I

110TH CONGRESS
1ST SESSION

H. R. 789

To amend the Public Health Service Act to establish an Office of Men's Health, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 31, 2007

Mr. TOWNS (for himself, Mrs. CHRISTENSEN, Mr. CONYERS, and Ms. LEE) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To amend the Public Health Service Act to establish an Office of Men's Health, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Office of Men's Health Act of 2007''.

SEC. 2. FINDINGS.

The Congress finds as follows:

(1) INTRODUCTION.—Men's health in the United States is in a state of crisis revealing a breadth of health inequities that warrant national

attention. This crisis has led to the need for an Office of Men's Health within the Department of Health and Human Services that coordinates the development of effective strategies and interventions designed to improve the health determinants as well as reduce and eliminate the widespread chronic diseases and health conditions that negatively affect the health of American men.

(A) According to Healthy People 2010, social determinants of health include education, housing, labor, justice, transportation, agriculture, and the environment.

(B) Improving the social determinants that affect men's health could substantially improve their health and well-being, as well as the health and well-being of their families and communities over time.

(2) WOMEN'S HEALTH.—While the men's health crisis concerns most if not all men, it also jeopardizes the lives of individuals in their families and social networks, particularly women. Women bear the direct and indirect caregiving burden for the family when male counterparts are unavailable due to declining health or premature death. Consequently, women's overall well-being and health are

threatened by conditions that compromise the health and shorten the lives of their male loved ones.

(3) GENDER-RELATED HEALTH INEQUITIES.—Significant gender disparities exist in health that should be addressed to improve the overall health profile of the Nation. While the average life expectancy for the general population is 77.9 years of age, women on average live six years longer than men. In some cases, the life expectancy for men is 20 years less than women, especially within communities of color.

(A) Overall, men have higher death rates for the top 10 leading causes of death than women, including heart disease, cancer, chronic lower respiratory disease, unintentional injuries, suicide, chronic liver disease, homicide, and HIV/AIDS.

(B) In addition, men have a cardiovascular disease death rate 1.5 times higher than women, a lung cancer mortality rate 1.8 times higher than women, and an HIV/AIDS death rate that is roughly 3 times higher than women.

(C) Studies confirm that men are more likely than women to have less healthy lifestyles, less likely to seek and obtain needed

medical attention, more likely to engage in risky behaviors, and less likely to recognize the value of and adhere to preventive health care practices than women.

(D) Men are at least 25 percent less likely than women to visit a doctor, and are significantly less likely to have regular physician checkups and obtain preventive screening tests for serious acute and chronic diseases.

(4) RACIAL AND ETHNIC HEALTH INEQUALITIES.—Racial and ethnic inequalities exist in men's health with grave consequences for our most vulnerable populations.

(A) African American men have the highest incidence and mortality rates of many forms of cancer, have the highest levels of high blood pressure in the world, and are twice as likely as White men to have diabetes, thus detrimentally affecting their health status and dramatically reducing their life expectancy.

(B) The life expectancy for African American men is not only the lowest among all men, but is lower than that for African American women. Black urban men have the shortest life

expectancy (66.7 years of age), followed by Southern rural Black men, at 67.7 years of age.

(C) African American men are more likely to suffer serious side effects from chronic diseases and have higher mortality rates from heart disease and obesity than any other racial or ethnic group.

(D) African American men generally access medical facilities in later disease stages, thus reducing their chances for adequate treatment and recovery and increasing the cost of care. This affects mortality rates in a wide range of chronic diseases, including testicular disease and end-stage renal disease related to diabetes.

(E) American Indian and African American men, 15 to 29 years of age, have higher overall death rates than Hispanic, White, and Asian American men of the same age group.

(F) Since 2001, the only men of color for whom HIV disease is a major cause of death are African Americans (fourth ranked) and Latinos (tenth ranked).

(G) Diabetes mellitus is the fifth ranked cause of death for American Indian and Alaska Native men, the sixth ranked cause among

Latino men and White men, and the seventh ranked cause among Asian and Pacific Islander men and African American men.

(5) ORAL HEALTH.—Oral diseases are prevalent among men of color, particularly African Americans. Men suffer disproportionately from oral diseases, many of which can be treated and prevented with appropriate diagnosis and care.

(A) More than 50 percent of African American men have untreated dental decay compared to only 28 percent of White men.

(B) African American men have the highest incidence of oral cancer and the lowest survival rates of any group.

(6) MENTAL HEALTH.—Mental health is often ignored in discussions and intervention strategies related to men's health. However, mental health is an indispensable component of personal health and well-being. Mental health defines and affects interpersonal relationships, the ability to adapt and cope with adversity, and an individual's relationship to his family, community, and society. The mental health status of men is a growing concern for this country and can have significant health consequences. From 1980–1995, the suicide rate among African Amer-

ican males ages 10 to 14 increased 233 percent, compared to 120 percent of comparable non-Hispanic White men. Additionally, research indicates that suicide death rates are more than four times higher among men than women.

(7) NATIONAL IMPACT.—Nationally, the men's health crisis has a profound and often detrimental impact not only on the health, well-being, and productivity of men, but also on the strength and viability of the communities in which they live, work, and do business.

(A) This health crisis has had a negative impact on the national economy. As a consequence, substantial additional burdens have been placed upon a significant portion of our Nation's labor force.

(B) The current men's health crisis is a major concern for the private sector, labor unions, health providers, and government—from local governments to the Federal Government. Both the private sector and the public sector experience substantial additional costs related to absorbing the burden of health disparities related to men. These disparities are exacerbated even further in terms of men who

are unable to afford or gain access to reliable and appropriate care in their communities and men of color who bear a dual burden related to ethnicity and gender.

(C) The inequities in men's health are a core concern for employers, particularly those offering health benefits to employees and their dependants.

(i) Men's health issues challenge employers' efforts to contain the direct and indirect costs associated with providing health care insurance for employees.

(ii) Disparities in men's health, particularly in communities of color, leave men in the workforce in poorer health and at greater risk for the most costly chronic and acute conditions. These communities are especially at risk for increased rates of absenteeism and lower rates of productivity for health-only reasons.

(8) HEALTH INSURANCE.—Access to medical care in this country is largely predicated upon having health insurance coverage. Dramatically higher rates of uninsured men of color have had major consequences for the health of our Nation, our States,

and our communities. This lack of health insurance creates barriers to access to appropriate health care services and treatments and may have a profound impact on the health status and health outcomes of men, their families, and their communities. Health insurance is a primary source of health care for both prevention services and treatment of illnesses. Overall, racial and ethnic minority men are disproportionately more likely than White men to be uninsured, as well as to suffer from chronic and acute conditions, and die prematurely from often preventable conditions during their most productive life years.

(A) More than half (56 percent) of all Hispanic men, about 45 percent of all American Indian and Alaska Native men, 47 percent of all Native Hawaiian and Pacific Islander men, and 38 percent of all African American men, 18 to 29 years of age, were uninsured in 2004, compared to 26 percent of all White men in the same age group.

(B) In 2004, the percentage of all uninsured men of color, 30 to 44 years of age, was higher than that of white men of the same age group. The percentage of uninsured Hispanic

men, ages 30 to 44 was more than two and a half times higher than that of White men in the same age group. American Indian and Alaska Native men of the same age group had uninsured rates that were two times higher than White men.

(9) HEALTH LITERACY AND EDUCATION.—Providing a culturally competent and ethnically diverse health care workforce is likely to improve quality of health care and health outcomes for men. Additionally, finding ways to better educate men, their families, and health care providers about the importance of early detection of male health problems can result in reducing rates of mortality for male-specific diseases, as well as improve the health of America's men and its overall economic well-being.

(A) A majority of men of color, most notably those with lower levels of education, have difficulty understanding medical information. Men of color have reported limited medical literacy. More than half of African American (54 percent), Hispanic (59 percent), and Asian (63 percent) men reported that they did not find information from their doctor's office easy to understand. Others reported a similar difficulty

understanding the information written on prescription bottles.

(B) Asian, Pacific Islander, and Latino men, the men for whom English is more likely to be a second language, most frequently reported dissatisfaction with the quality of care received from health care providers.

(10) PRISON HEALTH.—The rates for incarcerated men of color are generally much higher than for White men. Men of color also enter the prison population suffering from a wider range of primary and chronic diseases. Men of color, who are ex-offenders, also return to low-income communities with the fewest health resources. The unmet health needs of these men threaten scarce public resources by placing additional burdens on the health infrastructure of a wide range of urban and rural communities.

(A) In 2005, the percentage of African American and Hispanic men who were incarcerated was significantly higher than the incarceration rate for White men.

(i) Many of these inmates suffer with HIV/AIDS, hepatitis, and tuberculosis and

various chronic diseases such as diabetes, hypertension, and asthma.

(ii) Even more male inmates suffer from undiagnosed or untreated mental illness.

(B) These disproportionate rates of chronic disease and conditions have a tremendous affect on many low-income communities, both urban and rural.

SEC. 3. ESTABLISHMENT OF OFFICE OF MEN'S HEALTH.

Title XVII of the Public Health Service Act (42 U.S.C. 300 et seq.) is amended by adding at the end the following section:

"SEC. 1711. ESTABLISHMENT OF THE OFFICE OF MEN'S HEALTH.

''(a) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish within the Department of Health and Human Services an office to be known as the Office of Men's Health, which shall be headed by a director appointed by the Secretary.

''(b) PERSONNEL.—The Secretary, acting through the Director of the Office of Men's Health, shall recruit and hire qualified personnel for the Office, including members of racial and ethnic minority populations with relevant expertise in men's health issues.

''(c) COORDINATION WITH FEDERAL HEALTH AGENCIES.—The Secretary, acting through the Director of the Office of Men's Health, shall collaborate with all relevant agencies and offices of the Federal Government, including the Institute of Medicine, the National Center for Health Statistics, and the National Center on Minority Health and Health Disparities at the National Institutes of Health, the Office of Minority Health, the Substance Abuse and Mental Health Services Administration, the Indian Health Service, the Agency for Healthcare Research and Quality, and others to identify and report on men's health data, including health disparities for chronic diseases and health conditions related to men of color.

''(d) DEFINITION.—In this section, the term 'racial and ethnic minority populations' means American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, and Native Hawaiian or other Pacific Islander populations.''.

SEC. 4. GRANTS.

(a) AUTHORIZATION.—The Secretary of Health and Human Services shall make grants to institutions of higher education for the purpose of—

(1) conducting conferences on men's health;

(2) conducting public education campaigns to reduce health disparities relating to men's health;

(3) evaluating the effectiveness of government and public sector resources that focus on men's health; and

(4) reporting on the gaps and problems that men of color have in utilizing health resources in a city or county.

(b) PRIORITY.—In evaluating grant proposals under this section, the Secretary of Health and Human Services shall give priority to proposals from Historically Black Colleges or Universities (HBCU) and proposals from historically Hispanic, Native American, or other ethnic colleges and universities.

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $50,000,000 for fiscal year 2008 and each subsequent fiscal year.

SEC. 5. REPORTING.

(a) IOM STUDY ON MEN'S HEALTH.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall enter into an agreement with the Institute of Medicine of the National Academy of Sciences—

(A) to conduct a comprehensive study on men's health; and

(B) to submit to the Congress a report on the results of such study, to be entitled ''Report to the Nation on Men's Health''.

(2) CONTENTS.—The study conducted under this subsection shall be a fair and impartial review of the state of men's health in the United States (including the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia, the Republic of Palau, and any other territory or possession of the United States) and shall—

(A) include information on racial and ethnic minority men and a focus on African American, Hispanic, Native American, and Asian and Pacific Island men and their health disparities;

(B) describe the activities and accomplishments of the Office of Men's Health;

(C) include statistics and information that indicate men's health in standard and customary health categories with commonly used health indices;

(D) provide, in addition to commonly used health indices, the status of social determinants of men's health;

(E) include all relevant qualitative materials that indicate the state of men's health, including statistical studies, qualitative evaluations, findings, and program evaluations of current programs and initiatives of the Department of Health and Human Services;

(F) draw from both primary and secondary research resources from local, State, and Federal agencies; and

(G) include updated information relative to the Institute of Medicine's study entitled ''Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare''.

(3) PANEL OF INDEPENDENT EXPERTS.—

(A) ESTABLISHMENT.—The agreement under paragraph (1) shall provide for the establishment of a panel of independent experts (in this paragraph referred to as the ''panel'') to assist in the conduct of the study under this subsection by reviewing and providing guidance on appropriate outcomes and assessments for

men's health and health disparities of men of color.

(B) COMPOSITION.—The agreement under paragraph (1) shall provide for appropriate representation on the panel from the racial and ethnic groups covered by the study under this subsection.

(b) ANNUAL REPORTING.—Subsequent to the submission of the report required by subsection (a)(1)(B), the Secretary of Health and Human Services, acting through the National Institutes of Health and the Director of the Office of Men's Health, shall submit an annual report to the Congress that—

(1) includes the same extent of information on men's health as is included in the Secretary's annual reporting to the Congress on women's health; and

(2) uses analytical tools similar to those used in such reporting on women's health.

(c) NATIONAL HEALTHCARE DISPARITIES REPORT.—In each report submitted under section 903(a)(6) of the Public Health Service Act (42 U.S.C. 299a–1(a)(6)), the Director of the Agency for Healthcare Research and Quality shall include analysis of available data on racial, ethnic, and geographic disparities in men's health, including rates for uninsured populations, heart

disease, cancer, chronic lower respiratory disease, unintentional injuries, mental health and suicide, oral and dental health, chronic liver disease, and HIV/AIDS.

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