BEFORE THE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ATLANTA, GEORGIA

In the Matter of	)	Centers for Disease Control and Prevention Division of Global Migration and Quarantine 1600 Clifton Road, NE, (E03) Atlanta, GA 30333 U.S.A.
CONTROL OF COMMUNICABLE DISEASES	)	
NOTICE OF PROPOSED RULEMAKING	)	42 CFR Parts 70and 71 RIN 0920-AA03

COMMENTS OF

THE ASSOCIATION OF ASIA PACIFIC AIRLINES

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The Association of Asia Pacific Airlines (AAPA) files these comments regarding the Notice of Proposed Rulemaking (NPRM) issued by the Department of Health and Human Services (HHS) to update 42 CFR parts 70 and 71 with the intent to clarify and strengthen existing procedures to enable the Centers for Disease Control and Prevention (CDC) to respond more effectively to current and potential communicable disease threats.

A. ASSOCIATION OF ASIA PACIFIC AIRLINES

AAPA is the trade association of seventeen major international airlines based in the Asia Pacific region. It was founded in 1966 to provide a forum for examining international air transport issues and for developing action plans on matters of mutual concern. Today, AAPA members are Air New Zealand, All Nippon Airways, Asiana Airlines, Cathay Pacific Airways, China Airlines, Dragonair, EVA Air, Garuda Indonesia, Japan Airlines, Korean Air, Malaysia Airlines, Philippine Airlines, Qantas Airways, Royal Brunei Airlines, Singapore Airlines, Thai Airways International and Vietnam Airlines.

AAPA is committed to promoting sustainable growth of the aviation industry serving both passenger and freight needs. Collectively, our members carry approximately 271 million passengers annually representing about one fifth of global passenger traffic measured in revenue passenger kilometers (RPK), as well as about one third of global air cargo traffic. Currently, thirteen AAPA members operate more than 500 weekly flights to the U.S.

B. INTRODUCTION

AAPA appreciates the opportunity to comment on the NPRM, and shall confine its comments to 42 CFR part 71 dealing with foreign arrivals. AAPA also fully supports the comments of the International Air Transport Association (IATA) on this NPRM and our submission is intended to complement that of IATA.

AAPA member airlines are recognised leaders in standards of service, with proven and established procedures for dealing with health issues. AAPA member airlines are committed to the wellbeing and safety of our passengers and employees. This is borne out by close cooperation with airports and the relevant national agencies to ensure that systems and procedures are in place according to the recommendations of local health authorities and the World Health Organisation (WHO) for current and potential health threats. Procedures are also in place to handle any incident of death or illness on board.

AAPA understands the CDC's need to be able to respond more effectively to health crises and is committed to collaborating with the CDC to improve its processes in an effective and practical manner.

Whilst AAPA is supportive of the need of governments to implement effective strategies to contain the spread of communicable diseases, we believe that such effectiveness relies on collaboration and standardisation at a global level.

C. GENERAL OBSERVATIONS

The AAPA notes that this NPRM focuses exclusively on air travel, even though there is no evidence that air travel is any more likely than other modes of transport, or indeed, other forms of social interaction, to increase infection levels from any particular disease.

Unless the CDC intends to collect the same additional contact data from passengers using trains, buses, automobiles, or from persons in cinemas, restaurants, shops, schools and various other public places, we fail to see how communicable diseases can be effectively controlled simply by targeting air travel.

Where international travel is concerned, the focus of the proposed 42 CFR part 71 is on inbound passenger travel and arrival screening. This approach is flawed, and in a sense discriminatory, as arguably the large numbers of outbound travellers from the U.S. are just as likely to be vectors of communicable diseases as inbound travellers to the US, yet, measures for departure screening for outbound international travel are glaringly omitted from this NPRM. For a more effective and coordinated global response to a global health crisis, we believe that it would be better to focus on discouraging or preventing ill persons from travelling, rather than focus exclusively on arrival screening. This was one of the key lessons from the successful containment of the SARS outbreak. We note further that 42 CFR part 70.4 proposes that the collection of passenger information be carried out at only 67 large and medium hubs "because this captures a majority (approximately 90%) of annual passenger boardings without burdening airlines that operate only in small hubs where passenger boardings are considerably lighter." AAPA submits that if the prevention of communicable diseases is the objective of the proposed changes, smaller carriers or flights/operations into smaller airports should not be excluded from the ambit of these changes, given the volume and ease of interstate travel within the USA.

We note that CDC is cognizant of the fact that airlines have spent considerable time and effort at considerable cost to transmit Advanced Passenger Information (API) to the Department of Homeland Security (DHS) under its API System (APIS). If CDC were to impose its varied data requirements relating to passenger information in the manner stated in the proposed rule, the operational and economic impact to carriers would be disruptive, and provide minimal additional benefits in return. Since the proposed data items would only be needed sporadically, such as during the 2003 outbreak of Severe Acute Respiratory Syndrome (SARS), the requirements would add an excessive cost burden to airlines.

Also of serious concern to AAPA member airlines is the imposition of a financial and/or criminal penalty on individuals for violations of any of the provisions as well as penalties of up to US$500,000 for a carrier.

Additionally, AAPA wishes to highlight potential privacy issues regarding the collection and storage of personal data, including but not limited to current European Union regulations on the subject (i.e. for flights arriving from EU states and/or flights with citizens of EU states). At least two AAPA member carriers operate flights from the EU to the US, while other members operate flights beyond other third countries to the U.S. This NPRM raises extra-territorial issues that should be addressed in order to ensure that international carriers operating to the US are not faced with conflicting regulations that would result in them contravening one set of laws to comply with those of another jurisdiction. Indeed, by working towards a more global approach to appropriate data collection through a multilateral international body such as the International Civil Aviation Organisation (ICAO), carriers can effectively operate in a global network at a time of crisis with a relative ease of compliance.

D. 42 CFR PART 71

Section 71.4 Bills of Health

(*Proposed §71.4 allows the CDC to require a carrier at any foreign airport clearing or departing for any U.S. airport to obtain a bill of health from a U.S. consular or medical officer designated for such purpose*)

AAPA requests that the requirements of the CDC be clearly set out, and the process of obtaining a bill of health including qualifying criteria and factors be taken into account in the process. Sufficient lead time would also be needed so that flights would not be delayed significantly.

Section 71.6 Report of Death or Illness on Board Flights

(Proposed §71.6a requires carriers to report, directly to the CDC Director or any approved authorized representative, any deaths or ill persons that occur on board flights as soon as such occurrences are made known to the pilot and, where possible, at least one hour before arrival)

The definition of 'ill person' under the proposed §71.1, as drafted, includes very generic criteria, e.g. high temperature, diarrhoea, respiratory distress. The prevalence of such symptoms amongst the general public on an everyday basis, and the fact that they could result from any number of relatively benign medical conditions or mild infections would result in a very high risk of false positives when using such criteria as a means of identifying suspected cases of a new infectious disease. On the other hand, it should be noted that certain symptoms may not be obvious to the crew unless these are brought to their attention by the passenger experiencing such symptoms, or by other passengers. A case in point would be where a passenger is running a temperature or has diarrhoea. Under common industry practice, where passengers have requested assistance, an airline crew would enlist the help of medical volunteers or ground-to-air telemedical services to help assess the situation and report it if necessary. Therefore, it would be very difficult for cabin crew to determine that a particular passenger may be suffering from a communicable disease and report it as required by the CDC, particularly in cases where symptoms are not made known to the crew or where no assistance is requested by the passenger.

AAPA does not view with any enthusiasm the prospect, not to say the likelihood, of planeloads of innocent people being subjected to quarantine procedures on arrival into the U.S., out of excessive and over-zealous caution on the part of those concerned. Indeed, experience with SARS provided several illustrations of such well-intentioned but ill-conceived and unnecessarily disruptive actions.

In addition, we are concerned that the requirement for crew to make assessments as to the state of health of a passenger in the revised rule may confer upon them responsibilities and duties analogous to those of qualified medical professionals, for which they are not trained in their capacity as cabin crew. An international approach for such standards by ICAO should be implemented to avoid multiple regulations from foreign governments in the event of a global health crisis.

Although it is noted that CDC does not "intend to mandate a particular pathway of communication as long as a report is made…" AAPA submits that some general guidelines related to the manner of communication would help avoid confusion in the event such a report has to be made.

Sections 71.7 and 71.11 Written plans

AAPA seeks clarification and guidance from CDC on the requirements for conducting drills and exercises under the respective proposed written plans for reporting deaths or illness on board flights and for passenger information. Unless adequate guidance is provided by the CDC on the nature of the "policies and procedures necessary to facilitate communication between the Director and the airline agent on a 24-hour basis, 7 days a week", including the extent to which this would depart from current practice for crew of notifying authorities of death or illness on board a flight, it would be difficult for us to comment on the adequacy of the proposed 90-day limit for the submission of such plans.

Section 71.10 Passenger Information

(Proposed §71.10 requires carriers to collect the following information from each passenger and crew member: Full name; emergency contact information; e-mail address; current home address; passport number/travel document number and issuing country; name of travelling companions or group; flight information; returning flight information; and at least one current telephone number. Carriers would be required to retain this information for 60 days and transmit it to CDC within 12 hours from CDC's request. Carriers also need to inform passengers as to the purpose of the information collection at the time the passengers arranged their travel)

As the CDC is aware, AAPA member airlines operating flights to the U.S. are already transmitting Advance Passenger Information to the DHS as standard operating procedure. Passenger information requested by the NPRM for the CDC such as emergency contact information, email address and current home address, are not collected today, as they are not within the ambit of the API requirements. Furthermore, most airline systems do not have the capability to store such a large amount of data for the proposed extended 60-day period of time. All airlines' data collection systems would have to be enhanced, at significant financial cost, to capture the data fields required by CDC. Given that there is no way to verify the accuracy of the information provided by the passenger at the time of reservations or check-in, the benefits to be gained from such large-scale and costly data systems modification is questionable.

AAPA is concerned that the collection of the additional data will further burden operational processes and result in a domino effect throughout the whole network. The prolonged transaction time at reservations/ticketing will affect airlines' service quality standards and procedures by adding another layer of confusion; time needed to check-in passengers would increase, leading to greater inconvenience for passengers. We do not think that the CDC's estimate of one minute for a passenger to provide the additional information requested is realistic. Often, language difficulties, terminal noise levels, pre-departure stress, non-familiarity with new or existing procedures at the check-in counter, and the need for ground check-in staff to explain the same to passengers, will cumulatively add more than one minute to each passenger's check-in experience. Furthermore, the cumulative impact on queuing passengers and hence average waiting times for check-in are likely to be substantial, with implications for airport processing capacity. As such, airlines expect an increase in the number of passenger complaints caused by inconvenience and the reluctance/resistance of some to provide the personal information.

On the collection of the required information from crew members, CDC should note that such information may not be readily available in the format required by the CDC, and that some carriers maintain a separate system for crew data. Additional costs involved in modifying and maintaining separate systems for crew have not been reflected in CDC's cost estimates.

Under "Archiving and other Administrative Costs" on Page 71917 CDC expects to routinely request passenger information 10 to 12 times per month. AAPA seeks clarification if this figure is applicable on an individual carrier basis, and if this information will be required regardless of the alert level relating to any specific communicable disease threat.

Comments on relative merits of the analyzed alternative options presented in section VI, section. E (page 71914), as well as on regulatory options that may fall outside the scope of the options analyzed, including but not limited to the scope of the passenger information collected

Given that the underlying premise of the CDC's need to capture additional passenger information is to ensure that during a health crisis, passengers can be contacted after their journey as expeditiously as possible, this NPRM should seek to obtain from passengers any ***one*** type of emergency contact information, be it a mobile telephone number, a fixed line

number or an e-mail address, rather than all of the fields proposed. Subject to further cost/benefit analysis, this could help alleviate the very significant time and cost implications of additional data capture requirements as proposed in the NPRM.

Comments on the most efficient means of collecting accurate passenger contact information

Rather than establishing a separate data collection process and channel, AAPA believes CDC should instead consider establishing a communication / data link with DHS to share APIS data and any additional data elements required subject to the necessary cost-benefit justification.

At times when there is a specific public health threat, CDC may also wish to consider adopting the use of standardised Passenger Locator Cards, which were developed jointly by airlines/airports/health authorities, and proposed by IATA to the ICAO States for their consideration and adoption. This would be preferable to imposing unilateral and onerous requirements on both passengers and airlines. These landing cards would be the most effective way of collecting the information required by the CDC, and would ensure that the information is collected in a uniform format, from all carriers. U.S. Customs and Border Protection (CBP) officers could collect additional CDC data required of international arrivals during their interaction at the airport. Standardised landing cards would also ensure that AAPA member air carriers are adhering to the many foreign government guidelines within their global networks.

Government agencies such as the CDC are responsible for public health and social affairs, hence, the operational and financial burden of collecting additional passenger data to fulfil CDC's objectives should not be placed solely on the airlines.

Comments on the economic analysis, including the estimated costs, based on the assumption that data collection efforts could be coordinated with contemporary rulemaking efforts by other Federal agencies

In general, AAPA submits that the cost estimates provided in the NPRM were too conservative for the following reasons:

The NPRM discussed and costed two scenarios for data collection: Point of Sale (POS) and Point of Departure (POD). The NPRM however inferred that carriers would only need to implement one, rather than both, of these scenarios. The reality is that if CDC mandates the collection of these data, carriers would need to implement both POS and POD collection. This hybrid scenario was not considered in the costs provided in the proposed rule. As mentioned, the collection of data at POS would not be a comprehensive solution as passengers frequently do not have all details until the time of travel, and even then, such details can be subject to change. Airlines could endeavour to collect all the required passenger data at POS, but they would also need to implement a POD solution as travel agents or GDSs are not required under the proposed legislation to collect the information on their behalf of carriers. The reluctance of travel agents and GDS to share such client contact information with airlines, for reasons of commercial confidentiality, has also not been taken into account in the NPRM.

Although CDC attributed a number of costs to the Global Distribution Systems (GDSs), in reality, since the proposed rule does not directly require GDSs to provide these data to CDC, GDSs are not obliged to make system changes to accommodate the additional data requirements. However, even if system changes are made, such costs will almost certainly be passed back to airlines. Therefore, these costs are effectively costs to airlines and not GDSs as wrongly assumed by CDC.

The figures provided by CDC regarding processing time at POD are also too conservative. Under APIS, collection of ‘address in the U.S.’ takes an additional 45 seconds. Carriers also expect to spend 45 seconds to collect ‘home address’, 45 seconds to collect ‘emergency contact address’ plus an additional 45 seconds for all the additional data. This, however, only refers to the additional processing time for each passenger. Time will also be needed for interaction with passengers for explanation of data collection, clarification to ascertain accuracy of data, and time taken by the passenger to provide the information. Such extra time has not been taken into account by CDC.

Further, CDC considered the impact on carriers by comparing the cost of compliance against carrier revenue. Again, this is simplistic and does not give a realistic account of the impact on airlines. A more realistic account would be for carrier costs to be compared against carrier profits, if any.

Finally, no costs were assessed or included for implementing system changes to provide crew data. CDC assumed that a single system would be used to collect and provide crew and passenger data. For some carriers, crew information is stored in a separate system requiring a different solution and a separate change implementation resulting in additional costs.

One AAPA member estimates that to maintain its current service standards at reservations or check-in given the new data collection requirements, additional annual manpower costs of over US$200,000 would be incurred, at a minimum. This figure excludes the cost of infrastructure enhancements such as additional check-in counters, larger telephone capacity or system enhancements, which would necessitate additional expense beyond the abovementioned figure.

In any given State, public health is a national issue and therefore any costs associated with enhancing CDC's ability to effectively counter the threat of introduction, transmission, and spread of infectious disease via travel should be borne by the Government. AAPA objects to placing the financial burden solely on the carriers, when the responsibility is more appropriately borne by the State's public health programmes.

Section 71.31 Penalties

(Violation by an individual is punishable by a fine of up to US$250,000 or one year in jail, or both. Organizations may be fined up to US$500,000 per violation.)

AAPA seeks clarification of the term "individual" as used in the NPRM, as it is unclear whether it refers to a passenger or an airline employee. AAPA strongly objects to the imposition of such stiff penalties. We believe that any measures aimed at ensuring compliance should be administrative, not criminal, in nature.

E. CONCLUSION

This NPRM raises many issues of concern to the AAPA. Fundamentally, it focuses exclusively on air travel, which, as mentioned earlier, is no more likely than other modes of transport or other forms of social interaction to increase the infection risks of a communicable disease.

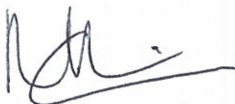
Secondly, the focus of the proposed 42 CFR part 71 exclusively on inbound passenger travel and arrival screening, while ignoring departure screening, is both discriminatory and contrary to expert thinking with respect to the best methods of international cooperation in minimising the spread and impact of communicable diseases. Experience with SARS has demonstrated the greater effectiveness of carrying out outbound screening on departure. We believe that global health crises need to be met with coordinated responses amongst governments, including a globally harmonised approach on screening procedures.

On a more specific level, the additional data requested by the CDC, the manner in which this is to be collected and communicated, and the conservative and often inaccurate cost estimates, all suggest a lack of understanding of airline processes and practices.

AAPA strongly objects to carriers shouldering the financial responsibility of what is essentially a State public health programme. We also oppose the proposed imposition of criminal penalties as draconian and unnecessary.

We reiterate that in order to implement effective strategies to contain the spread of communicable diseases, collaboration and standardisation is needed on a global level. The CDC ought to, in the first instance, consult and work with international organisations such as the World Health Organisation (WHO) and ICAO, which has adopted a Resolution A35-12 in 2004 on the protection of the health of passengers and crews and prevention of the spread of communicable disease through international travel, and the airline industry to minimize the burden on international travel. AAPA, therefore, urges the CDC to carefully reconsider the merits of this proposed rule before taking any further action.

Respectfully submitted by



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