. OK. So you are fine with going forward with the regulations?

Ms. WOOLLUMS. We will comply with whatever regulations Congress passes or EPA implements.

Senator WHITEHOUSE. Got you. The other issue is the cross-State misallocation, a State like Missouri, for instance, does 100 percent of its power with coal or pretty close to 100 percent of its power with coal, and we are downwind of a lot of it. If you look at some of the maps, you can actually see the power plants along the Ohio River Valley. And they point right at New England.

So if the wind is coming across them, it is picking up not the load of one power plant or two or three or four, but one after another. And many of them have built high stacks, whose purpose appears to be inject that effluent up high enough that it falls on my State instead of on theirs. And indeed if I am not mistaken, Senator Carper has made this point very passionately and eloquently earlier, if I am not mistaken, there are some States that are actually in attainment, even though they are emitters, because the dump it up into the atmosphere and it falls on my State, which like Delaware, is not an attainment State, could never be an attainment State because of the pollution that is raining down on us from other States. I don't have any political say in what those States do. My only hope is EPA.

So if EPA gets wounded in its ability to protect the Clean Air Act, I have a real problem on my hands, because there is nobody looking out for Rhode Island's interest in Missouri. That is my guess, anyway.

Anyway, I see my time is expired. I apologize.

Senator CARPER. It kind of makes you wonder if people aren't just picking on the little States. What do you think?

Senator WHITEHOUSE. Maybe older States.

Senator CARPER. Maybe that is better.

I want to ask, first of all, a question of Sarah Bucic. I just would say, we talked earlier, Senator Whitehouse and I have spoken many times here about the idea that other States get cheap energy, they don't cleanup their emissions. They get cheaper energy, they have reasonably clean air and we ended up with more expensive

energy and dirty air. We concluded a long time ago that Federal standards are the best way to ensure consistent air pollution reductions occur around our Country, whether they happen to be little States, old States, big States, young States.

Your thoughts about whether Federal standards are the best way to ensure consistent air pollution reductions, please?

Ms. BUCIC. I think Federal standards are integral, because of what you just stated. Small States can do all that they can and my county that I live in is in non-attainment for particulate matter 2.5 and ozone. And like you said earlier, we could close down all of the industry in our State, and it still wouldn't put us in attainment. That is the air we breathe.

We give our patients these directions as nurses, to do these specific things, these are your discharge instructions, do this. It is interesting that other industries don't have those kinds of prescriptions. As a hospital, if you threw all your syringes out, people would find that to be problematic. You were asking earlier about, Senator Whitehouse, about at what point does something become important to do. Well, that would be a good example. If I threw all my trash into my neighbor's yard, that would be bad.

So I think at some point, Federal regulations are the only thing that can protect States, all the States.

Senator CARPER. Thanks. A question, if I could, for Dr. Munzer. I would ask Dr. Paulson and Ms. Bucic to take a shot at this one as well.

As some of my colleagues know, I like to run. Last couple of weeks have been very special, because our oldest son is home. He is 22 years old, he is a tri-athlete. I get to run with him maybe once a week. He runs me into the ground. And it is a humbling experience, but we all need to be humbled.

I remember some times in Delaware running, especially in the summer, when I wondered whether I was doing more harm than good for my body because of the air quality. I know plenty of times, I was a naval flight officer for many years and got to serve all over the world. I can remember being in some places and running when I knew I was doing more harm than good.

In Delaware during the summer, we oftentimes have what we call Code Orange days, worrying about the high levels of ozone for a particular day. I would just ask the three of you if you could maybe take a minute or two to describe how high levels of ozone actually damage my lungs, my son's lungs, other people's lungs, if we take a long run on a Code Orange day. If I do this kind of thing often, I run a couple of days a week, but if we do this kind of thing often, could we permanently scar or damage our lungs? Do you want to start off, Dr. Munzer?

Dr. MUNZER. Thank you very much. Ozone is a very, very powerful irritant to the respiratory tract. It causes swelling, inflammation of the air passages. As they swell, it becomes more and more difficult to have air pass through the air passages, go through the air passages, making breathing much more labored.

In addition to that, ozone is also a cellular poison. So it interferes with the lung's ability to cleanse itself of bacteria and viruses, making us much more susceptible to respiratory infections.

Now, when a person runs, a healthy person, the amount of air that the move in and out of their lungs increases easily ten-fold, which means that they increase their exposure to air pollution ten-fold as well. So even for healthy individuals, it is not wise to be exercising outdoors when the air is polluted, like a Code Orange day.

Senator CARPER. Ms. Bucic.

Ms. BUCIC. Ozone is obviously something good that should be in the upper atmosphere. But when it is in the lower atmosphere, it is a very bad chemical. It reacts, we have these high ozone days. And if you have more than nine, you go into non-attainment. I believe in Delaware we are close to seven or eight already, Code Orange days. These are things that aren't supposed to be in the lower atmosphere. They are not supposed to be on the ground. So any kind of extended exposure to them is very bad for you.

Senator CARPER. Thanks.

Dr. Paulson, again, the question, can you just describe for us how high levels of ozone can actually damage our lungs if we are out there running long distances on one of these Code Orange days?

Dr. PAULSON. Yes, Senator Carper, thank you for the question.

I want to talk about two particular sets of research, one that comes out of Southern California that shows that children growing up in more polluted areas, include ozone particulate, $SO_x$ and $NO_x$, have smaller lungs when they are 18 or 20 than kids who grow up in less polluted areas. Not so much that they are symptomatic at that point in time. But I do really worry what happens to somebody at 20 if they have less lung reserve than somebody else when they get to be 60, 70 or 80. So that is one set of research that gives me concern.

Another set of researchers, if you look at varsity athletes, and I certainly was not a varsity athlete in high school, but if you look at people who are in three varsity sports, the fittest of the fit, I can't imagine one varsity sport, so I certainly can't imagine three, but the fittest of the fit, now, when do we send our high school athletes out to practice? Late in the afternoon. When is pollution worse? Late in the afternoon.

Those kids who are the fittest of the fit who practice outside have three times the risk of developing asthma compared to children who are in varsity sports that don't practice outside.

So we are harming, we are demonstrably harming our children by sending them outside to practice their athletics.

Senator CARPER. That was sobering. That was a sobering note to close this hearing on. I want to thank, again, we want to thank, on behalf of Senator Barrasso and myself, we want to thank each of you for coming today and for sharing your thoughts with us and responding to our questions.

I think there is a moral imperative at work here. About 24 hours from now, the Chaplain of the U.S. Senate will be holding forth in a Bible study group with a number of our colleagues. One of the things that, as Senator Barrasso know, one of the things that the Chaplain is always imploring us to do is use the Golden Rule. He calls it the Cliff Notes of the New Testament. And to treat other people the way we want to be treated.

I think that is good guidance for almost everything that we do in our lives, especially good for those of us who are in the business of creating energy or electricity, and in some cases, creating emissions and pollution because of that. Just to keep in mind that we have, I think, a moral obligation to do our best in a cost-effective way to reduce those emissions and reduce that chance of harm. There is a way that we can do it, and I think EPA is trying to do that with respect to the mercury rule. And I think we have heard that here today and in other places. We need to do it in a cost effective way that does not impede our economic recovery. There is a way to do it, and a not very smart way.

I hope that we continue to do it in a way that I think is well informed. Again, our thanks, Senator Barrasso and myself, our thanks to all of you. Colleagues have 2 weeks to submit their questions to you if they are not here. Please respond to those questions. Thank you so much.

With that, this hearing is adjourned.

[Whereupon, at 12:55 p.m., the committee was adjourned.]

STATEMENT OF HON. JEFF SESSIONS, U.S. SENATOR
FROM THE STATE OF ALABAMA

Administrator Jackson, thank you for coming before our committee today. Let me begin by saying that I am very concerned with the state of our economy. Look at the numbers:

9.1; percent of the workforce currently unemployed.

22,462,000; Number of workers currently unemployed and underemployed.

We need to find ways to get this economy going forward again. Yet, it seems to me that EPA is systematically going about regulating the American economy in a manner that is not justified.

Here are some more numbers:

30; Number of major new rules that EPA is developing or has finalized.

170; Number of major policy revisions that EPA is undertaking.

11; Number of greenhouse gas regulations promulgated by EPA in 2010.

I only have time to focus on one issue today.

Administrator Jackson, you are familiar with your agency's plans to change the standards for ground level ozone. This is really among the most concerning proposals to come out of your agency.

Listen to these numbers:

125 parts per billion; EPA's ozone standard in the 1970s.

85 ppb; the ozone standard in the 1990s.

75 ppb; the ozone standard adopted by EPA in 2008, just 3 years ago. EPA believed in 2008 that this standard was sufficient but not more stringent than necessary, to protect public health.

60 ppb; the ozone standard that EPA has proposed.

The congressional Research Service recently stated: ″At [60 parts per billion], 650 counties——virtually every county with a monitor——exceeding the proposed standard.″[1] That would be an increase from 85 countries today. Why is that significant? An ozone standard that results in ″non-attainment″ for that many areas will curtail economic growth around the country.

Let me give an example, In 2007, Thyssenkrupp Steel selected Calvert, Alabama as the home of their new state-of-the-art carbon steel processing facilities. At the time, it was one of the largest economic development projects of the entire country. Since 2007, ″TK Steel ' has hired approximately 2,000 workers; paid over $100 million in wages; created over 9,000 construction jobs; and generated millions in state and local tax revenue. Why do I mention this project?

That area of my state (without considering TK Steel) would very likely be considered non-attainment if EPA adopts the 60 ppb standard. When asked about this possibility, and official with the state air regulation department was quoted in the Mobile Press-Register newspaper as saying: ″It would be very difficult to locate another ThyssenKrupp plant in Mobile if [zone] non-attainment was determined. ″This

[1]http://www.crs.gov/Products/R/PDF/R41062.pdf

is not just Alabama problem. According to the Business Roundtable, the ″proposed new ozone regulations... would cost nearly $90 billion dollars per year by 2020... ″[2] Another economic analysis by the MAPI Manufacturers Alliance similarly concluded that the economic impact of the tighter ozone standards would be in the range of $1 trillion from 2020-2030.[3] Those are staggering figures.

I look forward to asking you a few questions about this issue.

Thank you.

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[2]http://businessroundtable.org/uploads/studies-reports/dowloads/2011—04—National—Ambient—Air—Quality—Standard—for—Ozone.pdf

[3]http://www.mapi.net/MediaCenter/news/Lists/Posts/Post.aspx?ID=189