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Jackson (IL)
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Jenkins
John
Johnson (CT)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
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Kilpatrick
Kind (WI)
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Millender-McDonald
Miller (FL)
Miller, Gary
Miller, George
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Toomey
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Traficant
Turner
Udall (CO)
Udall (NM)
Upton
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Visclosky
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Wamp
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Watts (OK)
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Weiner
Weldon (FL)
Weldon (PA)
Weller
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Weygand
Whitfield
Wicker
Wilson
Wise
Wolf
Woolsey
Wynn
Young (AK)
Young (FL)

NAYS—2

Nadler
Sabo

ANSWERED ''PRESENT''—6

Blumenauer
Capuano
Frank (MA)
Houghton
Schakowsky
Watt (NC)

NOT VOTING—8

Gutierrez
Hoyer
Obey
Riley
Scarborough
Tancredo
Thomas
Wu

□ 1442

Mr. BLUMENAUR and Mr. HOUGHTON changed their vote from ''yea'' to ''present.''

So (two-thirds having voted in favor thereof) the rules were suspended and the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. THOMAS. Mr. Speaker, on rollcall Nos. 455 and 456, I was emavoidably detained. Had I been present, I would have voted ''Yea''

MESSAGE FROM THE PRESIDENT

A message in writing from the President of the United States was communicated to the House by Mr. Sherman Williams, one of his secretaries.

HEALTH RESEARCH AND QUALITY ACT OF 1999

Mr. GOSS. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 299 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 299

Resolved, That at any time after the adoption of this resolution the Speaker may, pursuant to clause 2(b) of rule XVIII, declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of the bill (H.R. 2506) to amend title IX of the Public Health Service Act to revise and extend the Agency for Health Care Policy and Research. The first reading of the bill shall be dispensed with. General debate shall be confined to the bill and shall not exceed one hour equally divided and controlled by the chairman and ranking minority member of the Committee on Commerce. After general debate the bill shall be considered for amendment under the five-minute rule. It shall be in order to consider as an original bill for the purpose of amendment under the five-minute rule the amendment in the nature of a substitute recommended by the Committee on Commerce now printed in the bill. Each section of the committee amendment in the nature of a substitute shall be considered as read. No amendment to the committee amendment in the nature of a substitute shall be in order except those printed in the portion of the Congressional Record designated for that purpose in clause 8 of rule XVIII and except pro forma amendments for the purpose of debate. Each amendment so printed may be offered only by the Member who caused it to be printed or his designee and shall be considered as read. The Chairman of the Committee of the Whole may: (1) postpone until a time during further consideration in the Committee of the Whole a request for a recorded vote on any amendment; and (2) reduce to five minutes the minimum time for electronic voting on any postponed question that follows another electronic vote without intervening business, provided that the minimum time for electronic voting on the first in any series of questions shall be 15 minutes. At the conclusion of consideration of the bill for amendment the Committee shall rise and report the bill to the House with such amendments as may have been adopted. Any Member may demand a separate vote in the House on any amendment adopted in the Committee of the Whole to the bill or to the committee amendment in the nature of a substitute. The previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions.

□ 1445

The SPEAKER pro tempore (Mr. PEASE). The gentleman from Florida (Mr. GOSS) is recognized for 1 hour.

Mr. GOSS. Mr. Speaker, for purposes of debate only, I yield the customary 30 minutes to the distinguished gentlewoman from Rochester, NY (Ms. SLAUGHTER) pending which I yield myself such time as I may consume. During consideration of this resolution, Mr. Speaker, all time yielded is for the purpose of debate only.

Mr. Speaker, this is a fair and appropriate rule for this particular legislation. In fact, had it not been for the amount of money H.R. 2506 authorizes, doubling the current authorization level to $900 million, the bill would have been considered under the suspension process. The bill was voted out of the Committee on Commerce by a voice vote and the Committee on Rules reported a modified open rule to ensure that no extraneous amendments to the Public Health Service Act would be considered. The rule allows any Member who has preprinted an amendment in the CONGRESSIONAL RECORD to offer that amendment. This will ensure a full and open, yet targeted debate on the merits of this particular agency covered by this legislation.

When the Agency for Health Care Policy and Research, AHCPR as it is known in its acronym, was created in 1989, the health care universe looked far different than it does today. Traditional fee for service plans still dominated the market and managed care was still very much in its infancy period. Utilization review, peer review, these were largely unknown concepts, at least fully tried or tested. H.R. 2506 modernizes the agency to reflect these and other changes and provides resources to enable more effective collection of data.

Many Americans sitting at home watching may be wondering why we need yet another Federal agency involved in health care quality. Well, health care quality is a critical issue these days. As someone who has always believed that Congress too often stands in the way of true health care quality, I share concern with the people at home who are worried about this. To the extent that this ''reformed'' agency can promote better research and encourage successful partnerships between the public and private sectors with limited Federal red tape, it can be a worthy investment. And, of course, that is the goal. But we must retain vigorous oversight and maintain high expectations to ensure that these precious taxpayer dollars are indeed put

to good use. Again, we think that is the reason for this legislation and we congratulate its authors for this effort.

As I stated before, this is an eminently fair rule that should engender no controversy as far as I know.

Mr. Speaker, I reserve the balance of my time.

Ms. SLAUGHTER. Mr. Speaker, I thank my distinguished colleague from Florida for yielding me the 30 minutes, and I yield myself such time as I may consume.

(Ms. SLAUGHTER asked and was given permission to revise and extend her remarks.)

Ms. SLAUGHTER. Mr. Speaker, this is an ''almost open'' rule, for the majority has again relied on a preprinting requirement for amendments which may affect some Members of the House. But I rise in support of the rule and in support of H.R. 2506, the Health Research and Quality Act of 1999. The bill is being brought to the floor by the gentleman from Florida (Mr. BILIRAKIS) for the majority and the gentleman from Ohio (Mr. BROWN) for the minority.

This bipartisan legislation reauthorizes the Agency for Health Care Policy and Research and renames the agency as the Agency for Health Research and Quality, AHRQ, pronounced ''arc.'' This agency promotes health care quality through research, synthesizing and consolidating medical information, and disseminating scientific evidence. Building on its current initiatives, the agency will play a key role in partnering with the private sector to improve the quality of health care in the United States.

As a longtime supporter of health care research, I believe this piece of legislation will benefit patients, caregivers and insurance providers with vital information and statistics on how to improve the Nation's health care system. The agency's research and information consolidation will play a key role in extending quality care and improving health service delivery throughout the country. This agency provides vital information and resources that foster improvement in health care systems from America's smallest rural townships to its most populous inner cities.

The agency's mission includes fostering the extension of quality health care systems to those Americans left behind as our Nation continues its economic growth. The agency's work is especially important as health care delivery in our country evolves. When the AHCPR was established a little over 10 years ago, the health care system was vastly different from what we know today. More people now receive their care through managed plans and HMOs. The growing complexity of health plans bewilderers many patients and contributes to the growing tensions between patients and insurers.

This legislation directs AHRQ to address the public's growing concern for the quality of patient care and the number of medical errors that continue to grow each day. Their research helps hospitals and clinics around the country to reduce the injuries arising from mismanagement of cases.

A recent study examined the records of more than 30,000 hospital patients in my home State of New York. The study found that nearly 4 percent of patients suffered serious injuries that were related to the management of their illnesses rather than the illnesses themselves. This is a vital area of research for the agency and another reason why the reauthorization of funding for this agency and the redirection of its mission is important.

The legislation does more than merely change the name of the agency. It directs the agency to develop new public-private partnerships in the health care arena. This will bring new perspectives to improving the dissemination of health information and the development of health care systems that better serve our neighborhoods, towns and cities. These partnerships will also leverage greater private investment and commitment to creating improved health care service systems throughout the Nation. In the process, AHRQ will also support increased efficiency and quality of Federal program management.

According to testimony provided to the committee during a recent hearing, nine out of 10 people surveyed supported health research as well as the amount of Federal money spent on our Nation's health care. Mr. Speaker, this agency costs just one one-hundredth of one percent of the total funds spent by the government on health care and is a sound investment in our Nation's future health.

I support this initiative even though it is only a modest step toward guaranteeing that all our citizens have access to the finest medical care in the world. Citizens across the United States are crying out for more. We need comprehensive health care reform that includes a provision to ban genetic discrimination in insurance. We need a true Patients' Bill of Rights.

Mr. Speaker, I yield back the balance of my time.

Mr. GOSS. Mr. Speaker, I yield back the balance of my time, and I prove the previous question on the resolution.

The previous question was ordered.

The resolution was agreed to.

A motion to reconsider was laid on the table.

The SPEAKER pro tempore (Mr. KNOLLENBERG). Pursuant to House Resolution 299 and rule XVIII, the Chair declares the House in the Committee of the Whole House on the State of the Union for the consideration of the bill, H.R. 2506.

□ 1454

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 2506) to amend title IX of the Public Health Service Act to revise and extend the Agency for Health Care Policy and Research, with Mr. PEASE in the chair.

The Clerk read the title of the bill.

The CHAIRMAN. Pursuant to the rule, the bill is considered as having been read the first time.

Under the rule, the gentleman from Florida (Mr. BILIRAKIS) and the gentleman from Ohio (Mr. BROWN) each will control 30 minutes.

The Chair recognizes the gentleman from Florida (Mr. BILIRAKIS).

Mr. BILIRAKIS. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I am pleased to bring H.R. 2506, the Health Research and Quality Act of 1999, to the floor today. This widely supported bipartisan bill was approved by voice vote in the Committee on Commerce and the Subcommittee on Health and Environment. In April, experts from both the public and private sector testified about the critical function of this agency at a hearing before the subcommittee.

I introduced this measure jointly with the gentleman from Ohio (Mr. BROWN), the ranking member of the House Commerce Subcommittee on Health and Environment, to reauthorize the Agency for Health Care Policy and Research and redefine its mission. Our bill renames it as the Agency for Health Research and Quality, or, one of those famous Washington acronyms, AHRQ.

The purpose of this new name, and the reauthorization, is to foster comprehensive improvements in our health care system. Our bill refocuses the efforts of this critical agency to support private sector initiatives. Building on its current activities, the new agency will become a key partner to the private sector in improving the quality of health care in America.

The bill specifically prohibits the agency from mandating national standards of clinical practice or quality health care standards. Instead, it emphasizes the agency's nonregulatory role in building the science of health care quality.

The bill also includes provisions to overcome barriers to access to preventive health care through a public-private partnership. It authorizes grants for the establishment of regional centers to improve and increase access to preventive health care services.

By approving the legislation before us, we can ensure the continued availability of the objective, science-based information this agency provides.

I urge Members to join us in supporting passage of H.R. 2506, the Health Research and Quality Act of 1999.

Mr. Chairman, I reserve the balance of my time.

Mr. BROWN of Ohio. Mr. Chairman, I yield myself such time as I may consume.

I am pleased that the gentleman from Florida (Mr. BILIRAKIS) and I

could work together to introduce the Health Research and Quality Act and pass it out of the Committee on Commerce. We hold similar views on why this issue is important. It is important because research is important.

The U.S. health care system is far from transparent. In fact, in many ways it is not even a system. It is a complex set of relationships influenced by science, demographics, politics, money and cultural trends. Whether the focus is on health care financing or health care delivery, common sense alone rarely explains what is going on. In fact, it often throws policymakers off track. If we want to improve on the status quo in health care, we have to get a realistic picture of what the status quo is. By conducting and supporting health services research, AHCPR helps paint that picture for us.

If we want to improve on the status quo in health care, we have got to find out what improvement actually means. By conducting and supporting outcomes, effectiveness and cost effectiveness research, AHCPR helps us determine the best way to spend the limited health care dollars that we do have.

And if we want to improve on the status quo in health care, we need to get the word out to the people in the institutions, in the agencies and the industries that somehow keep the whole thing running. By disseminating research and data broadly, AHCPR helps ensure that our investment in data collection, health services research and biomedical research pays off.

This reauthorization makes research and broad dissemination of information AHCPR's main focus. We could definitely use more of both.

I urge support of this important legislation.

Mr. Chairman, I reserve the balance of my time.

Mr. BILIRAKIS. Mr. Chairman, I yield 2 minutes to the gentleman from California (Mr. GARY MILLER).

(Mr. GARY MILLER of California asked and was given permission to revise and extend his remarks.)

Mr. GARY MILLER of California. Mr. Chairman, I rise today in support of H.R. 2506, the Health Research and Quality Act. First I want to thank the bill's author the gentleman from Florida (Mr. BILIRAKIS) and the cosponsors for all their hard work on this issue.

H.R. 2506 is an important piece of legislation which will improve the quality of health care by directing the Agency for Health Care Policy and Research to emphasize medical research, synthesizing and disseminating scientific evidence, and advancing public and private efforts to improve health care quality.

With the explosion of medical research and information being produced, medical practitioners face the increasingly difficult task of keeping current with medical literature and putting the latest scientific findings into perspective. As one study indicated, even if a doctor read two peer-reviewed journals each night for a year, he or she would still be 800 years behind in their reading.

Access to up-to-date, quality research will improve the care that patients obtain from all levels of the health care system. H.R. 2506 will provide a means whereby medical group practices can obtain and contribute to such a body of information. This legislation frees the Agency for Health Care Policy and Research from the difficult task of providing guidelines and standards of care and allows it to focus on providing unbiased, science-based research to the health care community. H.R. 2506 will help health care professionals and policymakers better understand the future demands on the Nation's health care system.

Again, I lend my strong support to this measure and urge my colleagues to join me in voting in favor of the Health Research and Quality Act of 1999.

□ 1500

Mr. BILIRAKIS. Mr. Chairman, I yield such time as he may consume to another gentleman from California (Mr. BILBRAY).

Mr. BILBRAY. Mr. Chairman, I rise to strongly support H.R. 2506, and let me just say as someone who has the privilege of representing the 49th District of California, one of the capitals of both public and private research, I want to commend the chairman and the ranking member for a cooperative effort here at really serving the American people.

The concept of reform and change sometimes scares people in these chambers and they worry about what could go wrong, and I think we have to remind ourselves again and again that reform and change is also an essential step to improvement. And this bill will allow us to take that step towards an improvement of not only the cost effectiveness, the cost efficiency, but also the effectiveness of our total health care system through the information age.

Mr. Chairman, 2506 will be that kind of step. And I hope that in the future we will be able to look back at H.R. 2506 and look back at the cooperative effort between the chairman of the subcommittee and the ranking member of this subcommittee and say this was the beginning of a very productive relationship between both sides of the aisle and a productive relationship with the American people and their health care system.

Mr. Chairman, I would ask all of us to support this bill and support the attitude that is behind this bill and to support the entire concept that Democrats and Republicans can work together for the good of the safety and the health of the American people.

Mr. BLILEY. Mr. Chairman, I commend the gentlemen from Florida and Ohio for bringing H.R. 2506, the Health Research and Quality Act of 1999, to the floor. This legislation, introduced by Representatives BILIRAKIS and BROWN, represents an important commitment to provide the science-based evidence that we need to improve health care quality.

We need sound and reliable information to help patients make informed decisions, to help health care providers make sense of new discoveries, to help purchasers get value for their health care dollar, and to help avoid medical errors. Today's legislation builds on the progress the Agency for Health Care Policy and Research has already made. It will enable us to benefit from our investment in biomedical research, to improve the health care delivery programs under our jurisdiction, and to build the science of quality measurement and improvement.

This emphasis on quality measurement and improvement is important. The focus on health outcomes is critical. If we are unable to determine the long-term effect of the care patients receive today, we will be unable to improve upon that care tomorrow. To address the full continuum of care and outcomes research, and to link research directly with clinical practice in geographically diverse locations throughout the United States, this bill stresses the importance of health care improvement research centers and provider-based research networks.

Since the science of outcomes research is complex, this bill requires the agency to support research and evaluation to advance the use of information systems for the study of health care quality and outcomes. The importance of outcomes research and information dissemination in the continuous improvement of patient care cannot be overstated. For example, in the area of cancer care, the ability to chart patient outcomes from a variety of interventions and communicate these outcomes effectively among practitioners will allow significant improvement in the treatment of all types of cancer.

In summary, Mr. Chairman, the Health Research and Quality Act of 1999 is a sound investment in the future; it is legislation that both sides of the aisle can support. The Commerce Committee gave unanimous approval to this legislation and I hope it will enjoy similar support on the floor today.

Mr. BALDACCI. Mr. Chairman, I commend the Chairman, Mr. BILIRAKIS, and the Ranking Member, Mr. BROWN, for introducing this valuable legislation. I particularly want to thank the Members for the special attention given to rural health care in the bill.

Access and quality of health care in rural America is of particular importance to me. I represent the largest geographic district east of the Mississippi. Recently, compounding changes in Medicare reimbursement and regulations have had a devastating impact on my district, and have endangered a very vulnerable population of my state. People in rural areas do not have the same choices available to those in urban areas. I am concerned that the rate of the uninsured in Maine continues to grow. Maine citizens rely heavily on community care, and we ought to promote research into enhancing quality of and access to health care in these areas. Careful studies of the delivery of health services in rural America will allow us to make better public policy, and I thank the Chairman and Ranking Member for their attention to this issue.

I am also pleased to see the legislation address the critical issue of health insurance. Section 913 requires that there must be surveys on, among other factors, the types and

costs of private health insurance. As we know, there is a growing trend to consolidation among health insurance companies, and I am particularly concerned about the ability of these large companies to direct costs and types of care offered when they buy out smaller local insurers. It is my hope that with this component of the bill, we will gain a better understanding of what effect the consolidation in the health insurance market is having on quality, access, and cost of insurance to rural Americans. Again, I thank the Chairman and Ranking Member for addressing this issue.

Mr. BILIRAKIS. Mr. Chairman, we have no further requests for time.

Mr. BROWN of Ohio. Mr. Chairman, I yield back the balance of my time.

Mr. BILIRAKIS. Mr. Chairman, I yield back the balance of my time.

The CHAIRMAN. All time for general debate has expired.

Pursuant to the rule, the committee amendment in the nature of a substitute printed in the bill shall be considered by sections as an original bill for the purpose of amendment, and each section is considered read.

No amendment to that amendment shall be in order except those printed in the portion of the CONGRESSIONAL RECORD designated for that purpose and pro forma amendments for the purpose of debate. Amendments printed in the RECORD may be offered only by the Member who caused it to be printed or his designee and shall be considered read.

The Chairman of the Committee of the Whole may postpone a request for a recorded vote on any amendment and may reduce to a minimum of 5 minutes the time for voting on any postponed question that immediately follows another vote, provided that the time for voting on the first question shall be a minimum of 15 minutes.

The Clerk will designate section 1.

The text of section 1 is as follows:

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 ''Health Research and Quality Act of 1999''.

The CHAIRMAN. Are there any amendments to section 1?

The Clerk will designate section 2.

The text of section 2 is as follows:

SEC. 2. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

(a) IN GENERAL.—Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended to read as follows:

''TITLE IX—AGENCY FOR HEALTH RESEARCH AND QUALITY

''PART A—ESTABLISHMENT AND GENERAL DUTIES

''SEC. 901. MISSION AND DUTIES.

''(a) IN GENERAL.—There is established within the Public Health Service an agency to be known as the Agency for Health Research and Quality, which shall be headed by a director appointed by the Secretary. The Secretary shall carry out this title acting through the Director.

''(b) MISSION.—The purpose of the Agency is to enhance the quality, appropriateness, and effectiveness of health services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical and health system practices, including the prevention of diseases and other health conditions. The Agency shall promote health care quality improvement by—

''(1) conducting and supporting research that develops and presents scientific evidence regarding all aspects of health, including—

''(A) the development and assessment of methods for enhancing patient participation in their own care and for facilitating shared patient-physician decision-making;

''(B) the outcomes, effectiveness, and cost-effectiveness of health care practices, including preventive measures and long-term care;

''(C) existing and innovative technologies;

''(D) the costs and utilization of, and access to health care;

''(E) the ways in which health care services are organized, delivered, and financed and the interaction and impact of these factors on the quality of patient care;

''(F) methods for measuring quality and strategies for improving quality; and

''(G) ways in which patients, consumers, purchasers, and practitioners acquire new information about best practices and health benefits, the determinants and impact of their use of this information;

''(2) synthesizing and disseminating available scientific evidence for use by patients, consumers, practitioners, providers, purchasers, policy makers, and educators; and

''(3) advancing private and public efforts to improve health care quality.

''(c) REQUIREMENTS WITH RESPECT TO RURAL AREAS AND PRIORITY POPULATIONS.—In carrying out subsection (b), the Director shall undertake and support research, demonstration projects, and evaluations with respect to—

''(1) the delivery of health services in rural areas (including frontier areas);

''(2) health services for low-income groups, and minority groups;

''(3) the health of children;

''(4) the elderly; and

''(5) people with special health care needs, including disabilities, chronic care and end-of-life health care.

''SEC. 902. GENERAL AUTHORITIES.

''(a) IN GENERAL.—In carrying out section 901(b), the Director shall support demonstration projects, conduct and support research, evaluations, training, research networks, multi-disciplinary centers, technical assistance, and the dissemination of information, on health care, and on systems for the delivery of such care, including activities with respect to—

''(1) the quality, effectiveness, efficiency, appropriateness and value of health care services;

''(2) quality measurement and improvement;

''(3) the outcomes, cost, cost-effectiveness, and use of health care services and access to such services;

''(4) clinical practice, including primary care and practice-oriented research;

''(5) health care technologies, facilities, and equipment;

''(6) health care costs, productivity, organization, and market forces;

''(7) health promotion and disease prevention, including clinical preventive services;

''(8) health statistics, surveys, database development, and epidemiology; and

''(9) medical liability.

''(b) HEALTH SERVICES TRAINING GRANTS.—

''(1) IN GENERAL.—The Director may provide training grants in the field of health services research related to activities authorized under subsection (a), to include pre- and post-doctoral fellowships and training programs, young investigator awards, and other programs and activities as appropriate. In carrying out this subsection, the Director shall make use of funds made available under section 487.

''(2) REQUIREMENTS.—In developing priorities for the allocation of training funds under this subsection, the Director shall take into consideration shortages in the number of trained researchers addressing the priority populations.

''(c) MULTIDISCIPLINARY CENTERS.—The Director may provide financial assistance to assist in meeting the costs of planning and establishing new centers, and operating existing and new centers, for multidisciplinary health services research, demonstration projects, evaluations, training, and policy analysis with respect to the matters referred to in subsection (a).

''(d) RELATION TO CERTAIN AUTHORITIES REGARDING SOCIAL SECURITY.—Activities authorized in this section shall be appropriately coordinated with experiments, demonstration projects, and other related activities authorized by the Social Security Act and the Social Security Amendments of 1967. Activities under subsection (a)(2) of this section that affect the programs under titles XVIII, XIX and XXI of the Social Security Act shall be carried out consistent with section 1142 of such Act.

''(e) DISCLAIMER.—The Agency shall not mandate national standards of clinical practice or quality health care standards. Recommendations resulting from projects funded and published by the Agency shall include a corresponding disclaimer.

''(f) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to imply that the Agency's role is to mandate a national standard or specific approach to quality measurement and reporting. In research and quality improvement activities, the Agency shall consider a wide range of choices, providers, health care delivery systems, and individual preferences.

''PART B—HEALTH CARE IMPROVEMENT RESEARCH

''SEC. 911. HEALTH CARE OUTCOME IMPROVEMENT RESEARCH.

''(a) EVIDENCE RATING SYSTEMS.—In collaboration with experts from the public and private sector, the Agency shall identify and disseminate methods or systems that it uses to assess health care research results, particularly methods or systems that it uses to rate the strength of the scientific evidence behind health care practice, recommendations in the research literature, and technology assessments. The Agency shall make methods or systems for evidence rating widely available. Agency publications containing health care recommendations shall indicate the level of substantiating evidence using such methods or systems.

''(b) HEALTH CARE IMPROVEMENT RESEARCH CENTERS AND PROVIDER-BASED RESEARCH NETWORKS.—

''(1) IN GENERAL.—In order to address the full continuum of care and outcomes research, to link research to practice improvement, and to speed the dissemination of research findings to community practice settings, the Agency shall employ research strategies and mechanisms that will link research directly with clinical practice in geographically diverse locations throughout the United States, including—

''(A) Health Care Improvement Research Centers that combine demonstrated multidisciplinary expertise in outcomes or quality improvement research with linkages to relevant sites of care;

''(B) Provider-based Research Networks, including plan, facility, or delivery system sites of care (especially primary care), that can evaluate outcomes and promote quality improvement; and

''(C) other innovative mechanisms or strategies to link research with clinical practice.

''(2) REQUIREMENTS.—The Director is authorized to establish the requirements for entities applying for grants under this subsection.

''SEC. 912. PRIVATE-PUBLIC PARTNERSHIPS TO IMPROVE ORGANIZATION AND DELIVERY.

''(a) SUPPORT FOR EFFORTS TO DEVELOP INFORMATION ON QUALITY.—

''(1) SCIENTIFIC AND TECHNICAL SUPPORT.—In its role as the principal agency for health research and quality, the Agency may provide scientific and technical support for private and

public efforts to improve health care quality, including the activities of accrediting organizations.

''(2) ROLE OF THE AGENCY.—With respect to paragraph (1), the role of the Agency shall include—

''(A) the identification and assessment of methods for the evaluation of the health of—

''(i) enrollees in health plans by type of plan, provider, and provider arrangements; and

''(ii) other populations, including those receiving long-term care services;

''(B) the ongoing development, testing, and dissemination of quality measures, including measures of health and functional outcomes;

''(C) the compilation and dissemination of health care quality measures developed in the private and public sector;

''(D) assistance in the development of improved health care information systems;

''(E) the development of survey tools for the purpose of measuring participant and beneficiary assessments of their health care; and

''(F) identifying and disseminating information on mechanisms for the integration of information on quality into purchaser and consumer decision-making processes.

''(b) CENTERS FOR EDUCATION AND RESEARCH ON THERAPEUTICS.—

''(1) IN GENERAL.—The Secretary, acting through the Director and in consultation with the Commissioner of Food and Drugs, shall establish a program for the purpose of making one or more grants for the establishment and operation of one or more centers to carry out the activities specified in paragraph (2).

''(2) REQUIRED ACTIVITIES.—The activities referred to in this paragraph are the following:

''(A) The conduct of state-of-the-art research for the following purposes:

''(i) To increase awareness of—

''(I) new uses of drugs, biological products, and devices;

''(II) ways to improve the effective use of drugs, biological products, and devices; and

''(III) risks of new uses and risks of combinations of drugs and biological products.

''(ii) To provide objective clinical information to the following individuals and entities:

''(I) Health care practitioners and other providers of health care goods or services.

''(II) Pharmacists, pharmacy benefit managers and purchasers.

''(III) Health maintenance organizations and other managed health care organizations.

''(IV) Health care insurers and governmental agencies.

''(V) Patients and consumers.

''(iii) To improve the quality of health care while reducing the cost of health care through—

''(I) an increase in the appropriate use of drugs, biological products, or devices; and

''(II) the prevention of adverse effects of drugs, biological products, and devices and the consequences of such effects, such as unnecessary hospitalizations.

''(B) The conduct of research on the comparative effectiveness, cost-effectiveness, and safety of drugs, biological products, and devices.

''(C) Such other activities as the Secretary determines to be appropriate, except that a grant may not be expended to assist the Secretary in the review of new drugs.

''(c) REDUCING ERRORS IN MEDICINE.—The Director shall conduct and support research and build private-public partnerships to—

''(1) identify the causes of preventable health care errors and patient injury in health care delivery;

''(2) develop, demonstrate, and evaluate strategies for reducing errors and improving patient safety; and

''(3) promote the implementation of effective strategies throughout the health care industry.

''SEC. 913. INFORMATION ON QUALITY AND COST OF CARE.

''(a) IN GENERAL.—In carrying out 902(a), the Director shall—

''(1) conduct a survey to collect data on a nationally representative sample of the population on the cost, use and, for fiscal year 2001 and subsequent fiscal years, quality of health care, including the types of health care services Americans use, their access to health care services, frequency of use, how much is paid for the services used, the source of those payments, the types and costs of private health insurance, access, satisfaction, and quality of care for the general population and also for populations identified in section 901(c); and

''(2) develop databases and tools that provide information to States on the quality, access, and use of health care services provided to their residents.

''(b) QUALITY AND OUTCOMES INFORMATION.—

''(1) IN GENERAL.—Beginning in fiscal year 2001, the Director shall ensure that the survey conducted under subsection (a)(1) will—

''(A) identify determinants of health outcomes and functional status, the needs of special populations in such variables as well as an understanding of changes over time, relationships to health care access and use, and monitor the overall national impact of Federal and State policy changes on health care;

''(B) provide information on the quality of care and patient outcomes for frequently occurring clinical conditions for a nationally representative sample of the population; and

''(C) provide reliable national estimates for children and persons with special health care needs through the use of supplements or periodic expansions of the survey.

In expanding the Medical Expenditure Panel Survey, as in existence on the date of enactment of this title in fiscal year 2001 to collect information on the quality of care, the Director shall take into account any outcomes measurements generally collected by private sector accreditation organizations.

''(2) ANNUAL REPORT.—Beginning in fiscal year 2003, the Secretary, acting through the Director, shall submit to Congress an annual report on national trends in the quality of health care provided to the American people.

''SEC. 914. INFORMATION SYSTEMS FOR HEALTH CARE IMPROVEMENT.

''(a) IN GENERAL.—In order to foster a range of innovative approaches to the management and communication of health information, the Agency shall support research, evaluations and initiatives to advance—

''(1) the use of information systems for the study of health care quality and outcomes, including the generation of both individual provider and plan-level comparative performance data;

''(2) training for health care practitioners and researchers in the use of information systems;

''(3) the creation of effective linkages between various sources of health information, including the development of information networks;

''(4) the delivery and coordination of evidence-based health care services, including the use of real-time health care decision-support programs;

''(5) the structure, content, definition, and coding of health information data and medical vocabularies in consultation with appropriate Federal entities and shall seek input from appropriate private entities;

''(6) the use of computer-based health records in outpatient and inpatient settings as a personal health record for individual health assessment and maintenance, and for monitoring public health and outcomes of care within populations; and

''(7) the protection of individually identifiable information in health services research and health care quality improvement.

''(b) DEMONSTRATION.—The Agency shall support demonstrations into the use of new information tools aimed at improving shared decision-making between patients and their caregivers.

''SEC. 915. RESEARCH SUPPORTING PRIMARY CARE AND ACCESS IN UNDERSERVED AREAS.

''(a) PREVENTIVE SERVICES TASK FORCE.—

''(1) PURPOSE.—The Agency shall provide ongoing administrative, research, and technical support for the operation of the Preventive Services Task Force. The Agency shall coordinate and support the dissemination of the Preventive Services Task Force recommendations.

''(2) OPERATION.—The Preventive Services Task Force shall review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations for the health care community, and updating previous recommendations, regarding their usefulness in daily clinical practice. In carrying out its responsibilities under paragraph (1), the Task Force shall not be subject to the provisions of Appendix 2 of title 5, United States Code.

''(b) PRIMARY CARE RESEARCH.—

''(1) IN GENERAL.—There is established within the Agency a Center for Primary Care Research (referred to in this subsection as the 'Center') that shall serve as the principal source of funding for primary care practice research in the Department of Health and Human Services. For purposes of this paragraph, primary care research focuses on the first contact when illness or health concerns arise, the diagnosis, treatment or referral to specialty care, preventive care, and the relationship between the clinician and the patient in the context of the family and community.

''(2) RESEARCH.—In carrying out this section, the Center shall conduct and support research concerning—

''(A) the nature and characteristics of primary care practice;

''(B) the management of commonly occurring clinical problems;

''(C) the management of undifferentiated clinical problems; and

''(D) the continuity and coordination of health services.

''SEC. 916. CLINICAL PRACTICE AND TECHNOLOGY INNOVATION.

''(a) IN GENERAL.—The Director shall promote innovation in evidence-based clinical practice and health care technologies by—

''(1) conducting and supporting research on the development, diffusion, and use of health care technology;

''(2) developing, evaluating, and disseminating methodologies for assessments of health care practices and health care technologies;

''(3) conducting intramural and supporting extramural assessments of existing and new health care practices and technologies;

''(4) promoting education, training, and providing technical assistance in the use of health care practice and health care technology assessment methodologies and results; and

''(5) working with the National Library of Medicine and the public and private sector to develop an electronic clearinghouse of currently available assessments and those in progress.

''(b) SPECIFICATION OF PROCESS.—

''(1) IN GENERAL.—Not later than December 31, 2000, the Director shall develop and publish a description of the methods used by the Agency and its contractors for practice and technology assessment.

''(2) CONSULTATIONS.—In carrying out this subsection, the Director shall cooperate and consult with the Assistant Secretary for Health, the Administrator of the Health Care Financing Administration, the Director of the National Institutes of Health, the Commissioner of Food and Drugs, and the heads of any other interested Federal department or agency, and shall seek input, where appropriate, from professional societies and other private and public entities.

''(3) METHODOLOGY.—The Director shall, in developing the methods used under paragraph (1), consider—

''(A) safety, efficacy, and effectiveness;

''(B) legal, social, and ethical implications;

''(C) costs, benefits, and cost-effectiveness;

''(D) comparisons to alternate technologies and practices; and

''(E) requirements of Food and Drug Administration approval to avoid duplication.

''(c) SPECIFIC ASSESSMENTS.—

''(1) IN GENERAL.—The Director shall conduct or support specific assessments of health care technologies and practices.

''(2) REQUESTS FOR ASSESSMENTS.—The Director is authorized to conduct or support assessments, on a reimbursable basis, for the Health Care Financing Administration, the Department of Defense, the Department of Veterans Affairs, the Office of Personnel Management, and other public or private entities.

''(3) GRANTS AND CONTRACTS.—In addition to conducting assessments, the Director may make grants to, or enter into cooperative agreements or contracts with, entities described in paragraph (4) for the purpose of conducting assessments of experimental, emerging, existing, or potentially outmoded health care technologies, and for related activities.

''(4) ELIGIBLE ENTITIES.—An entity described in this paragraph is an entity that is determined to be appropriate by the Director, including academic medical centers, research institutions and organizations, professional organizations, third party payers, governmental agencies, and consortia of appropriate research entities established for the purpose of conducting technology assessments.

''SEC. 917. COORDINATION OF FEDERAL GOVERNMENT QUALITY IMPROVEMENT EFFORTS.

''(a) REQUIREMENT.—

''(1) IN GENERAL.—To avoid duplication and ensure that Federal resources are used efficiently and effectively, the Secretary, acting through the Director, shall coordinate all research, evaluations, and demonstrations related to health services research, quality measurement and quality improvement activities undertaken and supported by the Federal Government.

''(2) SPECIFIC ACTIVITIES.—The Director, in collaboration with the appropriate Federal officials representing all concerned executive agencies and departments, shall develop and manage a process to—

''(A) improve interagency coordination, priority setting, and the use and sharing of research findings and data pertaining to Federal quality improvement programs, technology assessment, and health services research;

''(B) strengthen the research information infrastructure, including databases, pertaining to Federal health services research and health care quality improvement initiatives;

''(C) set specific goals for participating agencies and departments to further health services research and health care quality improvement; and

''(D) strengthen the management of Federal health care quality improvement programs.

''(b) STUDY BY THE INSTITUTE OF MEDICINE.—

''(1) IN GENERAL.—To provide Congress, the Department of Health and Human Services, and other relevant departments with an independent, external review of their quality oversight, quality improvement and quality research programs, the Secretary shall enter into a contract with the Institute of Medicine—

''(A) to describe and evaluate current quality improvement, quality research and quality monitoring processes through—

''(i) an overview of pertinent health services research activities and quality improvement efforts conducted by all Federal programs, with particular attention paid to those under titles XVIII, XIX, and XXI of the Social Security Act; and

''(ii) a summary of the partnerships that the Department of Health and Human Services has pursued with private accreditation, quality measurement and improvement organizations; and

''(B) to identify options and make recommendations to improve the efficiency and effectiveness of quality improvement programs through—

''(i) the improved coordination of activities across the medicare, medicaid and child health insurance programs under titles XVIII, XIX and XXI of the Social Security Act and health services research programs;

''(ii) the strengthening of patient choice and participation by incorporating state-of-the-art quality monitoring tools and making information on quality available; and

''(iii) the enhancement of the most effective programs, consolidation as appropriate, and elimination of duplicative activities within various federal agencies.

''(2) REQUIREMENTS.—

''(A) IN GENERAL.—The Secretary shall enter into a contract with the Institute of Medicine for the preparation—

''(i) not later than 12 months after the date of enactment of this title, of a report providing an overview of the quality improvement programs of the Department of Health and Human Services for the medicare, medicaid, and CHIP programs under titles XVIII, XIX, and XXI of the Social Security Act; and

''(ii) not later than 24 months after the date of enactment of this title, of a final report containing recommendations.

''(B) REPORTS.—The Secretary shall submit the reports described in subparagraph (A) to the Committee on Finance and the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Ways and Means and the Committee on Commerce of the House of Representatives.

''PART C—GENERAL PROVISIONS

''SEC. 921. ADVISORY COUNCIL FOR HEALTH CARE RESEARCH AND QUALITY.

''(a) ESTABLISHMENT.—There is established an advisory council to be known as the Advisory Council for Health Care Research and Quality.

''(b) DUTIES.—

''(1) IN GENERAL.—The Advisory Council shall advise the Secretary and the Director with respect to activities proposed or undertaken to carry out the purpose of the Agency under section 901(b).

''(2) CERTAIN RECOMMENDATIONS.—Activities of the Advisory Council under paragraph (1) shall include making recommendations to the Director regarding—

''(A) priorities regarding health care research, especially studies related to quality, outcomes, cost and the utilization of, and access to, health care services;

''(B) the field of health care research and related disciplines, especially issues related to training needs, and dissemination of information pertaining to health care quality; and

''(C) the appropriate role of the Agency in each of these areas in light of private sector activity and identification of opportunities for public-private sector partnerships.

''(c) MEMBERSHIP.—

''(1) IN GENERAL.—The Advisory Council shall, in accordance with this subsection, be composed of appointed members and ex officio members. All members of the Advisory Council shall be voting members other than the individuals designated under paragraph (3)(B) as ex officio members.

''(2) APPOINTED MEMBERS.—The Secretary shall appoint to the Advisory Council 18 appropriately qualified individuals. At least 14 members of the Advisory Council shall be representatives of the public who are not officers or employees of the United States. The Secretary shall ensure that the appointed members of the Council, as a group, are representative of professions and entities concerned with, or affected by, activities under this title and under section 1142 of the Social Security Act. Of such members—

''(A) 3 shall be individuals distinguished in the conduct of research, demonstration projects, and evaluations with respect to health care;

''(B) 3 shall be individuals distinguished in the practice of medicine of which at least 1 shall be a primary care practitioner;

''(C) 3 shall be individuals distinguished in the other health professions;

''(D) 3 shall be individuals either representing the private health care sector, including health plans, providers, and purchasers or individuals distinguished as administrators of health care delivery systems;

''(E) 3 shall be individuals distinguished in the fields of health care quality improvement, economics, information systems, law, ethics, business, or public policy; and

''(F) 3 shall be individuals representing the interests of patients and consumers of health care.

''(3) EX OFFICIO MEMBERS.—The Secretary shall designate as ex officio members of the Advisory Council—

''(A) the Assistant Secretary for Health, the Director of the National Institutes of Health, the Director of the Centers for Disease Control and Prevention, the Administrator of the Health Care Financing Administration, the Assistant Secretary of Defense (Health Affairs), and the Under Secretary for Health of the Department of Veterans Affairs; and

''(B) such other Federal officials as the Secretary may consider appropriate.

''(d) TERMS.—Members of the Advisory Council appointed under subsection (c)(2) shall serve for a term of 3 years. A member of the Council appointed under such subsection may continue to serve after the expiration of the term of the members until a successor is appointed.

''(e) VACANCIES.—If a member of the Advisory Council appointed under subsection (c)(2) does not serve the full term applicable under subsection (d), the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

''(f) CHAIR.—The Director shall, from among the members of the Advisory Council appointed under subsection (c)(2), designate an individual to serve as the chair of the Advisory Council.

''(g) MEETINGS.—The Advisory Council shall meet not less than once during each discrete 4-month period and shall otherwise meet at the call of the Director or the chair.

''(h) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—

''(1) APPOINTED MEMBERS.—Members of the Advisory Council appointed under subsection (c)(2) shall receive compensation for each day (including travel time) engaged in carrying out the duties of the Advisory Council unless declined by the member. Such compensation may not be in an amount in excess of the maximum rate of basic pay payable for GS–18 of the General Schedule.

''(2) EX OFFICIO MEMBERS.—Officials designated under subsection (c)(3) as ex officio members of the Advisory Council may not receive compensation for service on the Advisory Council in addition to the compensation otherwise received for duties carried out as officers of the United States.

''(i) STAFF.—The Director shall provide to the Advisory Council such staff, information, and other assistance as may be necessary to carry out the duties of the Council.

''SEC. 922. PEER REVIEW WITH RESPECT TO GRANTS AND CONTRACTS.

''(a) REQUIREMENT OF REVIEW.—

''(1) IN GENERAL.—Appropriate technical and scientific peer review shall be conducted with respect to each application for a grant, cooperative agreement, or contract under this title.

''(2) REPORTS TO DIRECTOR.—Each peer review group to which an application is submitted pursuant to paragraph (1) shall report its finding and recommendations respecting the application to the Director in such form and in such manner as the Director shall require.

''(b) APPROVAL AS PRECONDITION OF AWARDS.—The Director may not approve an application described in subsection (a)(1) unless

the application is recommended for approval by a peer review group established under subsection (c).

''(c) ESTABLISHMENT OF PEER REVIEW GROUPS.—

''(1) IN GENERAL.—The Director shall establish such technical and scientific peer review groups as may be necessary to carry out this section. Such groups shall be established without regard to the provisions of title 5, United States Code, that govern appointments in the competitive service, and without regard to the provisions of chapter 51, and subchapter III of chapter 53, of such title that relate to classification and pay rates under the General Schedule.

''(2) MEMBERSHIP.—The members of any peer review group established under this section shall be appointed from among individuals who by virtue of their training or experience are eminently qualified to carry out the duties of such peer review group. Officers and employees of the United States may not constitute more than 25 percent of the membership of any such group. Such officers and employees may not receive compensation for service on such groups in addition to the compensation otherwise received for these duties carried out as such officers and employees.

''(3) DURATION.—Notwithstanding section 14(a) of the Federal Advisory Committee Act, peer review groups established under this section may continue in existence until otherwise provided by law.

''(4) QUALIFICATIONS.—Members of any peer-review group shall, at a minimum, meet the following requirements:

''(A) Such members shall agree in writing to treat information received, pursuant to their work for the group, as confidential information, except that this subparagraph shall not apply to public records and public information.

''(B) Such members shall agree in writing to recuse themselves from participation in the peer-review of specific applications which present a potential personal conflict of interest or appearance of such conflict, including employment in a directly affected organization, stock ownership, or any financial or other arrangement that might introduce bias in the process of peer-review.

''(d) AUTHORITY FOR PROCEDURAL ADJUSTMENTS IN CERTAIN CASES.—In the case of applications for financial assistance whose direct costs will not exceed $100,000, the Director may make appropriate adjustments in the procedures otherwise established by the Director for the conduct of peer review under this section. Such adjustments may be made for the purpose of encouraging the entry of individuals into the field of research, for the purpose of encouraging clinical practice-oriented or provider-based research, and for such other purposes as the Director may determine to be appropriate.

''(e) REGULATIONS.—The Director shall issue regulations for the conduct of peer review under this section.

''SEC. 923. CERTAIN PROVISIONS WITH RESPECT TO DEVELOPMENT, COLLECTION, AND DISSEMINATION OF DATA.

''(a) STANDARDS WITH RESPECT TO UTILITY OF DATA.—

''(1) IN GENERAL.—To ensure the utility, accuracy, and sufficiency of data collected by or for the Agency for the purpose described in section 901(b), the Director shall establish standard methods for developing and collecting such data, taking into consideration—

''(A) other Federal health data collection standards; and

''(B) the differences between types of health care plans, delivery systems, health care providers, and provider arrangements.

''(2) RELATIONSHIP WITH OTHER DEPARTMENT PROGRAMS.—In any case where standards under paragraph (1) may affect the administration of other programs carried out by the Department of Health and Human Services, including the programs under title XVIII, XIX or XXI of the Social Security Act, or may affect health information that is subject to a standard developed under part C of title XI of the Social Security Act, they shall be in the form of recommendations to the Secretary for such program.

''(b) STATISTICS AND ANALYSES.—The Director shall—

''(1) take appropriate action to ensure that statistics and analyses developed under this title are of high quality, timely, and duly comprehensive, and that the statistics are specific, standardized, and adequately analyzed and indexed; and

''(2) publish, make available, and disseminate such statistics and analyses on as wide a basis as is practicable.

''(c) AUTHORITY REGARDING CERTAIN REQUESTS.—Upon request of a public or private entity, the Director may conduct or support research or analyses otherwise authorized by this title pursuant to arrangements under which such entity will pay the cost of the services provided. Amounts received by the Director under such arrangements shall be available to the Director for obligation until expended.

''SEC. 924. DISSEMINATION OF INFORMATION.

''(a) IN GENERAL.—The Director shall—

''(1) without regard to section 501 of title 44, United States Code, promptly publish, make available, and otherwise disseminate, in a form understandable and on as broad a basis as practicable so as to maximize its use, the results of research, demonstration projects, and evaluations conducted or supported under this title;

''(2) ensure that information disseminated by the Agency is science-based and objective and undertakes consultation as necessary to assess the appropriateness and usefulness of the presentation of information that is targeted to specific audiences;

''(3) promptly make available to the public data developed in such research, demonstration projects, and evaluations;

''(4) provide, in collaboration with the National Library of Medicine where appropriate, indexing, abstracting, translating, publishing, and other services leading to a more effective and timely dissemination of information on research, demonstration projects, and evaluations with respect to health care to public and private entities and individuals engaged in the improvement of health care delivery and the general public, and undertake programs to develop new or improved methods for making such information available; and

''(5) as appropriate, provide technical assistance to State and local government and health agencies and conduct liaison activities to such agencies to foster dissemination.

''(b) PROHIBITION AGAINST RESTRICTIONS.—Except as provided in subsection (c), the Director may not restrict the publication or dissemination of data from, or the results of, projects conducted or supported under this title.

''(c) LIMITATION ON USE OF CERTAIN INFORMATION.—No information, if an establishment or person supplying the information or described in it is identifiable, obtained in the course of activities undertaken or supported under this title may be used for any purpose other than the purpose for which it was supplied unless such establishment or person has consented (as determined under regulations of the Director) to its use for such other purpose. Such information may not be published or released in other form if the person who supplied the information or who is described in it is identifiable unless such person has consented (as determined under regulations of the Director) to its publication or release in other form.

''(d) PENALTY.—Any person who violates subsection (c) shall be subject to a civil monetary penalty of not more than $10,000 for each such violation involved. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A of the Social Security Act are imposed and collected.

''SEC. 925. ADDITIONAL PROVISIONS WITH RESPECT TO GRANTS AND CONTRACTS.

''(a) FINANCIAL CONFLICTS OF INTEREST.—With respect to projects for which awards of grants, cooperative agreements, or contracts are authorized to be made under this title, the Director shall by regulation define—

''(1) the specific circumstances that constitute financial interests in such projects that will, or may be reasonably expected to, create a bias in favor of obtaining results in the projects that are consistent with such interests; and

''(2) the actions that will be taken by the Director in response to any such interests identified by the Director.

''(b) REQUIREMENT OF APPLICATION.—The Director may not, with respect to any program under this title authorizing the provision of grants, cooperative agreements, or contracts, provide any such financial assistance unless an application for the assistance is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Director determines to be necessary to carry out the program involved.

''(c) PROVISION OF SUPPLIES AND SERVICES IN LIEU OF FUNDS.—

''(1) IN GENERAL.—Upon the request of an entity receiving a grant, cooperative agreement, or contract under this title, the Secretary may, subject to paragraph (2), provide supplies, equipment, and services for the purpose of aiding the entity in carrying out the project involved and, for such purpose, may detail to the entity any officer or employee of the Department of Health and Human Services.

''(2) CORRESPONDING REDUCTION IN FUNDS.—With respect to a request described in paragraph (1), the Secretary shall reduce the amount of the financial assistance involved by an amount equal to the costs of detailing personnel and the fair market value of any supplies, equipment, or services provided by the Director. The Secretary shall, for the payment of expenses incurred in complying with such request, expend the amounts withheld.

''(d) APPLICABILITY OF CERTAIN PROVISIONS WITH RESPECT TO CONTRACTS.—Contracts may be entered into under this part without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

''SEC. 926. CERTAIN ADMINISTRATIVE AUTHORITIES.

''(a) DEPUTY DIRECTOR AND OTHER OFFICERS AND EMPLOYEES.—

''(1) DEPUTY DIRECTOR.—The Director may appoint a deputy director for the Agency.

''(2) OTHER OFFICERS AND EMPLOYEES.—The Director may appoint and fix the compensation of such officers and employees as may be necessary to carry out this title. Except as otherwise provided by law, such officers and employees shall be appointed in accordance with the civil service laws and their compensation fixed in accordance with title 5, United States Code.

''(b) FACILITIES.—The Secretary, in carrying out this title—

''(1) may acquire, without regard to the Act of March 3, 1877 (40 U.S.C. 34), by lease or otherwise through the Director of General Services, buildings or portions of buildings in the District of Columbia or communities located adjacent to the District of Columbia for use for a period not to exceed 10 years; and

''(2) may acquire, construct, improve, repair, operate, and maintain laboratory, research, and other necessary facilities and equipment, and such other real or personal property (including patents) as the Secretary deems necessary.

''(c) PROVISION OF FINANCIAL ASSISTANCE.—The Director, in carrying out this title, may make grants to public and nonprofit entities and individuals, and may enter into cooperative agreements or contracts with public and private entities and individuals.

''(d) UTILIZATION OF CERTAIN PERSONNEL AND RESOURCES.—

''(1) DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The Director, in carrying out this title, may utilize personnel and equipment, facilities, and other physical resources of the Department of Health and Human Services, permit appropriate (as determined by the Secretary) entities and individuals to utilize the physical resources of such Department, and provide technical assistance and advice.

''(2) OTHER AGENCIES.—The Director, in carrying out this title, may use, with their consent, the services, equipment, personnel, information, and facilities of other Federal, State, or local public agencies, or of any foreign government, with or without reimbursement of such agencies.

''(e) CONSULTANTS.—The Secretary, in carrying out this title, may secure, from time to time and for such periods as the Director deems advisable but in accordance with section 3109 of title 5, United States Code, the assistance and advice of consultants from the United States or abroad.

''(f) EXPERTS.—

''(1) IN GENERAL.—The Secretary may, in carrying out this title, obtain the services of not more than 50 experts or consultants who have appropriate scientific or professional qualifications. Such experts or consultants shall be obtained in accordance with section 3109 of title 5, United States Code, except that the limitation in such section on the duration of service shall not apply.

''(2) TRAVEL EXPENSES.—

''(A) IN GENERAL.—Experts and consultants whose services are obtained under paragraph (1) shall be paid or reimbursed for their expenses associated with traveling to and from their assignment location in accordance with sections 5724, 5724a(a), 5724a(c), and 5726(C) of title 5, United States Code.

''(B) LIMITATION.—Expenses specified in subparagraph (A) may not be allowed in connection with the assignment of an expert or consultant whose services are obtained under paragraph (1) unless and until the expert agrees in writing to complete the entire period of assignment, or 1 year, whichever is shorter, unless separated or reassigned for reasons that are beyond the control of the expert or consultant and that are acceptable to the Secretary. If the expert or consultant violates the agreement, the money spent by the United States for the expenses specified in subparagraph (A) is recoverable from the expert or consultant as a statutory obligation owed to the United States. The Secretary may waive in whole or in part a right of recovery under this subparagraph.

''(g) VOLUNTARY AND UNCOMPENSATED SERVICES.—The Director, in carrying out this title, may accept voluntary and uncompensated services.

''SEC. 927. FUNDING.

''(a) INTENT.—To ensure that the United States investment in biomedical research is rapidly translated into improvements in the quality of patient care, there must be a corresponding investment in research on the most effective clinical and organizational strategies for use of these findings in daily practice. The authorization levels in subsections (b) and (c) provide for a proportionate increase in health care research as the United States investment in biomedical research increases.

''(b) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this title, there are authorized to be appropriated $250,000,000 for fiscal year 2000, and such sums as may be necessary for each of the fiscal years 2001 through 2004.

''(c) EVALUATIONS.—In addition to amounts available pursuant to subsection (b) for carrying out this title, there shall be made available for such purpose, from the amounts made available pursuant to section 241 (relating to evaluations), an amount equal to 40 percent of the maximum amount authorized in such section 241 to be made available for a fiscal year.

''SEC. 928. DEFINITIONS.

''In this title:

''(1) ADVISORY COUNCIL.—The term 'Advisory Council' means the Advisory Council on Health Care Research and Quality established under section 921.

''(2) AGENCY.—The term 'Agency' means the Agency for Health Research and Quality.

''(3) DIRECTOR.—The term 'Director' means the Director of the Agency for Health Research and Quality.''.

(b) RULES OF CONSTRUCTION.—

(1) IN GENERAL.—Section 901(a) of the Public Health Service Act (as added by subsection (a) of this section) applies as a redesignation of the agency that carried out title IX of such Act on the day before the date of enactment of this Act, and not as the termination of such agency and the establishment of a different agency. The amendment made by subsection (a) of this section does not affect appointments of the personnel of such agency who were employed at the agency on the day before such date.

(2) REFERENCES.—Any reference in law to the Agency for Health Care Policy and Research is deemed to be a reference to the Agency for Health Research and Quality, and any reference in law to the Administrator for Health Care Policy and Research Quality.

AMENDMENT NO. 3 OFFERED BY MR. BILIRAKIS

Mr. BILIRAKIS. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 3 offered by Mr. BILIRAKIS:

Page 3, line 2, strike ''by'' and all that follows through ''research'' on line 3 and insert the following: ''by conducting and supporting—

''(1) research''.

Page 4, line 3, strike ''synthesizing and disseminating'' and insert ''the synthesis and dissemination of''.

Page 4, line 7, strike ''advancing'' and insert ''initiatives to advance''.

Page 4, beginning on line 11, strike ''shall undertake'' and all that follows through ''evaluations'' on line 12 and insert the following: ''shall conduct and support research and evaluations, and support demonstration projects,''.

Page 4, line 25, strike ''shall support'' and all that follows through ''activities'' on page 5, line 4, and insert the following: ''shall conduct and support research, evaluations, and training, support demonstration projects, research networks, and multi-disciplinary centers, provide technical assistance, and disseminate information on health care and on systems for the delivery of such care, including activities''.

Page 6, line 5, strike ''made available under section 487'' and insert ''made available under section 487(d)(3) for the Agency''.

Page 7, beginning on line 21, strike ''that it uses''.

Page 7, line 23, strike ''that it uses''.

Page 7, line 24, strike ''behind health care practice'' and insert ''underlying health care practice''.

Page 8, beginning on line 15, strike ''Health Care Improvement Research Centers'' and insert ''health care improvement research centers''.

Page 8, line 20, strike ''Provider-based Research Networks'' and insert ''provider-based research networks''.

Page 8, line 23, insert ''evaluate and'' before ''promote quality improvement''.

Page 13, beginning on line 7, strike ''In carrying out 902(a), the Director'' and insert ''The Director''.

Page 14, beginning on line 5, strike '', the needs'' and all that follows through ''and monitor'' on line 8 and insert the following: '', including the health care needs of populations identified in section 901(c), provide data to study the relationships between health care quality, outcomes, access, use, and cost, measure changes over time, and monitor''.

Page 15, beginning on line 10, strike ''shall support research, evaluations and initiatives to advance'' and insert ''shall conduct and support research, evaluations, and initiatives to advance''.

Page 18, beginning on line 15, strike ''clinical practice and health care technologies'' and insert ''health care practices and technologies''.

Page 18, beginning on line 21, strike ''health care practices and health care technologies'' and insert ''health care practices and technologies''.

Page 19, line 1, strike ''promoting education, training, and providing'' and insert ''promoting education and training and providing''.

Page 19, beginning on line 2, strike ''health care practice and health care technology assessment'' and insert ''health care practice and technology assessment''.

Page 20, line 4, insert ''health care'' before ''technologies''.

Page 25, line 5, insert ''National'' before ''Advisory Council''.

Page 29, beginning on line 4, strike ''the maximum rate of basic pay payable for GS–18 of the General Schedule'' and insert the following: ''the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day during which such member is engaged in the performance of the duties of the Advisory Council''.

Page 43, line 2, insert ''National'' before ''Advisory Council''.

Mr. BILIRAKIS. Mr. Chairman, this is an en bloc technical amendment to section 2 of the bill as reported by the Committee on Commerce. Section 2 of the bill is divided into three parts.

Part A provides for the reauthorization of the agency for health care policy and research and renames it the Agency for Health Research and Quality and outlines the agency's mission and general authorities. Part A also establishes specific requirements that the agency must meet as well as limitations on the agency's authority and provides the agency with authority to support training programs.

Part B outlines the specific programmatic authority of the agency in six broad areas and includes a seventh section to promote coordination and reduce unnecessary duplication of existing health services, research, quality research, and improvement activities. The six programmatic areas include outcomes research, organization and delivery research, quality and cost of care research, and data development information systems for health care improvement, primary care and access research, and practice and technology assessment.

Part C governs the daily administration of the agency, establishes its national advisory counsel and sets the authorization levels for the agency. This section outlines the agency's authority to support grants and contracts and establishes requirements for scientific peer review of research funded

by the agency and the dissemination of research findings.

The committee was unable, Mr. Chairman, to make these technical corrections to the text of the bill before reporting it, however we have met with the minority and with the administration, and we are all in agreement that these amendments are technical in nature, improve the underlying text and do not make substantive changes in the bill as it was reported. For these reasons, I ask my colleagues for support of this en bloc amendment.

Mr. BROWN of Ohio. Mr. Chairman, will the gentleman yield?

Mr. BILIRAKIS. I yield to the gentleman from Ohio.

Mr. BROWN of Ohio. Mr. Chairman, I agree. I concur with what the gentleman said. This is a by and large technical amendment that we worked on together as we worked on the bill together, and I ask my colleagues to support the Bilirakis amendment.

Mr. BILIRAKIS. Mr. Chairman, I yield back the balance of my time.

The CHAIRMAN. The question is on the amendment offered by the gentleman from Florida (Mr. BILIRAKIS).

The amendment was agreed to.

AMENDMENT NO. 12 OFFERED BY MR. ANDREWS

Mr. ANDREWS. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 12 offered by Mr. ANDREWS:

Page 16, after line 15, insert the following subsection:

(c) CERTAIN LINKAGES REGARDING HEALTH INFORMATION.—Initiatives under subsection (a) shall include the establishment, through a site maintained by the Director on the telecommunications medium known as the World Wide Web, of linkages that enable users of the site to obtain information from consumer satisfaction agencies or other entities that perform evaluations regarding the quality of health care, including more than one link to entities that evaluate health maintenance organizations, and including a link of the National Committee for Quality Assurance.

MODIFICATION TO AMENDMENT NO. 12 OFFERED BY MR. ANDREWS

Mr. ANDREWS. Mr. Chairman, I ask unanimous consent that slight technical modifications to the underlying amendment be considered in order.

The CHAIRMAN. The Clerk will report the modification.

The Clerk read as follows:

Modification to Amendment No. 12 offered by Mr. ANDREWS:

Page 16, after line 15, insert the following subsection:

(c) CERTAIN LINKAGES REGARDING HEALTH INFORMATION.—Initiatives under subsection (a) shall include the establishment, through a site maintained by the Director on the telecommunications medium known as the World Wide Web, of linkages that enable users of the site to obtain information from consumer satisfaction agencies or other entities that perform evaluations regarding the quality of health care, including more than one link to entities that evaluate health maintenance organizations, and including a link of the National Committee for Quality Assurance.

Mr. ANDREWS (during the reading). Mr. Chairman, I ask unanimous consent that the modification be considered as read and printed in the RECORD.

The CHAIRMAN. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

The CHAIRMAN. Is there objection to the modification?

There was no objection.

Mr. ANDREWS. Mr. Chairman, I first wanted to thank and congratulate the gentleman from Florida (Mr. BILIRAKIS) and the gentleman from Ohio (Mr. BROWN) for their leadership in bringing this legislation to the floor. It is worthy of unanimous support of the House, and I enthusiastically support the bill.

My amendment speaks to a very traditional value and a new technology. The traditional value is enlightened consumer choice. When we buy a toaster or an automobile or a house, we have all kinds of information available to us about the quality of the product that we are buying. There are government and private for-profit and private nonprofit sources of such information readily available. So should such information be available with respect to health care plans; and that is where this traditional value is combined with a new technology, the World Wide Web.

The purpose of my amendment is to call on the AHCPR to make available on a web site on the World Wide Web a collection of information offered by nonprofit and public groups that evaluate and give information about the quality of health care plans to consumers. If this amendment is included, consumers will be able to visit the web site and click on information from groups such as the National Committee for Quality Assurance and other institutions that provide independent, verifiable, valuable information to consumers about the quality of health insurance choices available to them. I believe that by bringing together the traditional concept of consumer empowerment and the relatively new technology of the World Wide Web that we help more American decision makers make better decisions about the health care choices before them.

Mr. Chairman, I urge the adoption of the amendment.

Mr. BILBRAY. Mr. Chairman, I rise in support of the amendment offered by the gentleman from New Jersey.

The majority has had an opportunity to review the amendment which would require that, as the gentleman said, that the director maintain Internet linkages to appropriate sites and provide information on consumer satisfaction with health care and specifically health maintenance organizations, and we are prepared to accept the amendment.

Mr. BROWN of Ohio. Mr. Chairman, I move to strike the last word.

I rise in support of the Andrews amendment and compliment him on his forward thinking on this issue. Transparency in the health care system is particularly important. I think this will contribute to that, and I ask Members on this side of the aisle and both sides of the aisle to support the Andrews amendment.

The CHAIRMAN. The question is on the amendment, as modified, offered by the gentleman from New Jersey (Mr. ANDREWS).

The amendment, as modified, was agreed to.

AMENDMENT NO. 16 OFFERED BY MR. DAVIS OF ILLINOIS

Mr. DAVIS of Illinois. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 16 offered by Mr. DAVIS of Illinois:

Page 6, strike lines 6 through 10 and insert the following:

''(2) REQUIREMENTS.—In developing priorities for the allocation of training funds under this subsection, the Director shall take into consideration shortages in the number of trained researchers who are members of one of the priority populations and the number of trained researchers who are addressing the priority populations.

Mr. DAVIS of Illinois. Mr. Chairman, let me first of all commend the gentleman from Florida (Mr. BILIRAKIS) and the ranking member, the gentleman from Ohio (Mr. BROWN), for the work that they have done on this particular bill.

Mr. Chairman, the mission of this bill is to enhance the quality appropriateness and effectiveness of health services and access to those services. The amendment that I offer today is consistent with the underlying mission of the bill. This amendment seeks to address the issue of under-representation of individuals from the priority populations who receive training funds. This amendment merely suggests that the director take into consideration to the extent possible shortages in the number of trained researchers who are members of one of the priority populations and the number of trained researchers who are addressing the priority populations.

Mr. Chairman, it is my position that trained individuals with the greatest levels of contact, experiences and interactions with priority populations have a better chance to have acquired keener insight into understanding the characteristics and behaviors of these population groups. That keener insight may help them better understand factors which impede individuals in priority populations from movement towards acquisition of equity in health care and health status. Their greater familiarity with low-income and minority groups may afford them the level of sensitivity that is needed to get them the results which are desired.

Mr. Chairman, it is not easy to arrive at the desired results because when we look at the numbers of pre- and post-doctoral fellows, health researchers

and medical doctors, the numbers from priority populations are very low and, in some instances, are in danger of even getting lower. According to Dr. Robert G. Petersdor, President of the Association of Medical Colleges, in 1992, he stated that not only have we not made any progress since the mid-1970s toward our goal of providing equitable access to medical school for students from all of society, we have been losing ground. For example, in 1996 there were reported to be 737,734 physicians in this country: 373,539 or 50.6 percent were of the majority population, 13,759 or 1.8 percent were black, 21,841 or 3.0 percent were Hispanic, 48,913 or 6.6 percent were Asian Oriental, 225 or .0003 or three tenths of one thousandth percent were American Native Alaskan, 11,943 or 1.6 percent with others, and 267,544 or 36.0 percent were unknown. Of course, the American Medical Association only had racial and ethnic data on about 64 percent of all the physicians in the United States.

In 1996, there were 100 fewer under-represented minorities accepted into medical schools and only 10 percent of all medical school graduates were members of these under-represented minority groups who make up a total of approximately 28 percent of the total U.S. population.

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We ought to make every effort to find individuals from these populations; and, in addition, we must make sure that these priority populations are adequately covered in terms of the number of trained researchers. It is my understanding that the Department of Health and Human Services supports this amendment and agrees that this effort must be made.

Therefore, I would urge its immediate adoption.

Mr. BILIRAKIS. Mr. Chairman, I rise in support of the amendment.

Mr. Chairman, the majority has had an opportunity to review the amendment which would require, as the gentleman said, that the director in allocating health services training grants under section 902 take into consideration shortages in the number of trained researchers who are one of a number of priority populations, as well as shortages in the number of trained researchers who are addressing the priority of populations. We are prepared to accept the amendment.

Mr. BROWN of Ohio. Mr. Chairman, I move to strike the last word.

Mr. Chairman, I rise in support of the Davis amendment and commend the gentleman on his work in promoting equal access for medical researchers and medical training. I think it is certainly an issue whose time has come. I thank the gentleman from Illinois for his work and ask the support of the House for the Davis amendment.

The CHAIRMAN pro tempore (Mr. QUINN). The question is on the amendment offered by the gentleman from Illinois (Mr. DAVIS).

The amendment was agreed to.

AMENDMENTS NO. 2 AND NO. 1 OFFERED BY MS. JACKSON-LEE of texas

Ms. JACKSON-LEE of Texas. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 2 offered by Ms. JACKSON-LEE of Texas:

Page 4, line 14, insert ''In inner-city areas and'' after ''health services''.

Ms. JACKSON-LEE of Texas. Mr. Chairman, let me thank the ranking member and the chairman and their staff for the cooperation with my staff on an issue that I think we all can agree on. Let me also note my agreement with the amendments of the gentleman from Illinois (Mr. DAVIS), in talking about adding historically black colleges and Hispanic-serving colleges to the idea or the concept of research.

This amendment adds the language ''inner-city'' to the provision of the bill which speaks to rural health care, and it does speak to minority groups; but this now makes it in particular an emphasis on some of our urban and inner-city areas.

I come from one of the largest cities in the Nation, in fact the fourth largest city in the Nation, and am an avid supporter for the access of health care to be spread throughout our Nation, rural areas, urban areas, and our particular unique groups. But I think it is important to emphasize some of the special health care needs that we find in the inner city in populations that tend to be minority.

For example, let me bring to the attention of my colleagues that, although we are talking about another matter, appropriations, I do not know if they are aware of the fact that last year we had 783 rural health clinics, and we are now down to 483 rural health clinics, particularly in my State, in the State of Texas.

In addition, we have determined that a one-third decrease has occurred in inner-city health clinics. So we know for sure that we are declining in the access of health care. So this particular legislation, which focuses on the research and determination of access and better health care, is extremely important.

If I might cite for you the issue of AIDS, it disproportionately affects the minority populations. Racial and ethnic minorities constitute approximately 25 percent of the total U.S. population, yet they account for nearly 54 percent of all AIDS cases. During 1995 and 1996, AIDS death rates declined 23 percent for the total U.S. population, while declining only 13 percent for blacks and 20 percent for Hispanics. Contributing factors for these mortality disparities include late identification of disease and lack of health insurance to pay for drug therapies. So this bill's actual impact will be far reaching as we define minorities to include the inner cities.

For men and women combined, blacks have a cancer death rate about 35 percent higher than that for whites. The incidence rate for lung cancer in black men is about 50 percent higher than in white men. Native Hawaiian men, Alaskan native men and women, Vietnamese women and Hispanic women particularly suffer from elevated rates of cancer; and although these different groups are located throughout the United States, many times, because of job searches, they look for the inner city and find themselves in the inner city. In fact, Mr. Chairman, many new immigrant groups will find themselves in the inner city additionally.

I would also like to note that, again, major disparities exist upon population groups, particularly for minority and low-income populations. The age-adjusted death rate for coronary heart disease for the total population declined by 20 percent from 1987 to 1995. For blacks, the overall decrease was only 13 percent. So we can see the screening for cholesterol is extremely important.

Diabetes is extremely important, which results in the complications such as end-stage renal disease, and amputations are much higher among black and American Indians when compared to the total population.

I am very pleased that we have this legislation on the floor of the House, and I simply would like to add this language of the inner city in order to ensure that all of the resources that are brought to bear on this problem will get all of our populations, and particularly those who suffer the greatest lack of access to health care.

I close by simply saying, Mr. Chairman, I have a very large public health system. It is overwhelmed. In fact, it suffers from lack of resources. I do know that the more knowledge we have about access of health care for minorities and inner-city residents, along with rural communities, will help our country in doing a better job of serving our constituencies. I would like my colleagues and solicit my colleagues' support for this amendment.

Mr. Chairman, I rise to offer an amendment to H.R. 2506 that would include inner city areas as special populations that deserve priority. I commend my colleagues for introducing this legislation to improve the quality and effectiveness of health services. This amendment simply extends the reach of this measure to areas of society that desperately need our assistance.

As written, this bill would provide innumerable benefits to Americans, but we must not be blind to the fact that many Americans cannot drink from this well. It is a sad fact that nowhere are divisions of race and ethnicity more sharply drawn than in the health of our people.

For instance, AIDS disproportionately affects minority populations. Racial and ethnic minorities constitute

approximately 25 percent of the total U.S. population, yet, they account for nearly 54 percent of all AIDS cases. During 1995 and 1996, AIDS death rates declined 23 percent for the total U.S. population while declining only 13 percent for blacks and 20 percent for Hispanics. Contributing factors for these mortality disparities include late identification of disease and lack of health insurance to pay for drug therapies.

Cancer is also a leading cause of death in America. Many minority groups suffer disproportionately from cancer. Disparities exist in both mortality and incidence rates. For men and women combined, blacks have a cancer death rate about 35 percent higher than that for whites. The incidence rate for lung cancer in black men is about 50 percent higher than in white men. Native Hawaiian men, Alaskan native men and women, Vietnamese women, and Hispanic women particularly suffer from elevated rates of cancer. We must provide far greater screening opportunities for these members of society, and we can do so with this amendment.

Cardiovascular disease is a leading killer and a leading cause of disability in the United States. Again, major disparities exist among population groups, particularly for minority and low-income populations. The age-adjusted death rate for coronary heart disease for the total population declined by 20 percent from 1987 to 1995; for blacks the overall decrease was only 13 percent. Rates of screening for cholesterol show disparities for racial and ethnic minorities, and without such screening, our citizens will continue to suffer from the debilitating effects of cardiovascular disease.

Diabetes also affects more minorities than whites. The prevalence of diabetes is approximately 70 percent higher than whites and the prevalence in Hispanics is nearly double that of whites. Preventative interventions should target high-risk groups. Diabetes complications such as End-Stage Renal Disease and amputations are much higher among black and American Indians when compared to the total population. Early detection, improved care, and education can prevent this disease from incapacitating America's men and women. But we must provide these important health care services.

Finally, infant mortality remains a threat to our children. Although the rate has declined to a record low of 7.2 per 1,000 live births in 1996, infant mortality still greatly threatens certain racial and ethnic groups. Infant death rates among blacks, American Indians and Alaska natives, and Hispanics were all above the national average. Infant morality can be combated with timely prenatal care, but 84 percent of white pregnant women received such care while only 71 percent of black and Hispanic pregnant women received early pre-natal care. Eliminating these disparities requires the removal of financial, educational, social, and logistical barriers to health care services.

This bill, as written, appropriately recognizes that rural areas are in particular need of health care. But as statistics clearly indicate, the inner city areas also need quality health care, and we can provide just that with this amendment. I strongly urge my colleagues to support this common-sense amendment.

Mr. BILIRAKIS. Mr. Chairman, will the gentlewoman yield?

Ms. JACKSON-LEE of Texas. I yield to the gentleman from Florida.

Mr. BILIRAKIS. Mr. Chairman, I thank the gentlewoman for yielding, and I say to her that the majority has had an opportunity to review the amendment, which would add inner-city areas to rural and frontier areas among the geographic priority populations included in the submission.

I commend the gentlewoman for formulating this amendment, and we are prepared to accept it.

Mr. BROWN of Ohio. Mr. Chairman, will the gentlewoman yield?

Ms. JACKSON-LEE of Texas. I yield to the gentleman from Ohio.

Mr. BROWN of Ohio. Mr. Chairman, I thank the gentlewoman from Houston and rise in support of the amendment. It makes good sense with the HCPR's work in the past in rural areas that inner cities should be included, and ask for support of the amendment.

Ms. JACKSON-LEE of Texas. Mr. Chairman, reclaiming my time, I thank the gentleman very much. Again, let me thank the chairman and the ranking member for their excellent leadership on this legislation.

Mr. Chairman, I have another amendment. There are colleagues on the floor. I would be able to discuss that amendment very quickly within this time frame and have us all out of the way. I understand that we have mutual agreement on moving forward.

Is that appropriate at this time, so that my other colleagues can go forward?

The CHAIRMAN pro tempore. The gentlewoman controls the time.

Ms. JACKSON-LEE of Texas. Mr. Chairman, I have an amendment at the desk.

The CHAIRMAN pro tempore. Is the gentlewoman asking to offer her amendment at this time?

Ms. JACKSON-LEE of Texas. I am.

The CHAIRMAN pro tempore. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 1 offered by Ms. JACKSON-LEE of Texas:

Page 4, line 9, strike ''(c)'' and all that follows through ''the Director shall'' on line 11 and insert the following:

''(c) REQUIREMENTS WITH RESPECT TO SPECIAL POPULATIONS.—There is established within the Agency an office to be known as the Office on Special Populations, which shall be headed by an official appointed by the Director. The Director, acting through such Office, shall''.

The CHAIRMAN pro tempore. Is there objection to considering these amendments en bloc?

There was no objection.

The CHAIRMAN pro tempore. The gentlewoman from Texas is recognized for 5 minutes.

Ms. JACKSON-LEE of Texas. Mr. Chairman, this amendment is dealing with creating an Office of Special Populations within the Agency for Health Research and Quality which will give us the opportunity to focus on the authority to conduct health care research, demonstration projects and evaluations with respect to low-income groups and minority groups.

I would simply say that this complements the earlier amendment that I have and would be delighted to have these accepted en bloc.

I rise to offer an amendment to H.R. 2506, the Health Research and Quality Act of 1999 that would create an office known as the Office on Special Populations, which shall be headed by an official appointed by the director.

I commend my colleagues for introducing this legislation to provide higher quality and more effective health services to our citizens. This bill will improve health care services and will provide greater prevention of diseases and other health conditions through improvements in clinical and health system practices.

Currently, the bill designates a Director of the Agency for Health Care Policy and Research to oversee this measure. While I agree that we must provide oversight to this plan, I feel that one position cannot possibly serve the needs of our citizens. My amendment would diminish the burden on the Director by providing an Office of Special Populations.

This office also would help the Director pinpoint the dilemmas facing our special populations—those living in rural or inner city areas. It is clear that these areas suffer from disease and health-related problems to a far greater extent than other areas.

A great disparity exists between whites and certain races and ethnic cultures. At this time, we do not know all of the reasons for this disturbing gap. Inadequate education, disproportionate poverty, discrimination in the delivery of health services, cultural differences likely contribute to the problem. This office could study these factors and pinpoint those that most affect the rural and inner city areas. Such research greatly would contribute to our ability to then find solutions to our current problems and would allow our health services to reach the people who need them the most.

This office would work concurrently with the Director to study and determine appropriate measures that will improve our Nation's health care. This office clearly would provide a support system for the Director, and it is my hope that this office would increase the overall efficiency of the Agency for Health Care Policy and Research.

The disparities that are detrimentally affecting our inner city and rural areas are unacceptable. We must provide a comprehensive initiative that will effectively eliminate this gap. This amendment would achieve such a goal by providing an office whose mission is to eliminate disparities in health care. I urge my colleagues to support this vital amendment.

Mr. BILIRAKIS. Mr. Chairman, I rise in support of the amendment.

Mr. Chairman, again, to reiterate, we have had an opportunity to review the

amendment, which would establish this Office of Special Populations within the agency to which the director would carry out the requirements specified in said section 901(c). We are prepared to accept the amendment.

Mr. BROWN of Ohio. Mr. Chairman, I move to strike the last word.

Mr. Chairman, I agree with the second part of the amendment too and support the en bloc amendment and commend the gentlewoman from Texas (Ms. JACKSON-LEE) for her good work on this.

The CHAIRMAN pro tempore. The question is on the amendments offered by the gentlewoman from Texas (Ms. JACKSON-LEE).

The amendments were agreed to.

AMENDMENT NO. 17 OFFERED BY MR. DAVIS OF ILLINOIS

Mr. DAVIS of Illinois. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 17 offered by Mr. DAVIS of Illinois:

Page 7, after line 14, insert the following subsection:

''(g) ANNUAL REPORT.—Beginning with fiscal year 2003, the Director shall annually submit to the Congress a report regarding prevailing disparities in health care delivery as it relates to racial factors and socio-economic factors in priority populations.''

Mr. DAVIS of Illinois. Mr. Chairman, I once again would commend the chairman and ranking member of this committee for the manner in which they have been able to bring this bill before us.

Mr. Chairman, this amendment seeks to make sure that Congress has the necessary information regarding prevailing health disparities by requiring an annual report to be submitted beginning with the fiscal year 2003 regarding prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors.

Mr. Chairman, racial and ethnic minority populations are among the fastest growing of all communities in America. Unfortunately, as African Americans, Hispanic, American Indians, Asian Americans and other Pacific Islanders in many respects have continued to grow, so too have their disparities in health care. These groups have poorer health and remain chronically underserved by the health care system.

Significant gaps in health data still exist, as we have not kept pace with growth of these population groups with health care infrastructure and personnel. Historically, participation in research and data gathering activities on the part of some minority groups has been modest, and especially among African Americans, who are wary of research and researchers, stemming in part from knowledge of the Tuskegee experiment, when the Federal Government withheld a syphilis cure from hundreds of male participants in a study that lasted 4 decades. President Clinton apologized for that experiment last spring, although it occurred long before his watch.

Fortunately, new approaches, techniques, guarantees and protective protocols are being put into place and used to make data gathering and research more appealing. These population groups are responding more positively, and we need to make sure that these focuses and activities continue.

I am aware that the Secretary of Health and Human Services has announced a plan to end racial disparities in health care and require the collection of data relative to racial factors. However, in this robust economy we have witnessed a widening of the gap in health care disparities. One would hope that we would have been more effective in narrowing the gap between the have's and the have-not's and between minority and majority population groups. In many instances, that has not happened.

Age-adjusted breast cancer mortality increased 3.9 percent for black women and declined 15.4 percent for white women between 1985 and 1996. While the number of tuberculosis cases among non-Hispanic whites actually decreased 42.9 percent between 1986 and 1997, the number of reported tuberculosis cases increased 51.1 percent for Asian Americans and Pacific Islanders and 30.3 percent for Hispanics, according to the Center for Disease Control.

I could go on and on and cite statistics relative to the prevalence of prostate cancer in African American men and the increasing rates of HIV-AIDS infection for African American women.

In short, we need an annual report to measure whether we are making progress in ending racial disparities in health care and improving the quality of life for all Americans.

This report will also underscore where we need to direct our resources and research. In my congressional district, for example, we have 22 hospitals, some of the finest in the country. At the same time, we have 175,000 people living at or below the poverty level. We also have some of the most dire health status indicators in Western civilization.

This amendment is designed to try and make sure that we have adequate and accurate information on which to base policy and budgetary decisions.

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Therefore, I urge support of this amendment and urge its immediate adoption.

Mr. BILIRAKIS. Mr. Chairman, I move to strike the last word.

Mr. Chairman, I just want to say that the majority has had an opportunity to review this amendment, which would require that the director of the agency submit an annual report to the Congress beginning with fiscal year 2003 regarding prevailing disparities in health care deliveries as related to racial and socioeconomic factors in priority populations.

We are prepared to accept the amendment and also commend the gentleman from Illinois (Mr. DAVIS) for his insight and preparation of this and the other amendments.

Mr. BROWN of Ohio. Mr. Chairman, I rise in support of the Davis amendment.

Mr. Chairman, I congratulate him and compliment him on his work on a very important issue. I think that the disparity in health care delivery, especially as it relates to different racial groups, different socioeconomic groups, is one of the most serious problems our health care system faces.

It is not something we have done especially well as a Nation or as a society in the past, and I think the Davis amendment is a major step forward in alleviating some of those discrepancies and variations.

I thank the gentleman for his good work and ask for support of his amendment.

The CHAIRMAN pro tempore (Mr. QUINN). The question is on the amendment offered by the gentleman from Illinois (Mr. DAVIS).

The amendment was agreed to.

AMENDMENT NO. 6 OFFERED BY MR. DAVIS OF ILLINOIS

Mr. DAVIS of Illinois. Mr. Chairman, I offer amendment No. 6.

The CHAIRMAN pro tempore. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 6 Offered by Mr. DAVIS of Illinois:

Page 21, line 6, insert after ''agencies,'' the following: ''minority institutions of higher education (such as Historically Black Colleges and Universities, and Hispanic institutions),''.

Mr. DAVIS of Illinois. Mr. Chairman, this amendment seeks to recognize the unique diversity of our Nation and take full advantage of minority institutions in clinical practice and technology innovation. This amendment simply urges the director to consider utilizing minority institutions such as historically black colleges and universities and Hispanic institutions when awarding such grants regarding healthcare technology.

Our historically black colleges and universities have produced some of the greatest pioneers in the medical profession, for example, Charles Richard Drew, who was the pioneer of blood plasma preservation, to Ernest Just, who formulated new concepts of cell life and metabolism and pioneered investigations of egg fertilization.

Inclusion of minority institutions in medical research has been inadequate. The National Institutes of Health Office of Financial Management reported that in 1997 they spent $12.7 billion on medical research. Of that, $8.46 billion went to higher education institutions. Historically black colleges and universities received just $79.8 million of these dollars, less than 1 percent of the National Institutes of Health higher-education pie.

It is our diversity that strengthens us as a Nation. Someone remarked that we are a Nation of communities, of tens and thousands of ethnic, religious, social, business, labor union, neighborhood, regional and other organizations, all of them varied, voluntary and unique; a brilliant diversity spread like stars, like a thousand points of light in a broad and peaceful sky.

This amendment merely seeks to capitalize on this Nation's great diversity by making minority institutions eligible and by urging them to seek these grants. I believe that this is an important amendment because it places valuable resources in the hands of institutions that are capable and able to help produce the needed researchers and professionals that this country relies so much upon. I urge adoption of this amendment.

Mr. BILIRAKIS. Mr. Chairman, I move to strike the last word.

Mr. Chairman, the majority has had an opportunity to review the amendment, finds that it is consistent with the functions of the agency which would expand the eligible entities to receive grants and contracts for clinical practices and technology innovation, as determined by the director to include minority institutions of higher education. We are prepared to accept the amendment.

Mr. BROWN of Ohio. Mr. Chairman, I rise in support of the amendment.

Mr. Chairman, the amendment underscores how all society benefits from the richness of diversity. I ask for support of the Davis amendment.

The CHAIRMAN pro tempore. The question is on the amendment offered by the gentleman from Illinois (Mr. DAVIS).

The amendment was agreed to.

AMENDMENT NO. 7 OFFERED BY MR. THOMPSON OF CALIFORNIA

Mr. THOMPSON of California. Mr. Chairman, I offer an amendment.

The CHAIRMAN pro tempore. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 7 offered by Mr. THOMPSON of California:

Page 21, after line 8, insert the following subsection:

''(d) MEDICAL EXAMINATION OF CERTAIN VICTIMS.—

''(1) IN GENERAL.—In carrying out subsection (a), the Director shall promote evidence-based clinical practices for—

''(A) the examination and treatment by health professionals of individuals who are victims of sexual assault (including child molestation) or attempted sexual assault; and

''(B) the training of health professionals on performing medical evidentiary examinations of individuals who are victims of child abuse or neglect, sexual assault, elder abuse, or domestic violence.

''(2) CERTAIN CONSIDERATIONS.—Evidence-based clinical practices promoted under paragraph (1) shall take into consideration the expertise and experience of Federal and State law enforcement officials regarding the victims referred to in such paragraph, and of other appropriate public and private entities (including medical societies, victim services organizations, sexual assault prevention organizations, and social services organizations).''

Mr. THOMPSON of California. Mr. Chairman, I would like to commend the Committee on Commerce and the bill's sponsors, the gentleman from Florida (Mr. BILIRAKIS) and the gentleman from Ohio (Mr. BROWN), for bringing this important bill to the floor today for our consideration.

Mr. Chairman, thousands of individuals are sexually assaulted or abused in our country every year. Over 300,000 individuals were the victim of rape or sexual assault in 1998 alone. Many are children and many are elderly. In fact, recent studies reveal that an increasingly high percentage of the victims of rape or sexual assault are likely to be children. Fifteen percent of rape victims are under the age of 12, and 44 percent are under the age of 18.

These are the most awful of crimes, and Congress has responded with enactment of new Federal penalties in 1994, as well as the establishment of a number of grant programs under the landmark Violence Against Women Act. There remain gaps in our Nation's response to this type of violence, particularly in our ability to prosecute the perpetrators. The amendment I offer is intended to fill some of these gaps.

The amendment adds an important provision related to the quality of the training of health professionals in several very sensitive areas of their work: the identifications, treatment, and examination of victims of sexual assault and the collection of forensic evidence for the use of possible criminal prosecutions.

While services encountered in some metropolitan centers can be excellent, access to trained medical practitioners is restricted and unevenly distributed. Many rural, mid-sized counties, and geographically large urban areas lack health professionals trained in identifying and treating victims of sexual assault and in conducting evidentiary examinations, collecting and preserving evidence and in interpreting findings. Many are inexperienced in collaborating with law enforcement agencies and investigating social workers.

As a result, many victims of child molestation, domestic violence, and elder abuse are underserved or ill-served in the medical treatment and counseling that they receive. At the same time, in instances where proper evidence collection procedures are not followed, district attorneys are forced to drop charges against dangerous perpetrators for lack of evidence. Rather than rely on bad testimony or testimony given by children who are emotionally wrought because of the crime that had been committed against them, the prosecutor is forced to allow the perpetrator to walk away; and this person is often free to do his crime or her crime again.

Lack of proper training and lack of retraining appears to be a particular problem in acute cases and in areas where multidisciplinary teams are not readily available. Lack of experience can have several deleterious consequences. First, professionals who lack experience with the delicate nature of such evaluations may psychologically traumatize children.

Mr. Chairman, the amendment before this body requires the director of the Agency for Health, Research and Quality to set forth and promote evidence-based clinical practices for identifying, examining, and treating victims of sexual assault and training medical professionals on how to perform medical evidentiary exams in child physical and sexual abuse, domestic violence and elder abuse cases.

The amendment is supported by a number of groups, including the International Association of Forensic Nurses, the National Association of Social Workers, the Pennsylvania Coalition Against Rape, and the administration. This amendment is a small but important step in addressing a serious national problem, and I urge its adoption.

Mr. BILIRAKIS. Mr. Chairman, I move to strike the last word.

Mr. Chairman, the staff has, as they have in all of these amendments, reviewed this amendment, spent an awful lot of time in many cases with the proposers' staffs. We have had an opportunity to review this particular amendment along with the others, which would require the director to include among the evidence-based clinical practices and health-care technologies promoted by the agency, the examination and treatment of victims of sexual assault, the training of health professionals in performing medical evidentiary examinations of persons who are victims of sexual assault, and we are prepared to accept this very good amendment.

Mr. BROWN of Ohio. Mr. Chairman, I rise in support of the Thompson amendment.

Mr. Chairman, I congratulate my friend from California (Mr. THOMPSON) for his leadership on issues of child abuse and abuse of the elderly. This amendment will lead to better training of health professionals to deal with those problems of sexual abuse and child abuse and abuse of the elderly, and I ask the House for support of the Thompson amendment.

The CHAIRMAN pro tempore. The question is on the amendment offered by the gentleman from California (Mr. THOMPSON).

The amendment was agreed to.

AMENDMENT NO. 20 OFFERED BY MR. PASCRELL

Mr. PASCRELL. Mr. Chairman, I offer an amendment.

The CHAIRMAN pro tempore. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 20 offered by Mr. PASCRELL:

Page 13, after line 5, insert the following subsection:

''(d) CANCER AND CARDIOVASCULAR DISEASES IN WOMEN.—The Director shall conduct and

support research and build private-public partnerships to enhance the quality, appropriateness, and effectiveness of and access to health services regarding cancer and cardiovascular diseases in women, including with respect to the comparative effectiveness, cost-effectiveness, and safety of such services.''

Mr. PASCRELL. Mr. Chairman, I would like to congratulate the gentleman from Florida (Mr. BILIRAKIS) for this terrific piece of common sense legislation. The amendment that I bring to the floor does not seek to undo any of the positive aspects of the bill. Instead, it improves upon an already outstanding bill by addressing one of our Nation's silent killers.

While there is a growing awareness of the devastating impact that breast cancer has on American women, there is still a misguided belief that cancer and cardiovascular disease are men's diseases. My amendment simply seeks to shine the light on this misinterpretation.

These misconceptions have kept us from realizing that these debilitating and deadly diseases have been historically understudied when it comes to their effect on women. In fact, it was not until the last decade that we have pushed the scientific and medical communities to study how diseases specifically impact upon women.

As we all know, cardiovascular disease is the leading killer in this country. Approximately 960,000 Americans die of cardiovascular disease each year. What is not well known is that more women die of this disease each year than men. Women have different heart attack symptoms than men. Therefore, they are frequently misdiagnosed. Where a man may have chest pain, left arm numbness, a woman may have a shortness of breath and stomach pain, symptoms that are seen in many other conditions, not just heart attacks.

Although women live longer than men, they typically suffer from other chronic disease which mask heart attack symptoms. Women also die of heart attacks at greater rates than men do. The lack of research in women's health issues has also been seen in cancer research. Cancer is the second leading killer in women, with lung cancer as the leading cause of cancer death.

Significantly, over the past 10 years, the death rate from lung cancer has declined in men, but has continued to rise in women. Women also suffer from breast, colorectal, cervical, and ovarian cancers at alarming rates. Although ovarian cancer has the lowest incidence of death, this is the deadliest of all cancers.

Let me explain for a second what I mean.

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One woman in 55, will develop ovarian cancer over her lifetime, one in 55; yet the 5-year survival rate for ovarian cancer is 35 to 47 percent. In contrast, prostate cancer has a 5-year 87 percent survival rate.

We all agree that we have reached a day where we must study these diseases further. We must also come to an understanding that diseases affect men very differently than they affect women.

Gender-specific research is critical in the move toward better treatment. Just as we must focus on rural and urban and underserved populations, we must also focus on the studying and treating women in the most beneficial, cost-effective, and safe way.

The Health Research and Quality Act gives such an opportunity when it comes to studying heart disease and cancers in woman. That will help us meet our shared goal of providing the best of all care.

I urge my colleagues to support my amendment.

Mr. BILIRAKIS. Mr. Chairman, will the gentleman yield?

Mr. PASCRELL. Yes, I yield to the gentleman from Florida.

Mr. BILIRAKIS. Mr. Chairman, I asked the gentleman to yield just to share with the House that the majority has had an opportunity to review his amendment which would require that the director bill private-public partnerships, enhance the quality of and access to health services regarding cancer and cardiovascular services for women.

I would also report to the gentleman that we have a markup at my committee in a couple of days, a breast cancer markup, a very important piece of legislation.

We are prepared, Mr. Chairman, to accept the amendment.

Mr. BROWN of Ohio. Mr. Chairman, I move to strike the last word.

Mr. Chairman, I thank the gentleman from New Jersey (Mr. PASCRELL), my friend, on his leadership on this issue and ask the House for support on the Pascrell amendment.

Two weeks ago, I sponsored a women's health fair in Brunswick, Ohio, in my district. Among other speakers was Dr. John Schaeffer, a prominent cardiologist from Elyria, Ohio, who talked about many of the things and emphasized many of the statements that the gentleman from New Jersey (Mr. PASCRELL) mentioned, among them that the incidence of heart attacks in men is higher, but the mortality rates are higher for women.

In other words, men are much more likely to recognize the symptoms of heart disease because we, too often, in this society have said that heart disease is a male disease more and not a female disease. But the fact is it is the largest killer among women. More women die of heart attacks than men. Women need to be aware of the symptoms that are present in heart attacks. As we have instructed men in this society to be aware of the symptoms, we need to do the same with women.

I think including the Pascrell amendment in this legislation will be a major step towards that. I ask the House support of the Pascrell amendment.

The CHAIRMAN pro tempore (Mr. QUINN). The question is on the amendment offered by the gentleman from New Jersey (Mr. PASCRELL).

The amendment was agreed to.

AMENDMENT NO. 9 OFFERED BY MR. TIERNEY

Mr. TIERNEY. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 9 offered by Mr. TIERNEY:

Page 12, after line 14, insert the following subparagraph:

''(C) The conduct of research on methods to reduce the costs to consumers of obtaining prescription drugs.

Page 12, line 15, strike ''(C)'' and insert ''(D)''.

Mr. TIERNEY. Mr. Chairman, my amendment is rather brief. What it does is it seeks to have this following subparagraph, ''the conduct of research on methods to reduce the costs to consumers of obtaining prescription drugs,'' be included in this bill.

Mr. Chairman, prescription drugs can improve health care, and it can save lives. But these benefits cannot be realized unless patients can afford their medications.

H.R. 2506 already requires research on ways that new and appropriate uses of drugs can improve health quality and costs. Our amendment would simply add support for research on ways of promoting prescription drug affordability as well.

Pharmaceutical manufacturers may argue that reducing prescription drug costs to consumers will reduce the profit incentive that drives researchers to develop new drugs. But, Mr. Chairman, that is a myth.

Currently, the drug companies enjoy such large profits that they have ample room to cut costs without sacrificing research. The largest pharmaceutical manufacturers spend less on research and development than they make in pure profit; and the size of that profit is, indeed, substantial. The drug industry is three times more profitable than the average profitability of all other Fortune 500 industries.

Moreover, if individual U.S. purchasers paid less, the drug manufacturers would likely continue to maintain their high-profit levels. They would simply make up for the decreased revenue by spreading costs, for instance, to other countries that now consistently pay far lower prices for their prescription drugs than do citizens in this country. Currently, many Americans find prescription drugs unaffordable, particularly our seniors.

A recent Standard and Poor's report on the pharmaceutical industry tells us that drugmakers have historically raised prices to private consumers to compensate for the discounts they grant to managed-care customers.

Seniors in my district, Mr. Chairman, and in my colleagues' are victims of this price discrimination. When we studied this issue in my district, we

found that seniors were being forced to pay, on average, more than twice as much as the large insurance companies' clients.

Other countries are also benefiting from discounts. Other countries are benefiting from discounts far more than our country. A drug that would cost $100 in the United States costs only $76 in Canada, $67 in Britain, $47 in Sweden, and $32 in Australia. There certainly is room for equalizing prices.

Let me add the human dimension to what we are talking about, Mr. Chairman. One of my constituents, Louise Duda of Newburyport, Massachusetts, recently had a letter published in the local newspaper, the Daily News of Newburyport. It was a tragically familiar tale, one that I am sure many of my colleagues can already account in their districts.

Mrs. Duda begins her letter by saying: ''I am sitting at my desk, with an involuntary flow of tears streaming down my cheeks. My husband sits close by, silently. I am angry, distraught, and feeling extremely defenseless. Why is our Government heartless toward the most vulnerable segment of our society?''

The letter goes on in which Mrs. Duda says: ''My husband just returned from the drugstore. When I read the receipt, I felt a sense of panic and my eyes welled up. $250? This has to be a mistake. No, it is $250. But how can that be? We just paid $400 2 weeks ago. We can't keep doing this. Our income tax return bailed us out the last time. Now what? I took a quick mental inventory of our financial status. Our one credit card is maxed. Our bankruptcy prevents us from obtaining a loan. We are living paycheck to paycheck. We have overdraft, but when that's exhausted, what do we do?'' She has no aces. She has no hope, just a prayer.

Mr. Chairman, I urge our colleagues to vote on this amendment to find an answer to Louise Duda's question about what we do about lowering the cost of prescription drugs in this country. I ask that Members help support the prescription drug affordability by supporting this common sense amendment.

Mr. BILIRAKIS. Mr. Chairman, I move to strike the last word.

Mr. Chairman, I commend the gentleman from Massachusetts (Mr. TIERNEY) for his amendment. We have spent the better part of today on a prescription drug hearing in my subcommittee and have another one scheduled for next week and one for shortly thereafter.

As the gentleman from Ohio (Mr. BROWN) knows, prescription drug problems is the forefront of what we are doing up here these days, and well it should be. Even though the agency, I think it is quite clear that their functions would include something like this, it is good that we sort of focus and highlight the need for many of these amendments, to basically instill in the agency the thought that, yes, they have got to spend some time on them.

So anyhow, we have studied this amendment and are prepared to accept it. I thank the gentleman from Massachusetts for offering it.

Mr. BROWN of Ohio. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I rise in support of the Tierney amendment and thank him for his efforts in a major step in dealing with the high price of prescription drugs that the gentleman from Maine (Mr. ALLEN) has worked on and the gentleman from California (Mr. WAXMAN) and the gentleman from Florida (Mr. BILIRAKIS) and the gentleman from Vermont (Mr. SANDERS) and the gentleman from Texas (Mr. TURNER) and many in this institution, the gentleman from Arkansas (Mr. BERRY), and others.

Some brief facts that I think that this agency will look at and need to look at about the price of prescription drugs: forty-three percent of the cost of research for new prescription drug products in this country are paid for by the National Institutes of Health; forty-three percent of the research dollars spent are spent by taxpayers through the National Institutes of Health.

Drug companies themselves pay only about 50 percent of all their research costs in this country in developing new prescription drugs.

In addition, this Congress has bestowed tax cuts on those drug companies for the dollars that they do spend on research and development. In turn, U.S. consumers are given the privilege of paying the highest drug prices in the world, two times, three times, four times the price that prescription drugs cost in countries like Britain and France and Germany and Japan and Israel and other countries that have a different pricing mechanism for their prescription drugs.

Some allow something called parallel importing which brings sort of an international competition in the price of prescription drugs. Others allow something called product licensing which allows generics in the marketplace to compete so that prices are not monopoly priced and are not set so high unilaterally by the drug companies.

The third point I would add, Mr. Chairman, is that one-half the drugs that are developed, the new prescription drugs developed in this country, are developed for the world market or developed outside the United States. That says when the drug companies threaten this institution, as they have repeatedly, by saying if we do anything to lower drug prices, the bill by the gentleman from Maine (Mr. ALLEN) or the bill by the gentleman from Arkansas (Mr. BERRY) or my legislation or any other, if we do anything like that, they are going to cut back on research and development dollars.

The fact is half the drugs developed around the world are developed in countries where governments have actually acted to lower prescription drug prices.

I thank the gentleman from Florida (Mr. BILIRAKIS) for his hearing today. We are going to have another hearing next Monday, which will bring forward Members of this body who are supporting and sponsors of other prescription drug legislation.

We all know the problem of high price of prescription drugs. I think the Tierney amendment will go a long way towards exploring solutions so we can in our committee move forward in dealing with the high cost of prescription drugs.

I ask for support of the Tierney amendment.

Mr. ALLEN. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I want to begin by recognizing the work of the gentleman from Florida (Mr. BILIRAKIS) and the gentleman from Ohio (Mr. BROWN) on this most important issue and to thank the gentleman from Massachusetts (Mr. TIERNEY) for bringing this amendment forward.

The fact is that I believe this amendment is needed. The bill, as it stands, does allow research into the costs of health-care services and access to such services, and I agree with the chairman that conduct into the research of prescription drugs could be seen to be within that issue, but it is better to make it clear.

Therefore, the Tierney amendment, which specifically mentions the conduct of research on methods to reduce the cost to consumers to obtain prescription drugs is the right sort of amendment.

Whenever I talk to seniors in my district in Maine, the subject of prescription drugs comes up and particularly the high cost of prescription drugs. Seniors are not the only ones affected, however. The fact is that the most profitable industry in the country, which is the pharmaceutical industry, is charging the highest prices in the world to those people who can least afford it in this country; and those people are seniors and others without prescription drug coverage.

Seniors make up 12 percent of the population, but they buy 33 percent of all prescription drugs. Spending on prescription drugs in this country is going up at the rate of 15 percent every single year.

We are dealing with an issue that is of immediate importance to men and women all across this country who thought, when they retired, they would be able to figure out how to get by. But now they find that their next trip to the doctor may leave them unable to pay the electric light bill or the rent or to buy food.

This is a burning issue for America's seniors, 37 percent of whom have no prescription drug coverage at all, and a significant additional portion do not have adequate, reliable coverage.

In the midst of all of this, the pharmaceutical industry is running a national TV campaign to try to stop any reform, to try to prevent a benefit under Medicare and to stop the kind of discount that I and others here have been urging.

This is an important issue. We need to do research. We need to figure out why prices in this country for people least able to afford it are the highest in the world. That is an appropriate area of research. Therefore, I rise to support the Tierney amendment.

Mr. GREEN of Texas. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I rise in support of the Tierney amendment; but, first, I want to thank both the chairmen of our Subcommittee on Health and Environment and Committee on Commerce for the hearing today and also the commitment over the next few weeks to deal with this issue, at least through the committee process, and also the gentleman from Ohio (Mr. BROWN), the ranking member.

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This is one of the most important issues I think that Congress is facing, is how to provide prescription drugs at an affordable price to the people who need them most, our senior citizens.

Several bills have been introduced to achieve this goal, but each has been met by critics who claim they are either inadequate, too costly, or unfair price controls. In fact, I am a cosponsor of the Allan-Turner, et al. bill that we had that my colleague from Maine talked about.

In fact, to follow up on his, I have seen the Flo advertisements on TV, and I have a little concern. I want to make sure people in our country realize who is paying for that multimillion dollar campaign on TV. It is the pharmaceutical and drug companies. Because, obviously, they do not pay for that ad on TV in Canada or Mexico, where constituents in my district may have to go, oftentimes, driving 6 hours to Mexico to get their drug prescriptions at a cost they can afford. The Tierney amendment may help provide some answers to the concerns on affordability and which method would truly meet the needs of seniors.

The fact is our Nation's health care system has dramatically evolved over the past 10 to 20 years to the point that prescription drugs are not only a major component of the health care system, but they can be critical to an individual's survival. Everyone agrees we need to find a way to make prescription drugs more affordable to seniors, who are least able to afford them but who need them the most.

Seniors are being forced to choose between buying food or their prescription medications or even postponing taking their prescription medications. Instead of taking them one a day, as prescribed, they may take them every other day just because they cannot afford them.

Because Medicare does not cover prescription drugs, so many seniors, 37 percent according to the GAO, but I think in my district it is much higher, do not have any prescription drug coverage and may incur these expenditures out-of-pocket. Worse yet, many of these beneficiaries have very limited coverage that do not even come close to meeting their medical needs.

While I am sensitive to the need for drug manufacturers to make profits on their drugs, it is unacceptable that the bulk of these profits are made on sales to people who can least afford to pay those prices. Discounts are available to HMOs, to the U.S. Government, to hospitals, and even foreign countries, but seniors are forced to pay the full price. That is just not right, and something needs to be done to correct it.

This amendment will give an important agency the opportunity to look at these issues and answer some of the questions surrounding them. Everyone knows this is a complex and difficult problem to solve. However, sitting back and doing nothing is not an acceptable option. Today, not only with this amendment, with this study, but also with what the Subcommittee on Health and Environment of the Committee on Commerce is doing, we are moving forward on it.

As new drugs are developed and approved, the access gap to these potential life-saving treatments are only widened. This amendment is reasonable and sensible, and I am glad to be a cosponsor of not only this bill but also the Turner-Allan bill that will provide a solution to this problem. Support for this amendment is important to research and study methods and practices.

Mr. LUTHER. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, first of all, let me thank the gentleman from Massachusetts (Mr. TIERNEY) for bringing this amendment forward. I think he does us a great service in this body.

We have entered a remarkable period in our Nation's history. Never before have we had so many life-enhancing prescription drugs. Yet, let us face the facts. These remarkable achievements are today overshadowed by the exorbitantly high prices consumers in America are being required to pay for these prescription drugs.

This is why I rise in support of the Tierney amendment. This amendment would expressly direct this agency, an important agency, to address this issue, an issue that is perhaps the most important issue we face in health care today. It would require that agency to recommend ways to make drugs more affordable for American consumers.

Mr. Chairman, earlier this year, I requested a study on comparative drug prices in my home district in Minnesota. The report was issued in March of this year, and the results were astonishing. The report showed that the average retail prices for the five best selling drugs for older Americans in Minnesota are more than twice as high as the prices that drug companies charge their most favored customers. For one drug, Minnesotans actually paid a price 15 times higher than the price enjoyed by preferred customers. This does not just impact senior citizens, it affects all American consumers who do not have prescription drug coverage today.

This type of unfairness needs to be addressed, and that is exactly what this amendment does. It does not dictate policy or set up a new layer of bureaucracy, it simply directs that we look at ways to create fairness and to help American consumers afford the cost of these wonder drugs that are available today. I urge Members to support this amendment.

Mr. MCGOVERN. Mr. Chairman, I rise today in support of the amendment offered by my good friend JOHN TIERNEY instructing the Agency on Health Research and Quality to study methods of reducing the costs of prescription drugs to consumers. This is an important study in light of the focus on a Medicare prescription drug benefit, as well as the increase in pharmaceutical productions.

Prescription drugs are an important means of providing healthcare in an outpatient setting. However, the costs of these drugs are too high. Earlier this summer, I commissioned a study to specifically examine the cost of prescription drugs in the Worcester/Attleboro/Fall River, Massachusetts area. This was the first and only study of its kind examining drug prices in Central Massachusetts. The results were alarming.

On average, seniors get more than eighteen prescriptions filled each year. I was shocked to learn that uninsured seniors in my district—those without any prescription drug benefit—pay 136% more for their prescription drugs than the drug companies most favored customers. This means that if a most favored customer pays ten dollars for a prescription, the uninsured senior in my district will pay twenty-three dollars and sixty cents for that same prescription. It is unconscionable that people who can least afford to pay these high costs are being gouged by the drug companies in the name of profits and I am sickened that seniors in my district, and across the country, are forced to choose between buying groceries and medicine.

Our top priority must be a prescription drug benefit. However, this amendment is a first step in this Congress acknowledging that drug prices are too high for uninsured seniors. I support President Clinton's efforts to implement a prescription drug benefit. I also support Congressman TOM ALLEN's bill to end price discrimination by the drug companies. Together, these efforts will lower prescription drug prices and allow seniors to buy both food and medicine. We must continue to raise awareness of the need for affordable prescription drugs, at least until this Congress is able to pass a comprehensive prescription drug benefit. I urge the adoption of this important study.

Mr. BERRY. Mr. Chairman, I rise today in support of the Tierney amendment and to talk, once again, about the affordability of prescription drugs.

We have all gone back to our districts and have heard from our constituents, especially

seniors, that they cannot afford the prescription drugs they need, often to stay alive.

When I hold meetings in the 1st Congressional District of Arkansas, I hear about two issues and that's the agriculture crisis and the high cost of prescription drugs, especially for seniors.

I also get letters from Arkansas seniors who tell me everyday they can't afford to pay for all their needs, specifically, all their medicine and their food.

Seniors all over this country are not following their doctors' orders. Some of them have been given prescriptions which they cannot afford to fill. Others have filled prescriptions which they cannot afford to take as directed.

Because they cannot pay the rent, pay the electrical bills, buy food and take very expensive prescription drugs, they either stop taking them, or they take less than what is prescribed by their doctor.

They are doing things that in the long run are harmful to their health.

I find it amazing that we tell our seniors they can live longer if they take this pill and that pill, but then if they can't afford their medication that keeps them alive, we don't do anything about it.

Thousands of consumers, especially seniors have found themselves affected by the price of prescription drugs in this country.

Seniors and other Americans go to Canada and Mexico because prescription drugs in these countries cost much less than in the United States.

In my District in Arkansas, seniors paid 81% and 72% more, respectively, for the 10 prescription drugs they most commonly use than their elderly counterparts in Canada.

I have introduced legislation, with Representatives EMERSON and SANDERS, the International Prescription Drug Parity Act, that amends the Food, Drug, and Cosmetic Act to allow American distributors and pharmacists to reimport prescription drugs into the U.S. as long as the drugs meet strict safety standards.

This will allow American pharmacies and distributors to benefit by purchasing their drugs at lower prices, which they can pass along to American consumers.

Mr. Chairman, the bottom line is, consumers should not have to choose between food and medicine.

I urge all members of this body to vote for the Tierney amendment.

The CHAIRMAN pro tempore (Mr. QUINN). The question is on the amendment offered by the gentleman from Massachusetts (Mr. TIERNEY).

The amendment was agreed to.

AMENDMENT NO. 11 OFFERED BY MR. TIERNEY

Mr. TIERNEY. Mr. Chairman, I offer an amendment, amendment No. 11.

The CHAIRMAN pro tempore. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 11 offered by Mr. TIERNEY:

Page 13, after line 5, insert the following subsection:

''(d) STUDIES OF METHODS TO IMPROVE ACCESS TO HEALTH SERVICE.—The Director shall conduct, and shall provide scientific and technical support for private and public efforts to conduct, studies of the organization, delivery, and financing of health services in order to determine the cost and quality effects of various methods of substantially increasing the number of individuals in the United States who have access to health services. Such studies shall include a study to determine the impact of a single payer insurance coverage program on health expenditures in the United States during the fiscal years 2000 through 2007 compared to the projected impact of the current system on health expenditures in the United States during such period.''

Mr. TIERNEY. Mr. Chairman, this particular amendment is going to request that the director conduct and provide scientific and technical support for the private and public efforts to conduct studies of the organization, delivery and financing of health services in order to determine the cost and quality effects of various methods of substantially increasing the number of individuals in the United States who have access to health services.

Mr. Chairman, those studies should include a study to determine the impact of a single-payer insurance coverage program on health expenditures in this country during the fiscal years 2000 to 2007 compared to the projected impact of the current system on health expenditures in the United States during that period.

Mr. Chairman, simply put, I bring this amendment forward for the gentleman from Washington (Mr. MCDERMOTT), the gentleman from Vermont (Mr. SANDERS), the gentlewoman from Wisconsin (Ms. BALDWIN), as well as myself. What we seek to do is to make more explicit one of the duties that the agency is already charged with, and that is the duty to study ways of increasing access to health services.

We have a situation in this country where there are estimates of 43 million Americans without health insurance coverage. Of those numbers, 11 million are said to be children. The balance of those people are adults, the majority of whom are working adults. This is simply a situation that is intolerable, Mr. Chairman, and it is about time that we started to look at the reasons why that is so and what we can do about changing that dynamic and making sure that all Americans have access to affordable health care.

As a former small business president of the Chamber of Commerce and someone who deals often with small businesses, I can tell my colleagues that there has been a change of mind amongst many people in the small business industry. They, at one time, were listening to the larger national organizations and international organizations about how terrible it would be if we had universal health care. Now they are seeing the alternative of what happens under the current system. They see the number of people that are uncovered, and they realize that the premiums they are paying to cover their employees and their own families are increased by virtue of the fact that those premiums are also covering the 43 million Americans who have no coverage.

That has to be paid for somewhere. Those people do get health care. They unfortunately get it when it is later on in their situation, when the situation is more critical, when treatment is more expensive, and now we need to know why that is so. Now we need to know why we cannot cover everybody.

I think it has come around to providers, whether they be doctors or nurses or others. It has come around to hospitals, to CEOs who I have talked to, as well as business people and consumer groups. We need to look at a more effective health care system in this country.

It is more than enough to say that we have a problem. It is time to do something. And when we talk about some of the immediate solutions, and my colleagues have heard as well as I have that we need to put more money back into community hospitals, particularly teaching hospitals because of the cuts in the 1997 Balanced Budget Act, and that is so.

The estimates were that we were going to cut $112 billion and that we were then going to be able to take care of fraud and abuse and get preventive services, and that was going to help it be more affordable. The fact of the matter is, that estimate was overshot. Some $200 billion is estimated to have been squeezed, and those hospitals and home care providers and others do need some money to be put back in. But to just put money back in would be a temporary fix. The system is broken. It is not working. We are not covering everybody. And if we do not cover everybody, we cannot control the cost and cannot make sure that we provide good quality services to everyone.

What this bill will do, Mr. Chairman, is to get this agency to do a study and to compare it to what we have now. What will improve the cost situation. More importantly, what will improve the accessibility and the affordability issues.

Now, among those things we asked to be studied is the single-payer system. That is one option. In no way does my amendment say that that is all we should study or that we should predetermine that is exactly where we have to go. It is a proposal that I think has considerable merit. The Massachusetts Medical Association had two independent studies done, and not to the surprise of many, it came back saying the single-payer system would have been a better system if applied in Massachusetts over the next 8 years. It would save money, it would cover more people in that State, it would provide them better services.

We should find out if that is so for all the States in this country. We should find out if we should have a single-payer system or some other form of universal health care. We should balance and measure those systems against each other and how they will do. And then we should measure it against the current system to find out what would be best.

MODIFICATION TO AMENDMENT NO. 11 OFFERED BY MR. TIERNEY

Mr. TIERNEY. Mr. Chairman, some people are concerned about the language because they thought my amendment was simply saying that we would study only single-payer, but, in fact, we have looked at some language and I am more than happy to ask for unanimous consent that my amendment be modified in accordance with the modification that has been sent to the desk which says that the study shall include an examination of the financial impacts of a range of health care reform proposals to include, but not be limited to, a single-payer insurance program compared to the current system across an 8-year period beginning in fiscal year 2000.

The CHAIRMAN pro tempore. The Clerk will report the modification.

The Clerk read as follows:

Modification to amendment No. 11 offered by Mr. TIERNEY:

The second sentence of the amendment is modified to read as follows: ''Such studies shall include an examination of the financial impacts of a range of health reform proposals to include, but not be limited to, a single payor insurance program compared to the current system across an eight-year period beginning in fiscal year 2000.''

The CHAIRMAN pro tempore. Is there objection to the modification offered by the gentleman from Massachusetts?

There was no objection.

Mr. BILIRAKIS. Mr. Chairman, I rise in support of the amendment, as modified.

Mr. TIERNEY. Mr. Chairman, will the gentleman yield?

Mr. BILIRAKIS. I yield to the gentleman from Massachusetts.

Mr. TIERNEY. Mr. Chairman, I thank the gentleman very much for that courtesy. I simply wanted to reiterate the point that we must study all the available reforms on that, and this, of course, is one important one.

Mr. BILIRAKIS. Mr. Chairman, reclaiming my time, we are not in disagreement, as far as that area is concerned. We have studied the amendment and have talked with the gentleman and talked with the gentleman's staff, and we accept the amendment, as modified, and do not object to it.

Ms. LEE. Mr. Chairman, I move to strike the last word.

I want to thank my colleague from Massachusetts for offering this amendment, and I rise in strong support of the Tierney amendment to authorize studies or methods to improve access to health services. While serving in the California legislature, I had the opportunity to work on similar legislation. I am proud to say that the bill was passed by the California legislature and is now before the governor for his signature.

This Nation, as well as my home State of California, really needs the study, and also the California study, because of the profound failures of the present system. By now we have had 5 years of experience of depending on the private sector for the delivery of our health care, 5 years of knowing intimately that a market-driven health care system leaves more and more people frustrated, angry, and sick.

I also carried managed care bills while I was in the California legislature. I authored many of them. And I want to say that people are becoming increasingly more disappointed with the outcome of these managed care approaches. They are frustrated because medical decisions about operations, about how long to be hospitalized, about which illnesses are to be treated and by whom, crucial medical decisions are being made each and every day, each and every moment by accountants and executives of managed care companies who earn fortunes by denying medical care to their subscribers.

The statistics on what CEOs are making are staggering and should make us really squirm in shame. These are profits at the expense of our right to live or our right to be as healthy as we can be. Now, simultaneously, we have had 5 years of a market-driven health care system which leaves more and more Americans uninsured. At last count we were at about 45 million, increasing at the rate of 1 million uninsured people a year.

□ 1615

Are these health care companies with their immense profits working to raise our knowledge and our standards of health care? Are they helping us to understand that an ounce of prevention is really worth a pound of cure? Sadly, it appears not.

What has the industry done in these 5 years? Are they controlling health care costs? Sadly, again, it appears not. Health care premiums are once again rising.

For example, the health care industry has spent millions successfully lobbying so far to defeat the Patients' Bill of Rights. Health insurance companies have had the gall recently to propose $60 billion in new Federal programs to subsidize insurance for 28 out of the 45 million uninsured Americans.

The current efforts to expand Medicare to cover prescription drugs, which, of course, I support, is now motivating, however, the health insurance industry to compete with the pharmaceutical companies by insisting that the uninsured should come before those needing prescription drugs.

So to pit one group of Americans against those who need health care versus another group who needs health care to me is just basically wrong.

Mr. Chairman, I am convinced that as long as profits provide the driving force in the health care industry, we will fall way short of providing health care, affordable and accessible health care, for all.

For instance, recent studies show that for-profit hospitals drive up Medicare costs in general as a group. In another study, for-profit health plans perform worse than nonprofits in providing preventive health care. One study concluded that if all American women were enrolled in for-profit HMOs instead of nonprofits, over 5,900 more women would die from breast cancer each year due to lower rates of mammography.

This Nation spends more money per person on health care than any other industrialized country. Yet, in 1997, Newsweek reported that current figures for longevity projections for the year 2050 for African-Americans will be less than the longevity of all other ethnic groups.

Could that be because our health care dollars are not going for health care for all based on an equitable basis but going into the ever deeper and ever hungrier pockets of the top echelons of those health care insurance companies?

Georgetown University Medical Center reported this February that their study together with Rand Corporation and the University of Pennsylvania indicated that African-Americans and women with chest pain would be referred for cardiac catheretization at 60 percent of those of whites and men. This disparity was most dramatic for black women, where odds of being referred were 40 percent of those of white men. This is really a shame.

We need to get out of the competition by profit-making companies for our meager health dollars. We need to know that other ways are possible. For instance, we do need to know how much a single-payer system costs. We do need to know how much provision of universal health care without profits for insurance companies would cost. We need this information provided in the Tierney amendment.

I urge my colleagues to support the amendment.

Ms. BALDWIN. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, the Tierney amendment is a worthwhile step toward what must be a larger goal.

As we approach the new millennium, Mr. Chairman, the United States is still the only country in the industrialized world that does not offer comprehensive affordable health care to all of its citizens. This, Mr. Chairman, is unconscionable, it is untenable, and it is wrong.

As we reach the closing days of the 20th century, 43 million Americans have no health care coverage at all. In this wondrous century, we have put astronauts on the moon, we have created a global village united by computer technology, we have perfected travel from one end of the world to the other in mere hours, and yet 43 million of us cannot afford or cannot get health care insurance.

Most of those people have jobs. But increasingly they work in small businesses or in the service sectors that either do not cover employees or require them to pay so much for health insurance that they simply cannot afford it.

There are millions more Americans who are under-insured who have health insurance but would be at risk of having to spend more than 10 percent of their income on health care bills in the event of a catastrophic illness. And there are tens of millions of Americans who have lost faith in the system, lost faith that comprehensive quality health care will be available to them without a struggle when they need it, where they need it, and from whom they want it. And these numbers continue to rise.

The National Coalition on Health Care, a bipartisan group headed by former Presidents Bush, Carter, and Ford, put out its latest report on the erosion of health insurance coverage in the United States, which found that even if the rosy economic conditions prevalent since 1992 prevail for another decade, one in five Americans will be uninsured in 2009. Should a recession occur, that number is likely to jump as far as one in four.

Mr. Chairman, it is time to put health care for all at the top of our national agenda. Many people have called for it. Many more believe it should happen.

Mr. Chairman, universal health care will never happen until we create the national will to make it so. Let us begin.

American medicine is the best in the world. Of that there is no doubt. And yet our nursing teams are understaffed, underpaid, and overworked. Our health care costs continue to rise at twice the rate of inflation. Today's one-trillion-dollar system will double in cost to $2 trillion in the next decade. This will adversely affect our economy, the deficit, the Nation's small businesses, and the middle class's standard of living.

Universal health care will actually lower health costs by providing less expensive preventative health care and treating illnesses before they become more complex and costly.

It was just a year ago that I traveled around my district telling the voters of Wisconsin's second district that I wanted to go to Congress to re-ignite the national debate on health care. One reporter even called me from a prominent paper on the East Coast to talk about the campaign. I asked, Why are you interested in a race so far away? He said, Because you are one of the few candidates anywhere who is willing to talk about health care for all. It is a hot potato that no one wants to touch.

Well, my constituents did not just touch it, Mr. Chairman. They embraced it. The voters in my district are tired of hearing, we cannot. The voters in my district reject the cynicism, the naysayers, the keepers of the status quo. The voters in my district posed the same question to this Congress that I posed during my campaign: If you are not for health care for all, then who would you leave behind? And if you agree that everyone should have access to affordable quality health care, then let us talk about the best way to achieve it.

It is time to begin.

Mr. FRANK of Massachusetts. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I congratulate the sponsors of this amendment for bringing it forward. The lack of an adequate universal health care system is one of the gravest defects in public policy in America.

Now, there are many of us who are in favor of it on equitable grounds. I am going to take that segment for granted in my comments and talk to those on the more conservative side, the people in positions of responsibility, the financial community, and try to explain to them why I believe it is very much in their interest to get behind what we hope will be the first step in leading to the establishment of a universal health care system and would I say a single-payer health care system.

By the way, for those who raise questions about the feasibility of a single-payer health care system, let us talk about one which we have had in this country for over 30 years. It is called Medicare. Medicare is a universal single-payer health care system if they are over 65. And those who think it is a bad idea, go tell the recipients of Medicare that they are going to abolish it and let them go back to other ways and I think they will find a great deal of negative response.

Indeed, one of the great mistakes this Congress made in 1997 was to cut Medicare. Exactly how it happened, I do not know. Because so many people who were for cutting Medicare in 1997 are so vehemently against it now that I think there was something in the air, that people were, like, absent but voting because they did not know what they did.

But here is the argument for going further. In 1993, when the President put forward a health care plan, we were told, well, look, most people get health care and we are solving this problem through our current system. In fact, the opposite has been the case. People have been losing health care. They are losing it, in part, because of the international competitive situation. Holding down the costs to employers, particularly in manufacturing, has become a major factor worldwide.

Alan Greenspan a couple of months ago gave a speech in which he lamented the fact that the former national consensus for free trade had eroded and he complained that so many people today are not for tree trade anymore. And he said, I understand how some people get hurt, that some people who do not have access to the skills in information technology will lose their job in the short-run, but we should not let our inability to help them keep us from going forward with globalization.

Well, the fact is that we do not have an inability to help them, we have an unwillingness, because this very wealthy Nation clearly has the resources.

One of the single best things that people should understand, and here is what I want to address, conservatives, people who believe in globalization, people who want China in the WTO, people who want to go forward with Fast Track authority, who want a new round in Seattle to lead to further trade reductions, we are not going to get that until we have satisfied working people in America that they will not be unfairly disadvantaged.

And one of the biggest problems they have, I think the single biggest problem now is, when they lose their jobs, they lose their health care; and when they get new jobs, having lost their jobs, they may well get a job without health care. Because with the lower paying jobs, the service jobs, it is not simply a reduction in income that people face when they lose a manufacturing job and go into another industry, they may very well not have health care.

The insecurities that people in this country feel because of our patchwork health care system and the absence of a reliable universal health care system, I think it should be single-payer, but the reliance of that, the knowledge that losing their job could mean losing their health care for them and their family, their children, their spouse, that is one of the biggest obstacles to the support these people are looking for for globalization.

So Mr. Greenspan is right to acknowledge that many of us are unwilling to go forward with the process of globalization if it is going to hurt some of the people at the lower end economically, but he is wrong to say that the reason we are not helping them is that it is an inability.

There used to be a problem, we thought, 10 years ago. We thought we were spending too much on health care. We said the American economy was stagnating because we were spending too much on health care. We now are clearly the best performing economy in the world. The fact that our health care expenditures per capita are higher than in some other places is obviously not an economic problem.

We face a moral problem in condemning people to inadequate care. But they also, I have to say to the establishment and financial community, must understand that there is going to have to be a trade-off. And if people want to reverse the move away from support for globalization internationally, those who believe that is very much in our interest economically have to understand that social equity is going to have to be part of that deal. And they are not going to go forward with the kind of economic global integration they want to see until they do a number of things, and one of them is the provision of a universal health care system.

So, as I said, I know we got some votes for equity. But fairness is not enough to win. We are in a trade-off situation. And if we look at the Congresses of the past few years, we have

had increasing contention over American support for the international financial institutions, American support for reductions in tariffs. That will get worse rather than better as long as we get a refusal to recognize the legitimate claims of American workers for a universal health care system.

Mr. TRAFICANT. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, we begin to talk about the economic principles that have probably caused the inability to provide it. I agree with the previous speaker that it is probably more willingness.

Until we take the major costs off American corporations, they will continue to leave our country and we will continue to struggle and lose our manufacturing base.

I think it is time, though, that while we are talking about the symptoms that we should start addressing the root causes and problems. It is time to take a look at the progressive income tax, the burdensome cost of compliance, and the negative economic competition globally that it places us in.

We are now beginning to talk about the reasons why we cannot perform many of the deeds our constituents believe we should be addressing, and we will never do it with the complicated Tax Code that we have in place.

□ 1630

We reward companies for leaving. We reward imports. We kill exports. And then we talk about trade and then we talk about universal health care. Well, there will be no universal health care, there will be no improvement to the health care system until we change a tax code that rewards competitive imbalance overseas and negates America's opportunity to provide these programs. But it is interesting to see it. It is not an inability. It is not an unwillingness. It is a tax code that simply makes it almost impossible to provide this type of competitive program. We should get rid of it.

Ms. SCHAKOWSKY. Mr. Chairman, I move to strike the requisite number of words.

I want to thank the gentleman from Massachusetts for this amendment which I strongly support. Like my colleague from Wisconsin, in large part I wanted to come to this body to address the issue of health care, the crisis that so many families face, those that have insurance but find it inadequate, those that lose their jobs and lose their insurance, those that have no insurance and have no hope of affording it.

I just wanted to read a letter from a constituent. This is typical. This is one of many. It is an e-mail I got the other day that says,

The cost of health care is killing me. I'm self-employed and the cost of medical insurance for my family of three is about $9,000 a year. That's with high deductibles. That means we also have to pay several thousands of dollars a year in medical bills. These costs are getting out of control. I don't believe that private insurance or even HMOs are the answer anymore. I think it's time for a single-payer insurance system backed by the Federal Government. I would appreciate your working with others in Congress to start moving in this direction.

And so I rise to support an amendment that I think does move us at least in the direction of exploring how we can answer this gentleman who wrote on behalf of his family. Five years ago, we failed to pass comprehensive health reform and instead we left it to the for-profit health insurance industry to make critical decisions: whom to cover, what to cover and what to charge. Today what do we have? More uninsured Americans, more underinsured Americans, more American families struggling to pay premiums and medical costs that are increasingly unaffordable.

The gentleman's amendment is needed for four reasons. First, we must act now to provide health insurance to the uninsured. It is embarrassing, 44.3 million people now lacking any health coverage in this the wealthiest Nation in the world, a 1.7 million jump from the year before. Eleven million of these people are children. In my State nearly one of eight are uninsured and the numbers keep growing.

According to an AFL-CIO study, 8 million fewer Americans in working families have employer-based coverage now than in 1989. If that erosion continues, the study concluded that 12.5 million more people would lose coverage over the next 5 years.

And, second, we need to act to improve coverage for the poorly insured. Millions of insured Americans lack coverage for critical benefits. That includes 13 million senior citizens who lack prescription drug coverage as well as families who lack access to mental health services, rehab therapy, long-term care and other important services. Even if they have an insurance card, they are still effectively uninsured for services if their policies do not cover the services they need.

Third, we must act to lower health care costs for individuals and families as well as for our Nation. High insurance premiums and out-of-pocket costs present insurmountable barriers blocking access to needed care. A recent Commonwealth Foundation survey found that 40 million people went without needed medical care because they could not afford it and another 40 million said they did not have enough money to pay their medical bills.

Finally, we pay a high price for not guaranteeing access to needed medical care. We pay a high price. Lack of insurance, inadequate insurance and high costs keep millions of Americans from getting the health care that they need. There is a cost to the individuals and families who cannot get care and as a result suffer from illnesses and conditions that could be prevented. There is the cost to society, to all of us, from lost wages and productivity from those who cannot work because of the preventable injuries or who cannot work because the job does not provide coverage. And there is the cost of paying for expensive illnesses and emergency care that could have been avoided through a more rational approach to health care.

This amendment moves us in the right direction. I urge my colleagues to act now to pass it.

Mr. STARK. Mr. Chairman, I rise in support of Representative TIERNEY's amendment to require the Agency for Health Research and Quality to conduct a study about the effect of universal health care and other access expansions on health quality and costs.

The U.S. is the only industrialized nation that fails to provide universal health coverage for our citizens—and yet we continue to spend more on health than any of those nations.

A key factor impacting our nation's health expenditures is that we have 43 million Americans left out of our system whom we are covering in the most expensive manner—through emergency rooms, late in their illnesses, and often without the benefit of appropriate prescription drugs since many of these people cannot afford them.

It is time for Congress to return to the vitally important issue of expanding health insurance coverage. There are viable means to achieve that goal.

The most direct routes to providing universal coverage would be to enact a single payer system or to expand Medicare coverage to everyone. There are other more incremental approaches which would also move us in the right direction:

We could use a tax credit approach, like that I have authored in HR 2185, the Health Insurance for Americans Act.

We could expand Medicare coverage to persons aged 55–64 under HR 2228, The Medicare Early Access Act, which is supported by many of my colleagues and the Administration.

We could expand Medicare to children—creating a much more effective coverage policy than the State Children's Health Insurance Program, which continues to leave millions of our nation's children without coverage. That could become an avenue leading to Medicare for all.

I urge support of the Tierney amendment which, if passed, would provide us with further evidence for moving forward to expand health insurance in our country. That is a debate to which Congress must return.

The CHAIRMAN pro tempore (Mr. QUINN). The question is on the amendment, as modified, offered by the gentleman from Massachusetts (Mr. TIERNEY).

The amendment, as modified, was agreed to.

AMENDMENT NO. 21 OFFERED BY MR. STEARNS

Mr. STEARNS. Mr. Chairman, I offer an amendment.

The CHAIRMAN pro tempore. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 21 offered by Mr. STEARNS:

Page 21, after line 8, insert the following subsection:

''(d) CERTAIN TECHNOLOGIES AND PRACTICES REGARDING SURVIVAL RATES FOR CARDIAC ARREST.—In carrying out subsection (a) with

respect to innovations in health care technologies and clinical practice, the Director shall, in consultation with appropriate public and private entities, develop recommendations regarding the placement of automatic external defibrillators in Federal buildings as a means of improving the survival rates of individuals who experience cardiac arrest in such buildings, including recommendations on training, maintenance, and medical oversight, and on coordinating with the system for emergency medical services.''

Mr. STEARNS. Mr. Chairman, I would first like to say that I support H.R. 2506, to reauthorize the Agency for Health Care Policy and Research, I guess it is called the Health Care Quality Agency. This agency is an invaluable resource because the outcomes of research it provides improves the quality of health care for all of us.

Under this reauthorization, the new agency would refocus and its responsibilities would be to promote quality by sharing information, building public-private partnerships, providing cost and quality care reports on an annual basis, supporting new technologies, and assisting in providing access to those in underserved areas.

Mr. Chairman, the amendment I am offering adds a new section to section 916 entitled ''Certain Technologies and Practices Regarding Survival Rates for Cardiac Arrest.'' By adding this language, we are merely attempting to point out how valuable we believe automatic external defibrillators are, AEDs, to saving the lives of individuals who experience cardiac arrest. We are asking the Director to develop recommendations regarding the placement of AEDs in Federal buildings.

Mr. Chairman, more than 1,000 Americans each and every day suffer from cardiac arrest. Of those, more than 95 percent die. That is unacceptable, because we have the means at our disposal to change those statistics. Studies show that 250 lives can be saved each and every day from cardiac arrest by using automatic external defibrillators, AEDs. Those are the kinds of statistics that nobody can argue with.

The AEDs which are produced today are easier to use and require just absolutely minimal training to use and operate. They are also easier to maintain and they cost less. This affords a wider range of emergency personnel to be trained and equipped.

One of the goals of this agency is to enhance the quality of health care. My amendment would help achieve this by directing the agency to develop recommendations for public access to defibrillation programs in Federal buildings in order to improve the survival rates of people who suffer cardiac arrest in Federal facilities. The programs should include training security personnel and other expected users in the use of AEDs, notifying local emergency medical services of the placement of the AED, and ensuring proper medical oversight and proper maintenance of the device.

My reason for offering this amendment highlights that it is possible to prevent thousands of people suffering sudden cardiac arrest from dying by making the equipment and trained personnel available at the scene of such emergencies.

I am hopeful that we can pass my bill in a larger sense which I have 66 cosponsors, H.R. 2498, the Cardiac Arrest Survival Act, in its entirety in the 106th Congress. My bill directs the Secretary of Health and Human Services to develop recommendations for public access to defibrillation programs in Federal buildings.

The bill I introduced in this Congress differs from previous versions which primarily sought to encourage State action to promote public access to defibrillation. The States have responded to this call and many have passed legislation, over 40 States have since done it, to promote training and access to AEDs. So I think it is time for the Federal Government to catch up with the vast majority of our States and pass the legislation.

Mr. Chairman, I hope the amendment I offered, which is fairly innocuous, will be passed and accepted by the gentleman from Florida.

Mr. BILIRAKIS. Mr. Chairman, will the gentleman yield?

Mr. STEARNS. I yield to the gentleman from Florida.

Mr. BILIRAKIS. Mr. Chairman, I appreciate the gentleman yielding. I want to commend the gentleman. He has been very vocal on this, on the use of AEDs and of their great value to us on an everyday basis in committee. Of course his amendment is very helpful because again even though the general scope on functions of the agency would and could include these, it is another case of focusing attention, if you will, to it. We have had the opportunity to review the amendment and do accept it.

Mr. BROWN of Ohio. Mr. Chairman, I rise in support of the Stearns amendment. I believe his amendment will take a major step in saving the lives of people that have heart attacks in public buildings and in other places.

I would also use this amendment briefly as an opportunity to talk for just one moment, Mr. Chairman, about cardiopulmonary resuscitation. Last week was National CPR Week. I have a resolution that I have introduced to encourage people around the country to get CPR training. Only 2 percent of Americans are trained in CPR. It would save literally tens if not hundreds of thousands of lives, both the recommendation that the gentleman from Florida (Mr. STEARNS) has and CPR training.

I urge my colleagues to think about taking that training and especially to talk about it at home when there are training sessions given by hospitals, by the Heart Association and by other organizations. I commend the gentleman from Florida (Mr. STEARNS) for his interest in this issue broadly and specifically and ask for the House support for the Stearns amendment.

The CHAIRMAN pro tempore. The question is on the amendment offered by the gentleman from Florida (Mr. STEARNS).

The amendment was agreed to.

Mr. VENTO. Mr. Chairman, I move to strike the last word.

(Mr. VENTO asked and was given permission to revise and extend his remarks.)

Mr. VENTO. Mr. Chairman, I rise to engage the distinguished subcommittee chairman from Florida and the ranking subcommittee member from Ohio in a colloquy.

A recent series of articles in my hometown paper, the St. Paul Pioneer Press in Minnesota, highlighted a disturbing incidence nationwide of patient fatalities and injuries due to hospital errors which I will insert in the RECORD under General Leave.

The most comprehensive study conducted by Harvard medical researchers found that the hospital mistakes caused the death of one of every 200 patients admitted to hospitals. This provocative study also estimates that 1 million patients are injured by errors during hospital treatment each year. Alarmingly, some experts think official estimates of the medical errors may be understated as some cases go unreported. Most of us are very concerned about this new report.

In section 912, part C, in my reading it is intended for the Agency for Health Research and Quality to include in its research a specific report on the number of hospital errors which result in patient injury and death.

Two questions I have for my colleagues who are managing this measure: Is it intended that the agency will be reporting its findings to Congress? And is it possible that the report will include specific findings from State to State on the number of hospital errors which result in patient injury and death?

Mr. BROWN of Ohio. Mr. Chairman, will the gentleman yield?

Mr. VENTO. I yield to the gentleman from Ohio.

Mr. BROWN of Ohio. I thank the gentleman from Minnesota for bringing this issue in front of the House. It is extraordinarily important. I think we all need to know more about it. That is something that perhaps our committee can consider. Certainly this Congress should. But specifically now clearly the agency should do that.

In section 924 of the bill, it specifically says the information shall be promptly made available to the public, this data developed in such research demonstration projects and evaluations. They will do that. We have a great interest that they do.

Mr. BILIRAKIS. Mr. Chairman, will the gentleman yield?

Mr. VENTO. I yield to the gentleman from Florida. I appreciate the gentleman's guidance.

Mr. BILIRAKIS. Mr. Chairman, I, too, commend the gentleman for bringing it to our attention. Obviously I

think we would all agree that any intelligent reading would indicate that the scope and the general function of the agency would be to include something like this. Again it is important to focus some of these and to red-flag them, if you will, for the agency.

The gentleman from Ohio mentioned section 924. Certainly section 912(c), Reducing Errors in Medicine, and I will not repeat that, goes into that. Then you can go into Information on Quality and Cost of Care, section 913, subparagraph 2, I guess it is, Annual Report, and it refers to an annual report. I would say that it is intended the agency will report its findings to the Congress.

And the second question when you talk about State to State, logically it would seem that that information would be accumulated by them on a State to State basis and thus reported from that standpoint. I honestly do not know why that would be a problem. So is it possible? I would say it is very possible.

□ 1645

Mr. VENTO. Mr. Chairman, I thank the subcommittee chairman and ranking member. Obviously this sort of study is of great concern. I am sure we want to know the accuracy of it and the circumstances that are arising out of it to build the type of quality and objectives that are broadly stated in this bill which I will revise and extend in support of under general leave and will put this article in the paper. I appreciate the chairman, the subcommittee chairman, and ranking member's interest and cooperation with regard to this measure.

[From the Knight Ridder News Service, Sept. 24, 1999]

HOSPITAL ERRORS KILL THOUSANDS OF PATIENTS EACH YEAR

(By Andrea Gerlin)

The Medical College of Pennsylvania Hospital is a typical teaching hospital. It is known for cutting-edge research programs, for training medical students and newly graduated doctors, and for providing advanced medical care.

It is also representative of modern American hospitals in another respect: In the last decade alone, records show, hundreds of MCP Hospital patients have been seriously injured, and at least 66 have died after medical mistakes.

The hospital's internal records cite 598 incidents reported by medical professionals to the hospital administration in the past decade. In some of those cases, patients or survivors were never told the injuries were caused by medical errors. None of the doctors involved in the incidents was subjected to disciplinary action.

For patients of all ages, serious injury and death caused by medical errors are well-known facts of life in the medical community. But they rarely are reported to the general public.

MCP Hospital's records came to light only because of bankruptcy proceedings last year, when its new owner publicly filed a detailed account of the 598 incidents reported at the facility from January 1989 through June 1998.

Those numbers mirror what is happening across the country. Lucian Leape, a Harvard University professor who conducted the most comprehensive study of medical errors in the United States, has estimated that one million patients nationwide are injured by errors during hospital treatment each year and that 120,000 die as a result.

That number of deaths is the equivalent of what would occur if a jumbo jet crashed every day; it is three times the 43,000 people killed each year in U.S. automobile accidents.

''It's by far the No. 1 problem'' in health care, said Leape, an adjunct professor of health policy at the Harvard School of Public Health.

In their study, Leape and his colleagues examined patient records at hospitals throughout the state of New York. Their 1991 report found that one of every 200 patients admitted to a hospital died as a result of a hospital error.

Researchers such as Leape say that not only are medical errors not reported to the public, but those reported to hospital authorities represent roughly 5 to 10 percent of the number of actual medical mistakes at a typical hospital.

''The bottom line is we have a system that is terribly out of control,'' said Robert Brook, a professor of medicine at the University of California at Los Angeles. ''It's really a joke to worry about the occasional plane that goes down when we have thousands of people who are killed in hospitals every year.''

In bankruptcy proceedings last year, Tenet Healthcare Corp.—which bought eight Philadelphia-area hospitals, including MCP, from the bankrupt Allegheny health system—publicly filed an account of medical errors reported at MCP from 1989 through 1998. Such documents, which are maintained by hospitals for legal and insurance reasons, are routinely kept confidential.

The Philadelphia Inquirer sent written requests seeking similar information from 34 other large hospitals in Philadelphia. Of 25 that responded, all declined to provide similar insurance reports, citing patient confidentiality. Tenet declined to provide comparable data for MCP since it acquired the hospital.

Contained in the MCP records is a history of one hospital's experience, providing an unprecedented glimpse into the extent and natural of hospital mistakes.

The cases run the gamut from benign to fatal, and involve patients whose health status ranged from young and vital to old and infirm.

They include:

Four patients who died after they received too much medication, the wrong medication or no medication.

Surgical ''misadventures'' during which patients' organs were punctured or blood vessels were pierced.

An epilepsy patient who died and another who was left paralyzed on one side after suffering brain hemorrhages during surgery by inexperienced and inadequately supervised residents. In those two cases, four doctors at MCP later signed a letter to a hospital administrator saying that mistakes by unsupervised surgical residents ''resulted in the unfortunate death of one of our patients.''

Two middle-age patients who died following cardiac emergencies—men who according to hospital records did not receive proper or timely treatment from emergency room residents. One man sat in the emergency room with dangerously elevated blood pressure for more than seven hours before dying of a heart attack.

An 18-year-old man who received the wrong type of blood in a transfusion after an automobile accident, and died after an apparent hemolytic reaction to the blood.

Eight surgical patients who required second operations to retrieve sponges, cotton or metal instruments left inside their bodies.

Inadquate intensive-care monitoring, which delayed response to a mother of two who had stopped breathing. She was left permanently brain-damaged.

The Allegheny Health, Education and Research Foundation, which owned MCP until November, declined to comment. Tenet, the hospital's current owner, declined to discuss specific cases and events at the hospital preceding its ownership.

A Tenet executive said the company is aggressive and systematic in monitoring the quality of care at the 130 hospitals it owns across the country.

As of June 30, 1998, the date of the MCP report, the hospital's insurers had paid roughly $30 million—excluding legal costs—in settlements or jury awards in 76 of the 266 cases that resulted in lawsuits. The figures include five cases settled for more than $1 million each.

Lawyers for MCP, a 400-bed hospital in East Falls, Pa., have consistently denied the hospital's liability in lawsuits arising from errors. The hospital's own records suggest that its experience is no different from that of most hospitals in America.

''I find nothing in there that's beyond the average,'' said Donald Berwick, a pediatrician who is president and chief executive officer of the Institute for Healthcare Improvement, a nonprofit organization based in Boston.

The MCP doctors who treated patients included in the report had a wide range of expertise. Some were first-year doctors-in-training, or residents, working under the supervision of attending doctors. Others were veteran faculty who had graduated at the top of their medical school classes and are regarded by their colleagues as among the most competent in their specialties.

None of the 40 doctors involved in some of the most serious mistakes at MCP was ever subjected to disciplinary action by the state Bureau of Professional and Occupational Affairs, according to an agency spokeswoman.

''Most people in health care really try hard, but they're human and they make mistakes,'' said Harvard's Leape, a co-author of the ''Harvard Medical Practice Study.'' Said Leape: ''Physicians are not infallible.''

Leape added: ''No nurse or doctor wants to hurt somebody and every nurse and doctor has hurt somebody. They don't want to do it again.''

Because most medical mistakes do not go beyond hospital walls, experts say, an estimated 2 to 10 percent of all cases involving medical error result in lawsuits.

''Because of the surveillance climate in health care, the tendency is not to report errors, but to conceal them or explain them away,'' Berwick said.

The CHAIRMAN pro tempore (Mr. QUINN). Are there any further amendments to section 2?

If not, the Clerk will designate section 3.

The text of section 3 is as follows:

SEC. 3. GRANTS REGARDING UTILIZATION OF PREVENTIVE HEALTH SERVICES.

Subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following section:

''SEC. 330D. CENTERS FOR STRATEGIES ON FACILITATING UTILIZATION OF PREVENTIVE HEALTH SERVICES AMONG VARIOUS POPULATIONS.

''(a) IN GENERAL.—The Secretary, acting through the appropriate agencies of the Public Health Service, shall make grants to public or nonprofit private entities for the establishment

and operation of regional centers whose purpose is to identify particular populations of patients and facilitate the appropriate utilization of preventive health services by patients in the populations through developing and disseminating strategies to improve the methods used by public and private health care programs and providers in interacting with such patients.

''(b) RESEARCH AND TRAINING.—The activities carried out by a center under subsection (a) may include establishing programs of research and training with respect to the purpose described in such subsection, including the development of curricula for training individuals in implementing the strategies developed under such subsection.

''(c) QUALITY MANAGEMENT.—A condition for the receipt of a grant under subsection (a) is that the applicant involved agree that, in order to ensure that the strategies developed under such subsection take into account principles of quality management with respect to consumer satisfaction, the applicant will make arrangements with one or more private entities that have experience in applying such principles.

''(d) PRIORITY REGARDING INFANTS AND CHILDREN.—In carrying out the purpose described in subsection (a), the Secretary shall give priority to various populations of infants, young children, and their mothers.

''(e) EVALUATIONS.—The Secretary, acting through the appropriate agencies of the Public Health Service, shall (directly or through grants or contracts) provide for the evaluation of strategies under subsection (a) in order to determine the extent to which the strategies have been effective in facilitating the appropriate utilization of preventive health services in the populations with respect to which the strategies were developed.

''(f) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2000 through 2004.''.

The CHAIRMAN pro tempore. Are there any amendments to section 3?

If not, are there any further amendments to the bill?

AMENDMENT NO. 18 OFFERED BY MRS. JOHNSON OF CONNECTICUT

Mrs. JOHNSON of Connecticut. Mr. Chairman, I offer an amendment.

The CHAIRMAN pro tempore. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 18 offered by Mrs. JOHNSON of Connecticut:

At the end of the bill, add the following new section:

SEC. 4. PROGRAM OF PAYMENTS TO CHILDREN'S HOSPITALS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following subpart:

''Subpart IX—Support of Graduate Medical Education Programs in Children's Hospitals

''SEC. 340E. PROGRAM OF PAYMENTS TO CHILDREN'S HOSPITALS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.

''(a) PAYMENTS.—The Secretary shall make two payments under this section to each children's hospital for each of fiscal years 2000 and 2001, one for the direct expenses and the other for indirect expenses associated with operating approved graduate medical residency training programs.

''(b) AMOUNT OF PAYMENTS.—

''(1) IN GENERAL.—Subject to paragraph (2), the amounts payable under this section to a children's hospital for an approved graduate medical residency training program for a fiscal year are each of the following amounts:

''(A) DIRECT EXPENSE AMOUNT.—The amount determined under subsection (c) for direct expenses associated with operating approved graduate medical residency training programs.

''(B) INDIRECT EXPENSE AMOUNT.—The amount determined under subsection (d) for indirect expenses associated with the treatment of more severely ill patients and the additional costs relating to teaching residents in such programs.

''(2) CAPPED AMOUNT.—

''(A) IN GENERAL.—The total of the payments made to children's hospitals under paragraph (1)(A) or paragraph (1)(B) in a fiscal year shall not exceed the funds appropriated under paragraph (1) or (2), respectively, of subsection (f) for such payments for that fiscal year.

''(B) PRO RATA REDUCTIONS OF PAYMENTS FOR DIRECT EXPENSES.—If the Secretary determines that the amount of funds appropriated under subsection (f)(1) for a fiscal year is insufficient to provide the total amount of payments otherwise due for such periods under paragraph (1)(A), the Secretary shall reduce the amounts so payable on a pro rata basis to reflect such shortfall.

''(c) AMOUNT OF PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION.—

''(1) IN GENERAL.—The amount determined under this subsection for payments to a children's hospital for direct graduate expenses relating to approved graduate medical residency training programs for a fiscal year is equal to the product of—

''(A) the updated per resident amount for direct graduate medical education, as determined under paragraph (2)); and

''(B) the average number of full-time equivalent residents in the hospital's graduate approved medical residency training programs (as determined under section 1886(h)(4) of the Social Security Act during the fiscal year.

''(2) UPDATED PER RESIDENT AMOUNT FOR DIRECT GRADUATE MEDICAL EDUCATION.—The updated per resident amount for direct graduate medical education for a hospital for a fiscal year is an amount determined as follows:

''(A) DETERMINATION OF HOSPITAL SINGLE PER RESIDENT AMOUNT.—The Secretary shall compute for each hospital operating an approved graduate medical education program (regardless of whether or not it is a children's hospital) a single per resident amount equal to the average (weighted by number of full-time equivalent residents) of the primary care per resident amount and the non-primary care per resident amount computed under section 1886(h)(2) of the Social Security Act for cost reporting periods ending during fiscal year 1997.

''(B) DETERMINATION OF WAGE AND NON-WAGE-RELATED PROPORTION OF THE SINGLE PER RESIDENT AMOUNT.—The Secretary shall estimate the average proportion of the single per resident amounts computed under subparagraph (A) that is attributable to wages and wage-related costs.

''(C) STANDARDIZING PER RESIDENT AMOUNTS.—The Secretary shall establish a standardized per resident amount for each such hospital—

''(i) by dividing the single per resident amount computed under subparagraph (A) into a wage-related portion and a non-wage-related portion by applying the proportion determined under subparagraph (B);

''(ii) by dividing the wage-related portion by the factor applied under section 1886(d)(3)(E) of the Social Security Act for discharges occurring during fiscal year 1999 for the hospital's area; and

''(iii) by adding the non-wage-related portion to the amount computed under clause (ii).

''(D) DETERMINATION OF NATIONAL AVERAGE.—The Secretary shall compute a national average per resident amount equal to the average of the standardized per resident amounts computed under subparagraph (C) for such hospitals, with the amount for each hospital weighted by the average number of full-time equivalent residents at such hospital.

''(E) APPLICATION TO INDIVIDUAL HOSPITALS.—The Secretary shall compute for each such hospital that is a children's hospital a per resident amount—

''(i) by dividing the national average per resident amount computed under subparagraph (D) into a wage-related portion and a non-wage-related portion by applying the proportion determined under subparagraph (B);

''(ii) by multiplying the wage-related portion by the factor described in subparagraph (C)(ii) for the hospital's area; and

''(iii) by adding the non-wage-related portion to the amount computed under clause (ii).

''(F) UPDATING RATE.—The Secretary shall update such per resident amount for each such children's hospital by the estimated percentage increase in the consumer price index for all urban consumers during the period beginning October 1997 and ending with the midpoint of the hospital's cost reporting period that begins during fiscal year 2000.

''(d) AMOUNT OF PAYMENT FOR INDIRECT MEDICAL EDUCATION.—

''(1) IN GENERAL.—The amount determined under this subsection for payments to a children's hospital for indirect expenses associated with the treatment of more severely ill patients and the additional costs related to the teaching of residents for a fiscal year is equal to an amount determined appropriate by the Secretary.

''(2) FACTORS.—In determining the amount under paragraph (1), the Secretary shall—

''(A) take into account variations in case mix among children's hospitals and the number of full-time equivalent residents in the hospitals' approved graduate medical residency training programs; and

''(B) assure that the aggregate of the payments for indirect expenses associated with the treatment of more severely ill patients and the additional costs related to the teaching of residents under this section in a fiscal year are equal to the amount appropriated for such expenses for the fiscal year involved under subsection (f)(2).

''(e) MAKING OF PAYMENTS.—

''(1) INTERIM PAYMENTS.—The Secretary shall determine, before the beginning of each fiscal year involved for which payments may be made for a hospital under this section, the amounts of the payments for direct graduate medical education and indirect medical education for such fiscal year and shall (subject to paragraph (2)) make the payments of such amounts in 26 equal interim installments during such period.

''(2) WITHHOLDING.—The Secretary shall withhold up to 25 percent from each interim installment for direct graduate medical education paid under paragraph (1).

''(3) RECONCILIATION.—At the end of each fiscal year for which payments may be made under this section, the hospital shall submit to the Secretary such information as the Secretary determines to be necessary to determine the percent (if any) of the total amount withheld under paragraph (2) that is due under this section for the hospital for the fiscal year. Based on such determination, the Secretary shall recoup any overpayments made, or pay any balance due. The amount so determined shall be considered a

final intermediary determination for purposes of applying section 1878 of the Social Security Act and shall be subject to review under that section in the same manner as the amount of payment under section 1886(d) of such Act is subject to review under such section.

''(f) AUTHORIZATION OF APPROPRIATIONS.—

''(1) DIRECT GRADUATE MEDICAL EDUCATION.—

''(A) IN GENERAL.—There are hereby authorized to be appropriated, out of any money in the Treasury not otherwise appropriated, for payments under subsection (b)(1)(A) —

''(i) for fiscal year 2000, $90,000,000; and

''(ii) for fiscal year 2001, $95,000,000.

''(B) CARRYOVER OF EXCESS.—The amounts appropriated under subparagraph (A) for fiscal year 2000 shall remain available for obligation through the end of fiscal year 2001.

''(2) INDIRECT MEDICAL EDUCATION.—There are hereby authorized to be appropriated, out of any money in the Treasury not otherwise appropriated, for payments under subsection (b)(1)(A) —

''(A) for fiscal year 2000, $190,000,000; and

''(B) for fiscal year 2001, $190,000,000.

''(g) DEFINITIONS.—In this section:

''(1) APPROVED GRADUATE MEDICAL RESIDENCY TRAINING PROGRAM.—The term 'approved graduate medical residency training program' has the meaning given the term 'approved medical residency training program' in section 1886(h)(5)(A) of the Social Security Act.

''(2) CHILDREN'S HOSPITAL.—The term 'children's hospital' means a hospital described in section 1886(d)(1)(B)(iii) of the Social Security Act.

''(3) DIRECT GRADUATE MEDICAL EDUCATION COSTS.—The term 'direct graduate medical education costs' has the meaning given such term in section 1886(h)(5)(C) of the Social Security Act.''.

Mrs. JOHNSON of Connecticut. Mr. Chairman, first I would like to commend the gentleman from Florida (Mr. BILIRAKIS) on the underlying bill, the Health Research and Quality Act which I consider to be a very progressive modernization of the mission of the Agency for Health Care Policy and Research, and I commend him on the thoughtful work done to enable that agency to serve us in the future in a focused and aggressive manner.

I also would like to thank the subcommittee chairman, the gentleman from Florida (Mr. BILIRAKIS), for his support of a solution to the problem that our children's centers faced. He has been a strong advocate of our children's centers, and a great help to me as we moved this matter forward. I would like to thank also the chairman, the gentleman from Virginia (Mr. BLILEY) of the Committee on Commerce who also has been helpful in the support of the gentleman from California (Mr. THOMAS) who is chairman of the Subcommittee on Health of the Committee on Ways and Means and for the help and assistance and guidance of the gentlewoman from Ohio (Ms. PRYCE) who has been so very interested in the work of the children's hospital and is so conscious of the excellent opportunity they provide for children with complex, difficult illness.

Mr. Chairman, I offer this amendment, and I ask the support of my colleagues because our children's medical centers are facing an unprecedented financial crisis that threatens future advances in children's health care. All our teaching hospitals are facing a terrible challenge in just maintaining the resources needed to treat medically complex patients, the uninsured and the poor, and in addition, to maintain their training and teaching capabilities. It is increasingly difficult to get Medicare, Medicaid, and private payers to reimburse at a rate that is adequate to cover the unique responsibilities of our medical centers including the additional added costs of training physicians and conducting health care research. In today's price-competitive health care market, private payers no longer are willing to cover the costs of the public mission of training our physician work force. Children's teaching hospitals face an additional and unique burden because they receive no significant Federal support for their graduate medical education programs.

Mr. Chairman, GME is principally funded through the Medicare program. Teaching hospitals receive funding based on the number of Medicare patients that they treat. Because children's hospitals treat very few Medicare patients, they receive no significant support for their teaching programs from the Federal Government.

Freestanding children's hospitals receive on average less than one-half of 1 percent of what other teaching facilities receive in Federal GME funding. The grant program embodied in this amendment would provide GME support for children's hospitals. That is just commensurate with Federal GME support that other teaching facilities receive under Medicare. This amendment merely establishes interim assistance to our children's hospitals to maintain their teaching programs while Congress reforms the way we as a Nation fund medical education.

Mr. Chairman, the grant program would provide $280 million in fiscal year 2000, $285 million in fiscal year 2001; that is, authorize that money. Since comprehensive GME reform will take more time to develop, this amendment would provide immediate financial assistance through a capped time limited authorization of appropriations.

Mr. Chairman, freestanding children's hospitals are responsible for the pediatric training of almost 30 percent of the Nation's pediatricians and almost half of pediatric specialists. They also provide training to substantial numbers of residents of other institutions who require pediatric rotations. Even though they make up less than 1 percent of all hospitals, 59 facilities, freestanding teaching children's hospitals educate and train over 5 percent of all residents nationwide.

Make no mistake about it, Mr. Chairman. Top notch training programs are critical to ensure quality health care for our children. Kids with unusual and medically complex diseases depend on the sophisticated resources of our children's medical centers. Quality pediatric care depends on high-quality training of pediatric specialists and sub-specialists, and improvements in diagnosing and treating disease depend on sophisticated basic and clinical research carried out in our children's hospitals.

This grant program has broad bipartisan support. It is co-authored by over 190 Members, including the chairs and ranking members of the critical committees, and I urge my colleagues' support of it here today.

Mr. BILIRAKIS. Mr. Chairman, I rise in support of the amendment offered by the gentlewoman from Connecticut (Mrs. JOHNSON).

Mr. Chairman, the majority had a chance to review the amendment. It would provide graduate medical education payments to the children's hospitals by creating a financing system for pediatric physical training. The amendment was introduced as the Children's Hospital Education and Research Act, H.R. 1579, with significant bipartisan support.

Mr. Chairman, few contest the historic inequity in GME funding for children's hospitals. Because Medicare is the largest single payer of GME and since freestanding children's hospitals treat few Medicare patients, as the gentlewoman from Connecticut said, their GME funding is very low. This gap in Federal support jeopardizes highly successful pediatric training programs.

Since comprehensive GME reform may take more time to develop, this amendment will provide immediate financial assistance through a capped, time-limited appropriation of $280 million in fiscal year 2000 and 285 million in fiscal year 2001. This authorization would end after 2 years or with the enactment of GME reform, whichever occurs first.

Although, Mr. Chairman, I am not going to make a motion to contest the germaneness of this amendment, I do wish to point out that the bill under consideration now which reauthorizes an agency with a primary research mission is a questionable vehicle for authorizing appropriations for funding GME and children's hospitals, and I am sure the gentlewoman understands that and would acknowledge that. Moreover, on process grounds I can make a strong argument for moving the children's GME bill through the normal committee process rather than as an amendment to H.R. 2506.

But having said this, Mr. Chairman, of course I am a cosponsor of the Johnson GME bill, and I agree with my colleague from Connecticut that this authorization of appropriations will send an important message to the relevant appropriations committees that the Congress considers support of GME for doctors training in children's hospitals as a high, high priority, and therefore, Mr. Chairman, we are prepared to accept the amendment.

Ms. PRYCE of Ohio. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I rise in strong support of the Johnson amendment, and I congratulate my friend for her work on this very and most important issue, and I appreciate the chairman's support. Very simply, this amendment makes an investment in children's health by authorizing funds for physician training. Currently the Medicare program provides the most reliable and significant support for graduate medical education, but children's hospitals do not treat Medicare patients who are largely senior citizens.

Mr. Chairman, the current system leaves children's hospitals searching for compensation for the time-consuming and resource-intensive training they provide to enhance our physician work force. While children's hospitals or while children's teaching hospitals represent only 1 percent of all hospitals, they train nearly 30 percent of all pediatricians, nearly half of all pediatric specialists and a significant number of general practitioners.

Now I have spent the better part of the past year in and out of Children's Hospital in Columbus, Ohio, and I know firsthand the critical difference between medical care for adults and medical care for children and all the commensurate differences in training that go along with the treating of a sick child as opposed to a grown adult including very basically the size of medical equipment, the dosage of drugs, the size of prosthetics, the administration of anesthesia, the ongoing development, the physical development, of children, the communication barriers. The list goes on and on, and it is absolutely critical for the physicians who treat children to have the proper training to meet the needs and challenges that are specific to children.

It is this kind of training that our Nation's children's hospitals are uniquely qualified to provide. Our current system of financial support for medical training disadvantages children's teaching hospitals, and the Johnson amendment begins to address the inequities of our graduate medical education system by authorizing a grant program to advance pediatrician training and pediatric research. It is a small price to pay to ensure that our children's hospitals can continue their mission to care for the sickest and poorest children while training the next generation of caregivers. It makes sense to add this provision to legislation that is focused on promoting public-private partnership to ensure health care quality research and patient access to care.

This interim solution to fix the inequities of our GME system has the support of 190 Members of the House and 38 Senators who have cosponsored similar legislation. I urge the rest of my colleagues to join us in support of the Johnson amendment and in recognition of the special work that children's doctors devote their lives and energies to.

Mr. LARSON. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I rise today in support of the amendment offered by my esteemed colleague from Connecticut (Mrs. JOHNSON). The amendment provides funding for grants to children's hospitals to train pediatricians. This amendment incorporates the provisions of H.R. 1579, the Children's Hospitals Education and Research Act of 1999. It was one of the first bills I cosponsored on becoming a Member of this body.

This amendment greatly affects the 59 independent children's teaching hospitals across this Nation. Although these hospitals represent less than 1 percent of all hospitals in the Nation, they train over 5 percent of all physicians, 29 percent of all pediatricians and most pediatric specialists.

The Connecticut Children's Medical Center is located in the center of my district and is one of these hospitals that desperately needs this graduate medical funding for their education programs. I have heard from many of my constituents and work closely with the staff at the medical center, its president, Larry Gold, and Eva Bunnell who is a tireless advocate on behalf of the children of our great State of Connecticut.

As a parent of three children, I understand the importance and necessity of this funding. This amendment would authorize annual funding for 2 years and provide a more equitable, competitive playing field for independent children's teaching hospitals.

I wear this pin today, which is the Connecticut Children's Medical Center's logo. It represents an open-armed child made of colorful blocks. A 8-year-old from the hospital said the logo looks like a kid ready to give a hug.

We cannot turn our backs on the Nation's children and the care they deserve, and aside from the hugs they richly deserve, they need funding. Without this funding, these independent hospitals, which care solely for children, will find it hard to operate to the best of their ability.

I commend the gentlewoman from Connecticut (Mrs. JOHNSON) for her tireless work on behalf of children in the State of Connecticut and across this Nation. She has done so since she was a member of the Connecticut State Senate. I rise in support of this amendment today and urge our colleagues to join us.

Mrs. JOHNSON of Connecticut. Mr. Chairman, will the gentleman yield?

Mr. LARSON. I yield to the gentlewoman from Connecticut.

Mrs. JOHNSON of Connecticut. Mr. Chairman, it really is a pleasure to have the gentleman from Connecticut here and in support of the remarkable Children's Hospital in Hartford, Connecticut, but I think it gives us a good example of why this is so urgent and why my colleague, the gentleman from Florida (Mr. BILIRAKIS) has been so generous as to let us bring this on this bill.

□ 1700

Truly, in the environment in which our hospitals are operating, our remarkable little Children's Hospital is a good example of the terrible circumstances these children's centers face. They serve mostly children. Medicaid reimburses much worse than Medicare reimburses, to begin with, and then they are right in the middle of Hartford so they have many, many uninsured children, many very poor children, who need a lot of special care, and yet they get not one cent or hardly a cent of reimbursement for their teaching and research initiatives. We just cannot let this happen.

In the interim, we need this money to help them survive this period of extraordinary change in reimbursements. I just appreciate the gentleman's long working relationship with them, the help he has been on this bill.

I would also like to just take a moment to thank the ranking member, the gentleman from Ohio (Mr. BROWN), who has been a long solid advocate of children's hospitals and worked hard on this amendment for the year and a half or 2 years we have been working on it.

Mr. LARSON. Mr. Chairman, reclaiming my time, I can add no more to the gentlewoman's eloquence.

Mr. WAXMAN. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I rise in support of this amendment offered by our colleague, the gentlewoman from Connecticut (Mrs. JOHNSON). By providing adequate Graduate Medical Education funding to children's hospitals, this amendment will ensure that our Nation's premier pediatric health care institutions are capable of pursuing their research, training, and primary-care missions on a firm financial footing.

For too long Congress has failed to remedy a clear inequity in the funding of Graduate Medical Education at children's hospitals. Because GME funding is contingent upon an institution's Medicare census, children's hospitals have not received adequate funding for the direct and indirect expenses of operating essential pediatric residency programs.

This amendment has strong bipartisan support in both the House and the Senate. I urge my colleagues to cast a vote in favor of strengthening our children's health care by supporting this amendment.

Let me conclude by saying how pleased I am that the House has reauthorized AHCPR, soon to be called the Agency for Health Research and Quality. I am proud to have been the one to have introduced this legislation creating the agency in 1989 with Senator KENNEDY. Just three years ago, AHCPR underwent a near-death experience arising from partisan politics, so I am

especially pleased this essential agency once again has the bipartisan support it deserves.

Ms. MCCARTHY of Missouri. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I want to thank the chairman of the subcommittee, the gentleman from Florida (Mr. BILIRAKIS) for accepting this amendment, to thank the gentlewoman from Connecticut (Mrs. JOHNSON) for her tireless efforts in championing it, and to thank my ranking member, the gentleman from Ohio (Mr. BROWN), for his tireless work as well in support of our children.

I am a cosponsor of similar legislation, and I am very pleased we are moving forward now on this key issue, which will authorize $565 million in appropriations for children's hospitals to maintain their graduate residency training programs.

This is critical to the health of our children. Children's hospitals are responsible for the pediatric training of almost one-third of the Nation's pediatricians. A lack of Federal support jeopardizes all education and training programs in children's hospitals, thereby threatening not only the pediatric workforce, but future health-care research and our children's health. It would be penny-wise and pound-foolish to continue down this path.

In my district alone, this temporary funding will help train 70 doctors at Children's Mercy Hospital, a freestanding regional facility in Kansas City. The Johnson amendment supports the 59 children's teaching hospitals all across our country. I commend the sponsor and chairman and ranking member.

Mr. BACHUS. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, first of all, I would like to commend the gentlewoman from Connecticut (Mrs. JOHNSON), the chairman of the subcommittee, the gentleman from Florida (Mr. BILIRAKIS), and the gentleman from Ohio (Mr. BROWN) for offering this amendment.

Let me tell you what it means to one hospital of the 59. Children's Hospital of Alabama is the only freestanding pediatric hospital in the State of Alabama. It not only receives patients from Alabama, it receives patients from Mississippi and from as far away as Chattanooga, Tennessee.

Children's Hospital presently spends $4 million to $6 million annually for Graduate Medical Education. Unlike hospitals which treat Medicare patients, Children's Hospital receives no Medicare funds, and, therefore, no Medicare graduate medical expense reimbursement.

As the gentlewoman from Connecticut has said, Medicaid reimbursements are less, commercial insurers are not offering reimbursement for these expenses, and, with the recent changes in Medicaid and Medicare, all our hospitals are operating under cost controls, but our children's hospitals are operating on the severest of restraints.

Children's hospitals, we have heard various figures on how many of the pediatricians these hospitals train. Children's hospitals train 75 percent of the pediatricians in Alabama; and, nationwide, although children's hospitals train 25 percent or one-fourth of pediatricians, they train almost all pediatric sub-specialists. These are the people that treat our little boys and girls with cancer, with epileptic seizures, those children who are injured in accidents. Our sickest children come to our children's hospitals. They need the best of care, and they need medical doctors who are trained and trained well.

It is for this reason that I support enthusiastically the amendment of the gentlewoman from Connecticut (Mrs. JOHNSON), for, as we are fond of saying in this body, our children deserve the best, and that includes the best health care, and that includes the best trained health care pediatricians. This amendment will assure that.

To the gentlewoman from Connecticut (Mrs. JOHNSON), I thank you for your hard work; and I commend the body for its consideration of this measure.

Mr. BENTSEN. Mr. Chairman, I move to strike the requisite number of words.

(Mr. BENTSEN asked and was given permission to revise and extend his remarks.)

Mr. BENTSEN. Mr. Chairman, I rise in support of the amendment offered by the gentlewoman from Connecticut (Ms. JOHNSON) and commend her for offering this amendment. I also want to commend the ranking member, the gentleman from Ohio (Mr. BROWN). Both the gentlewoman from Connecticut (Mrs. JOHNSON) and the gentleman from Ohio (Mr. BROWN) have been the original sponsors, of which I am an original cosponsor, of the bill, H.R. 1579, the Children's Hospital Education Research Act, and I commend them for having the foresight to introduce this legislation.

The JOHNSON amendment would provide critically important Federal funding for our Nation's 59 independent children's hospitals, including six such hospitals in Texas. I have the honor and distinction to represent two children's hospitals, Texas Children's Hospital, which is a qualified independent children's hospital, as well as Memorial Hermann Children's Hospital, which is part of a larger hospital system. In addition to that, I have the Shriner's Orthopedic Hospital in my district in the Texas Medical Center complex, which is in the 25th District. All of these are teaching hospitals aligned with the Baylor College of Medicine and the University of Texas.

As has been pointed out by many Members today, there is a great disparity in the level of Federal funding for teaching hospitals for pediatrics versus other types of teaching hospitals. That is due in large part because of how we have structured our medical education program around the Medicare system.

As the gentlewoman knows from the Committee on Ways and Means, this is a broader issue that we need to address. Some of us, the gentleman from Maryland (Mr. CARDIN) and myself, have some ideas. Others have their ideas. The chairman of the Committee on Ways and Means, my next-door neighbor in Houston, has his ideas. But, nonetheless, we should not wait until we come to a conclusion on that. We ought to act as the chairman of the subcommittee said. This is the right thing to do right now.

As has been pointed out, these hospitals, while only being a small percentage, train a very large percentage of the pediatricians. As the gentlewoman from Connecticut (Mrs. JOHNSON) pointed out, these hospitals are under tremendous financial pressure. They are under financial pressure from the private sector in managed-care health plans. They are under pressure in the Medicaid program.

In fact, back in 1997, as part of the Balanced Budget Act, we made pretty dramatic reductions in the disproportionate share program. Fortunately, we were able to ease those a little bit as it affected States like mine in Texas, Connecticut, and others. Those reductions were made, nonetheless. We know that the Nation's children's hospitals do carry a disproportionate share of both indigent and Medicaid patients, which just adds to the fiscal burden that they have to address.

This bill would provide in a 2-year capped program some additional funding to address this situation. But, more importantly, in the long term it would underscore the Federal commitment to ensuring that we continue to have the world's best pediatric care and that we continue to have the world's best medical education program.

I hope by passage of this amendment, and hopefully passage of this bill and funding of this bill, that we can go a step further, and when we look at the overall Graduate Medical Education program or the medical education program, we will look beyond just Medicare and understand that training doctors and training the other allied health positions is not just something that is benefited by the Medicare beneficiaries; but all of us, including our children, benefit from this; and, thus, we should take that into account in structuring the program.

So I commend the gentlewoman from Connecticut, the gentleman from Ohio and the chairman of the subcommittee for accepting this amendment, and I ask my colleagues to support the amendment.

Mr. COOK. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I rise in support of the amendment being offered by the gentlewoman from Connecticut. Children's teaching hospitals play a vital and

unique role in our health care system. They are the training ground for future pediatricians, and nurses and they do groundbreaking research into children's illnesses. Many of these hospitals are freestanding facilities without the resources of a university or a health care organization to subsidize the higher costs the teaching hospitals incur.

Primary Children's Hospital in my State of Utah is one such hospital. It trains an average of 52 residents a year and has an outstanding reputation as one of the leading children's hospitals in the West. Most pediatricians in the 5–State Intermountain region have received at least some of their training at Primary Children's Hospital. But because children's hospitals treat few Medicare patients, they are at an economic disadvantage, since Graduate Medical Education is funded through the Medicare program. As a result, they receive less than one-half of 1 percent of what other teaching facilities receive in Federal assistance. This is not right. Our children deserve the finest health care that we can provide.

The $280 million grant funding proposed in the amendment offered by the gentlewoman from Connecticut (Mrs. JOHNSON) is a modest effort to provide some equity and relief to these hospitals and enable them to continue their fine work. I was a cosponsor of H.R. 1579, and I am proud to support this amendment. I hope my colleagues will join me and stand up for children's health by voting for this amendment.

Ms. LEE. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I rise in strong support of the amendment offered by the gentlewoman from Connecticut (Mrs. JOHNSON) to authorize $280 million in fiscal 2000 and $285 million in fiscal 2001 for a program that would provide grants to children's hospitals to train pediatricians.

On behalf of the Children's Hospital in Oakland, California, my district, I want to thank the gentlewoman from Connecticut (Mrs. JOHNSON) and the gentleman from Ohio (Mr. BROWN) for this amendment. This authorization is needed because freestanding children's hospitals are disadvantaged under the current Federal Graduate Medical Education funding for children's teaching hospitals.

Freestanding children's hospitals receive an average of less than one-half percent of what other teaching facilities receive in Federal Graduate Medical Education funding.

□ 1715

Now, in Oakland, California, in my district, Children's Hospital, a freestanding hospital, has 205 licensed beds. It is a regional trauma center and is an independent teaching hospital. It is a hospital that when my children were children played a very important role in the healthy development of my kids. It continues to be an exemplary medical facility and a very supportive environment for children and their families.

Now, because the hospital only treats children and not the elderly, it receives almost no graduate medical payments from Medicare, the one stable source of Graduate Medical Education support.

At Children's Hospital in Oakland, California, senior clinicians and scientists work with young doctors in pediatrics and pediatric specialities. It is these interns and residents who will become the pediatricians and scientists of tomorrow and who will bring us the miracles of the 21st century, a cure for cancer, new therapies, and other great possibilities. We need an equitable playing field in the price competitive health-care marketplace.

Medicare has become the only reliable source of significant support for Graduate Medical Education in teaching hospitals. Because children's teaching hospitals care for children, they receive less than .5 percent of the Medicare Graduate Medical Education support provided to other teaching hospitals. The current mechanism for Graduate Medical Education financing does not equitably recognize the contribution of these hospitals. So we must invest in children's health.

Independent children's teaching hospitals are less than 1 percent of all hospitals but train nearly 30 percent of all pediatricians and nearly half of all pediatric specialists. A strong academic program is critical to all facets of children's hospitals' missions. They care for the sickest and the poorest children, training the next generation of caregivers for children and research in order to improve children's health care. They are in the community, responding to the health care needs of our children and supporting their families.

So this amendment has broad bipartisan support. I urge my colleagues to support this amendment; and once again, I want to thank the gentlewoman from Connecticut (Mrs. JOHNSON) and the gentleman from Ohio (Mr. BROWN) for their support and commitment to children in our country.

Mr. BROWN of Ohio. Mr. Chairman, I rise in support of the Johnson amendment.

Mr. Chairman, I commend the gentlewoman for her work and also the gentlewoman from California (Ms. LEE) and others that have spoken before me. Before I introduced this legislation 2½ years ago, I visited the Akron Children's Hospital in Akron, Ohio, and saw the outstanding kind of work that medical personnel in that hospital did in pediatric medical advancement. As has been outlined by previous speakers, there is not a very good funding stream for medical education in children's hospitals and especially in freestanding children's hospitals.

Ohio is the home, I believe, of more freestanding children's hospitals than any State in the country. With the squeeze of managed care, coupled with the peculiarity of the way that we fund Graduate Medical Education through Medicare, children's hospitals simply cannot produce the pediatric specialists or, for that matter, the pediatric general practitioners that this country needs to produce. This is a very good amendment. This is a very important part of this bill. I commend the sponsor of the bill and ask for support of the Johnson amendment.

Mr. THOMAS. Mr. Chairman, I rise in support of Representative NANCY JOHNSON's amendment to the Health Research Quality Act (HR 2506). This amendment authorizes $280 million in FY 2000 and $285 million in FY 2001 for graduate training programs at children's hospitals.

Mr. Chairman, the way the government currently finances graduate medical education makes little objective sense. The system has unfairly penalized children's hospitals.

The training of physicians, in what is known as Direct Graduate Medical Education, is financed through Medicare's Hospital Insurance Trust Fund. Thus, the funds a hospital receives depends on the number of Medicare patients it serves. Since children's hospitals treat very few Medicare patients (primarily those with End Stage Renal Disease), they receive almost no funding from the Medicare program. Medicare pays teaching hospitals $7 billion in Graduate Medical Education, or about $76,000 per resident. Yet children's hospitals receive only about $400 per resident, despite training more than one-fourth of the nation's physicians and a majority of the pediatric specialties. In addition, free-standing children's hospitals constitute less than 1% of all hospitals but train more than 5% of all residents.

This illustrates one more reason why the entire direct graduate medical education program is in need of fundamental reform. Why should the training of residents who go on to treat patients of all demographic profiles be financed out of a program designed for the elderly and disabled? Second, why should we pay certain hospitals 5 or 6 times the amount per resident as we pay for the training of equally qualified residents at equally prestigious universities and teaching hospitals in other regions of the country?

Senator BILL FRIST, also a former physician, headed a task force within the Medicare Commission, which recommended that direct medical education be funded outside of the Medicare structure. I believe we can provide a more secure funding structure through a multiyear appropriations process because it provides a larger pool of resources: the General Fund. In addition, an appropriations process will provide needed oversight into the inequities that is lacking in the current entitlement structure.

I am pleased that Representative NANCY JOHNSON and the children's hospitals support the Medicare Commission's recommendation that children hospital DME be funded through the appropriations process. I strongly endorse this amendment and hope we can finally start providing needed resources to children's hospitals so that they may secure the important missions they perform.

Mr. SESSIONS. Mr. Chairman, freestanding children's hospitals are disadvantaged under the current federal GME (Graduate Medical Education) funding structure. GME is principally funded through the Medicare program.

Teaching hospitals receive funding based on the number of patients that they treat. Because children's hospitals treat few Medicare patients, they receive no significant federal support for GME.

Children's hospitals receive on average less than one-half of one percent (0.5%) of what other teaching facilities receive in federal GME funding. This grant program would provide GME support for children's hospitals that is commensurate with federal GME support that other teaching facilities receive under Medicare.

Training programs are necessary to ensure quality health care for children. The education and training programs of these institutions are critical to the future of pediatric medicine and therefore to the future health of all children.

In 1998, Children's Medical Center of Dallas served as the training site for 77 pediatric residents. Although hospitals like ''Children's Med. Center of Dallas'' represents less than 1% of all hospitals in the country, independent children's teaching hospitals are responsible for training nearly 30% of all pediatricians, nearly half of all pediatric subspecialties and train over 5% of all residents nationwide.

This amendment would establish interim assistance to children's hospitals to maintain their teaching program while Congress addresses the inequities in the current GME system through Medicare reform. The grant program would provide $280 million in FY2000 and $285 million in FY2001.

Mr. PORTMAN. Mr. Chairman, I rise in strong support of Mrs. JOHNSON'S amendment to establish interim funding assistance to children's hospitals. The amendment will enable children's hospitals in Ohio and across the nation to maintain their teaching programs while Congress addresses the inequities in the current graduate medical education (GME) system through Medicare reform.

The nation's 59 freestanding children's hospitals, including Children's Hospital Medical Center in Cincinnati, train about 30 percent of the nation's pediatricians and nearly half of all pediatric specialists. Many residents of other hospitals who require pediatric rotations are trained at these facilities as well. Although they make up less than 1 percent of all hospitals, freestanding children's hospitals educate and train over 5 percent of all residents nationwide.

However, the current system of federal funding assistance is tilted against pediatric training. Graduate medical education is funded primarily through Medicare based on the number of patients that teaching hospitals treat. Since few Medicare patients receive care at children's hospitals, these facilities get less than one-half of one percent of what other teaching hospitals get in federal GME funding. This unfair situation threatens the future of our nation's pediatric workforce and also hinders the development of new treatments since teaching facilities perform the majority of health care research.

Congress recognized this problem in the Balanced Budget Act of 1997 by directing both the Medicare Payment Advisory Commission and the Bipartisan Commission on the Future of Medicare to address the financing of graduate medical education in children's hospitals as part of a comprehensive evaluation of GME. However, GME reform will take a while to develop. Therefore, the Johnson amendment will provide immediate financial assistance to children's hospitals comparable to the federal GME support that other teaching facilities receive under Medicare. It would do this through a capped, time-limited authorization of appropriations.

The Johnson amendment is essentially the language of the Children's Hospital Education and Research Act, H.R. 1579. I am an original cosponsor of a bipartisan bill, which is supported by over 190 Members of the House, including the chairs, ranking members and other members of subcommittees and committees of jurisdiction—the Commerce, Ways and Means and Appropriations Committees.

I urge my colleagues to support this important amendment to provide children's hospitals with a level playing field by addressing the federal funding GME gap they face, and, at the same time, give children a better shot at growing up healthy.

Mr. HOBSON. Mr. Chairman, I rise in support of the amendment offered by the gentlelady from Connecticut. This issue is particularly important for children in Ohio, where thousands of sick children every year are treated at Ohio's six independent children's hospitals.

Over the recent district work period, I visited the Children's Medical Center in Dayton, Ohio. Not only does the Center provide first rate care for children, it also provides a caring and attentive environment that allows parents and relatives to actively participate in their children's care. We all know how important it is to be near our children when they are sick, and the nation's children's hospitals provide the atmosphere and specialized care that is the best medicine for our children.

At some hospital serving adult populations in Ohio, the federal reimbursement for resident training is about $50,000 per resident. This federal commitment to graduate medical education has helped ensure that our doctors and the quality of care they provide are the best in the world.

However, due to the way the reimbursement formula has been set up, the federal commitment to graduate medical education at children's hospitals is much smaller. For example, Children's Hospital in Columbus, Ohio received about $230 per resident last year.

This amendment restores some fairness to the reimbursement rates that children's hospitals receive and will help ensure that Ohio and other states with children's hospitals will continue to train qualified pediatricians. This is an issue of fairness, and an investment longoverdue, and I urge my colleagues to support this amendment.

Ms. DUNN. Mr. Chairman, I rise in support of Representative JOHNSON's amendment to provide grants to train medical residents at independent children's hospitals. I commend my friend for her leadership on this important issue and ask my colleagues to support her amendment.

The problem is simple: the federal government provides funding for graduate medical education through Medicare. Independent children's hospitals throughout this nation treat children under the age of 21, which is primarily a Medicaid population. Consequently, these hospitals do not receive Medicare funding for the medical professionals they train.

To rectify this discrepancy, this amendment will provide funding to children's hospitals that train medical doctors to be pediatricians. These hospitals are critical to serving sick children and providing important research to improve the quality of children's lives.

Earlier this year, Speaker HASTERT joined me in visiting the Children's Hospital and Regional Medical Center in Seattle, Washington. With 72 pediatric residents a year, Children's Hospital in Seattle is the dominant provider for training of pediatricians in the Pacific Northwest, covering the region of Washington, Wyoming, Alaska, Montana and Idaho.

In 1997, Children's Hospital invested $8 million in its medical education program and was reimbursed only $160,000 from Medicare and $2.4 million from Medicaid. This hospital cannot meet the needs of our community if it is forced to reduce the number of residents it trains. This amendment will improve quality of care by continuing to provide doctors who specialize as pediatricians or other pediatric subspecialties.

Independent children's teaching hospitals are less than 1% of all hospitals, but they train nearly 30% of all pediatricians. More importantly, we can continue our commitment to helping the sickest and poorest children in our communities.

As a parent of two sons, I know the importance of good quality health care for our children, and we must be very careful to leave no child behind. I urge my colleagues to support this important amendment. It is an investment in our children's health.

The CHAIRMAN pro tempore (Mr. QUINN). The question is on the amendment offered by the gentlewoman from Connecticut (Mrs. JOHNSON).

The amendment was agreed to.

AMENDMENT NO. 19 OFFERED BY MR. MCGOVERN

Mr. MCGOVERN. Mr. Chairman, I offer amendment No. 19.

The CHAIRMAN pro tempore. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 19 offered by Mr. MCGOVERN:

Page 46, after line 2, insert the following section:

SEC. 4. STUDY REGARDING SHORTAGES OF LICENSED PHARMACISTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), acting through the appropriate agencies of the Public Health Services, shall conduct a study to determine whether and to what extent there is a shortage of licensed pharmacists. In carrying out the study, the Secretary shall seek the comments of appropriate public and private entities regarding any such shortage.

(b) REPORT TO CONGRESS.—Not later than one year after the date of the enactment of this Act, the Secretary shall complete the study under subsection (a) and submit to the Congress a report that describes the findings made through the study and that contains a summary of the comments received by the Secretary pursuant to such subsection.

Mr. MCGOVERN. Mr. Chairman, my amendment calls attention to a very serious problem in this country, the potential shortage of pharmacists. As the population ages and prescription drug use continues to increase, we must examine whether there are enough qualified pharmacists to knowledgeably and safely distribute these medicines. My amendment would require that the Health Resources Services Administration study whether and

to what extent there is a shortage of licensed pharmacists and to report back to Congress in 1 year on its findings. The report would include comments from private and public entities.

Mr. Chairman, as we debate the specifics of a prescription drug plan, which is incredibly important, we must also examine the potential shortage of pharmacists serving our health-care community. Our health-care system is changing from inpatient to outpatient treatment. Pharmaceutical manufacturing is on the rise; and even though there is debate about the specifics of such a plan, I think we all recognize the need for a Medicare prescription drug benefit.

As these events continue to unfold, we must recognize the lag in the education and development of new, qualified pharmacists. Currently, pharmacy providers throughout northern New England and around the country are experiencing difficulty finding enough pharmacists to keep up with the demand for prescription drugs. Pharmacists often serve as a valuable link between patients and their doctors. They provide valuable information about side effects and drug interactions. They ensure that our prescriptions are filled correctly, and they provide important advice on a range of issues when one of us or a member of our family is not feeling well.

I am concerned, Mr. Chairman, that in the near future people will not have access to the important community-based prescription services that are vital to maintaining their health. Unfortunately, this situation will only worsen. For example, the National Association of Chain Drug Stores estimates that the number of prescriptions will increase from 2.8 billion per year today to 4 billion in the year 2005. The number of pharmacists, however, is not projected to keep up with this demand. Data from the National Association of Chain Drug Stores shows that while the number of prescriptions in Massachusetts, my State, will increase 39 percent between 1998 and 2005, the number of pharmacists will only increase 13 percent over that same amount of time.

That is Massachusetts. The same problem exists all over the country. I believe Congress needs to take action. I have been working with the Massachusetts College of Pharmacy, which is opening a campus in Worcester, Massachusetts, in an attempt to deal with what potentially can be a major health crisis in this country.

In my opinion, we need to support the creation of more pharmacy schools. We need to examine ways to help encourage more people to enter the field of pharmacy, and we need to make sure that the financial assistance is available for students who want to pursue a career in pharmacy. By voting for this amendment, Congress will take the first step in determining whether and to what extent there is a shortage of pharmacists in this country, and I believe this will lay the groundwork for us to take actions in the future to remedy this very significant problem.

Mr. Chairman, I urge support of this amendment.

Mr. Chairman, I insert the following letter for printing in the RECORD:

MASSACHUSETTS COLLEGE OF PHARMACY AND ALLIED HEALTH SCIENCES, OFFICE OF THE PRESIDENT,

September 24, 1999.

Hon. JAMES P. MCGOVERN,
416 Cannon House Office Building, Washington, District of Columbia.

DEAR CONGRESSMAN MCGOVERN: I want to commend you for addressing the current pharmacist shortage in America. I support your amendment to the Health Research Quality Act, H.R. 2506, which would study the impending crisis and report potential solutions.

The combination of new biomedical discoveries, and the substantial graying of a large segment of the population, will create demands for billions more prescriptions that will be critical to maintaining the health of many Americans in the 21st century. This increase will cause an equal demand on human resources, and the need to supply trained personnel in pharmacy and counseling. In their 1998 study, the National Association of Chain Drug Stores found over 3500 vacant positions among their members, concluding that the demand for pharmacists could grow by as much as 30% over the next two years.

Like a great many of our colleagues throughout the nation, the Massachusetts College of Pharmacy and Health Sciences has been mindful of this burgeoning health care crisis from the need for trained community pharmacists. The project that will allow us to help to alleviate this crisis is the development of a fully accredited MCPHS campus in the city of Worcester, Massachusetts. Aided by the support of both the public and the private sectors, our strategic planning outlines a growth in academic resources that will facilitate an increase of 500 more pharmacy graduates, to bring out total to almost 2200 degrees in pharmacy studies, by the year 2003. I believe that this project holds great potential as an effective public-private partnership that could truly serve as a national model of creative response to this impending cataclysm to national health care.

We, at MCPHS, urge you and your colleagues to give serious consideration in developing recommendations to address this serious shortage of licensed pharmacists.

Sincerely,

CHARLES F. MONAHAN, Jr.

NACDS, NATIONAL ASSOCIATION OF CHAIN DRUG STORES,

September 28, 1999.

Hon. JAMES P. MCGOVERN,
U.S. House of Representatives, Washington, DC.

DEAR CONGRESSMAN MCGOVERN: On behalf of the National Association of Chain Drug Stores (NACDS), I am writing to applaud your leadership in raising awareness about the national shortage of licensed pharmacists. We are proud to be working with you on this issue and look forward to continuing our cooperative efforts to find solutions to this important public health concern.

Toward this end, NACDS supports your efforts to amend H.R. 2506, the Health Research and Quality Act, to direct the Secretary of Health and Human Services to conduct a study on the shortage of licensed pharmacists. As you are well aware, NACDS had conducted research concluding that the pharmacist shortage is an acute situation that will only get worse as the national demand for prescription drug therapy continues to grow. With your amendment, Congress can take an important step towards developing solutions to ensure that an adequate supply of pharmacists is available to provide medication and pharmaceutical services to the public in the future.

We also appreciate that you have included in the amendment a definitive date for completion of the study, as this will ensure that this issue receives the urgent consideration it deserves. Given the potential consequences of prolonging the pharmacist shortage, this research is too important to delay.

Thank you for your ongoing efforts to ensure the Americans consumers have access to the best health care services available. If I may be of any assistance on this or other issues, please do not hesitate to contact me.

Sincerely,

ROBERT W. HANNAN,
President and Chief Executive Officer.

Mr. BILIRAKIS. Mr. Chairman, I move to strike the last word.

Mr. Chairman, the majority has had an opportunity to review the amendment. I personally spoke with the gentleman regarding his amendment. I commend him for it, and I would agree with him. Certainly in Florida, where we have such a much bigger demand than most of the States in the country, we have a tremendous shortage of pharmacists. Most of the members of my family are pharmacists, and I am able to keep up with that.

Mr. Chairman, we are prepared to accept the amendment.

Mr. BROWN of Ohio. Mr. Chairman, I rise in support of the McGovern amendment.

Mr. Chairman, I want to thank the gentleman for his commitment, particularly in light of what Congress looks like it may do on prescription drugs, for his commitment to this issue. I think it is something we need to know more about to see if it is regional, if it is national, how acute the shortage is; and I think this amendment will help us learn to do that and deal with coverage of prescription drugs nationally also. I commend him and ask for support of the amendment.

Mr. BERRY. Mr. Chairman, I rise today as a licensed pharmacist, in support of the McGovern amendment.

I always say that I am proud to have served in two of the most respected professions: as a farmer and a pharmacist.

I have stood here many times to talk about the affordability of prescription drugs. Today, I am here to ask that we pass this amendment for the sake of consumers.

Why? Because our nation's consumers, especially seniors, rely on pharmacists for their livelihood.

In the 1st Congressional District of Arkansas, these shortages are in the smaller towns.

The demand for full-time pharmacists has increased more than 25 percent in the past two years.

We all know from traveling in our districts that one of the main concerns of seniors is the affordability of prescription drugs. But we also know that not enough pharmacists to fill those prescriptions, this is also a major problem.

Let's pass the McGovern amendment.

The CHAIRMAN pro tempore. The question is on the amendment offered

by the gentleman from Massachusetts (Mr. MCGOVERN).

The amendment was agreed to.

AMENDMENT NO. 22 OFFERED BY MR. THOMPSON OF CALIFORNIA

Mr. THOMPSON of California. Mr. Chairman, I offer amendment No. 22.

The CHAIRMAN pro tempore. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 22 offered by Mr. THOMPSON of California:

Page 46, after line 2, add the following section:

SEC. 4. REPORT ON TELEMEDICINE.

Not later than January 10, 2001, the Director of the Agency for Health Research and Quality shall submit to the Congress a report that—

(1) identifies any factors that inhibit the expansion and accessibility of telemedicine services, including factors relating to telemedicine networks;

(2) identifies any factors that, in addition to geographical isolation, should be used to determine which patients need or require access to telemedicine care;

(3) determines the extent to which—

(A) patients receiving telemedicine service have benefited from the services, and are satisfied with the treatment received pursuant to the services; and

(B) the medical outcomes for such patients would have differed if telemedicine services had not been available to the patients;

(4) determines the extent to which physicians involved with telemedicine services have been satisfied with the medical aspects of the services;

(5) determines the extent to which primary care physicians are enhancing their medical knowledge and experience through the interaction with specialists provided by telemedicine consultations; and

(6) identifies legal and medical issues relating to State licensing of health professionals that are presented by telemedicine services, and provides any recommendations of the Director for responding to such issues.

Mr. THOMPSON of California. Mr. Chairman, telemedicine has been in existence for over 30 years but has only recently become one of the fastest growing areas of medicine. Telemedicine allows a consulting physician at one location to observe a patient or interpret data at another location via two-way audio or video links. Dermatology, oncology, cardiology, radiology, and surgery are just a few of the areas of medicine that have felt the positive impact of this technology.

If someone represents a rural district, as I do, they have heard from constituents who often have to travel long distances to consult with medical specialists. Telemedicine allows these same individuals to consult with their primary-care physician and a specialist at the same time without the burdens of extraordinary travel, but telemedicine does not just help rural districts. This field of medicine has the potential to provide a wider range of services to all underserved communities, both rural and urban.

The benefits of telemedicine are numerous; but in order to encourage its growth, we still need to research and answer a few critical questions.

Are patients who have received telemedicine benefiting from it? What criteria should be used to determine which patients need these services? What factors are inhibiting the expansion of accessibility of telemedicine networks?

Congress in the past has commissioned reports on telemedicine, including one under the Health Insurance Portability and Accountability Act of 1996 and another under the Balanced Budget Act of 1997. Although these reports address many important aspects of the field, there are still gaps that need to be filled in.

In working with the National Institutes of Health and other medical professionals throughout the country, I have drafted this amendment. It requires the Agency for Health Research and Quality to research and respond to Congress by January of 2001 on issues relating to patient screening and interstate licensing of medical professionals.

In addition, this amendment would require a review of the factors that may be inhibiting the expansion of telemedicine networks. It is necessary to identify the hurdles that still need to be overcome in this field in order to establish and promote successful systems of telemedicine.

I want to thank the chairman and the ranking member for their great work on this measure, and I would urge a yes vote on this amendment.

Mr. OSE. Mr. Chairman, I rise in support of the amendment by my good friend, the gentleman from California (Mr. THOMPSON).

Mr. Chairman, I have this past week spent much time in my district visiting the various facilities that serve the medical needs of the people who live in the Third District, and I will say firsthand, up front and personal, that this system works. I have been in the hospital in Colusa, a small city of around 5,500 in my district, where we actually communicated as I was standing there with people at the University of California at Davis Medical Center talking about issues affecting a patient.

Telemedicine works. It helps the people in my district, and the thing that is so critical here, the thing that actually makes a difference, that we should support here if for no other reason is that telemedicine is an effective, efficient, beneficial way to bring medical assistance to the people who live in our rural areas throughout this country.

I have seen it work. I want to say that. I have seen it work in my district. There is a camera. There is a screen. There are people on the other end, and it is just like talking from here to the Chair.

The amendment of the gentleman is well thought out. The fact that we can get some additional greater information to allow us to make reasoned, rational decisions regarding telemedicine merits our support. I thank the chairman for considering it.

Mr. BILIRAKIS. Mr. Chairman, will the gentleman yield?

Mr. OSE. I yield to the gentleman from Florida.

Mr. BILIRAKIS. Mr. Chairman, I thank the gentleman from California (Mr. OSE) for yielding.

Mr. Chairman, I really appreciate the gentleman sharing his story with us and commend the gentleman from California (Mr. THOMPSON) for offering this amendment. Back in the days when RON WYDEN from Oregon, who is now a U.S. senator, was here, he and I spent a lot of time on the issue of telemedicine. We ran into some roadblocks but it has been sort of a little bit of a cause of mine, a secondary cause of mine unfortunately, but I think it is an excellent resource.

Frankly, my opinion is that it is not being used to its full potential and hopefully the gentleman's amendment will focus the agency on this particular issue, and hopefully we can improve upon that. So in any case, we are prepared to accept the amendment.

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Mr. FALEOMAVAEGA. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I certainly want to commend the gentleman from Florida (Mr. BILIRAKIS), the chairman of the Subcommittee on Health and Environment, and the gentleman from Ohio (Mr. BROWN), our ranking member, for allowing this amendment to be brought before the floor.

Mr. Chairman, I rise today in full support of the proposed amendment of the gentleman from California (Mr. THOMPSON) to H.R. 2506 to require the Agency for Health Research and Quality to submit a report to Congress by January 2001 on telemedicine.

Mr. Chairman, I represent a group of Americans living in a remote area, far from the modern hospitals or other major health facilities. The people of my district get sick and are injured just like anyone throughout the country.

One big difference, Mr. Chairman, is that, if a person's serious injury or illness cannot be treated by a local physician, he may just have to wait awhile before he or she can be transferred to the nearest major hospital, which is about a 5-hour plane ride from Samoa to Honolulu. To make things more complicated, Mr. Chairman, there are only two flights per week between American Samoa and Honolulu.

In addition to that, Mr. Chairman, the cost of transporting a patient in a gurney, along with an attending nurse or physician 2,300 miles to Hawaii and back is quite significant, which leads to the very reason why I fully support this amendment for telemedicine.

Mr. Chairman, presently health and medical care needs in rural America and distant U.S. insular areas are simply overwhelming the available resources. Telemedicine can work to lessen the costs and, at the same time, can dramatically improve the quality of and access to needed health and medical care.

Telemedicine can be a very valuable tool to medical facilities in rural areas.

We now have the technology to assist rural America, but the infrastructure is not always in place, and the costs are still somewhat of a concern.

This amendment will require that we devote some of our resources to determining how best to move forward with this emergent technology to provide improved medical care for rural America.

Again, I thank the gentleman from California (Mr. THOMPSON) for his initiative by introducing this necessary amendment, and my appreciation to the chairman and the ranking member for their leadership and assistance by allowing this amendment to be included in this legislation.

I urge my colleagues to support this amendment.

Ms. WOOLSEY. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I, too, am in support of this amendment, an amendment to bring the delivery of health care into the 21st century.

Telemedicine is an innovative and fast growing field that provides real access and necessary access to medical care, particularly to areas that are not close to major medical facilities.

That is why this year the gentleman from California (Mr. THOMPSON) and I requested funding for a telemedicine network located in Santa Rosa at Santa Rosa Memorial Hospital to provide access to the children and families in northern California's remote and underserved population.

Santa Rosa Memorial Hospital is in my district, and the majority of the families that it would serve are in the district of the gentleman from California (Mr. THOMPSON). Together, that was a partnership to take care of the children in our area in general.

The U.S. Department of Health and Human Services has classified portions of our districts as medically underserved. Specialty and trauma care are often limited and episodic at best, making telemedicine the only viable answer to making care accessible to these families.

The children who need state-of-the-art medicine, but do not have it in their rural communities, will be served greatly by this amendment.

We have the technology to fix a problem. Now, let us have the courage. I hear on both sides of the aisle that the courage is there, and I appreciate it, to fix this problem permanently.

Telemedicine has been in existence for over 30 years, and it is time to make it a priority so that it will work and so that it will work right.

Again, I applaud the gentleman from California (Mr. THOMPSON) for his leadership on this issue. I urge my colleagues to support this amendment.

Mr. BROWN of Ohio. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I rise in support of the second Thompson amendment. I commend the gentleman from California for bringing attention to the potential of telemedicine and for outlining for us the success already of telemedicine. It is a terrific breakthrough in the last decade or so and in serving underserved remote areas, as the gentlewoman from California (Ms. WOOLSEY) said. I think this is a good amendment that will lead to more breakthroughs in telemedicine.

I ask support of the House for the Thompson amendment.

The CHAIRMAN pro tempore (Mr. QUINN). The question is on the amendment offered by the gentleman from California (Mr. THOMPSON).

The amendment was agreed to.

AMENDMENT NO. 23 OFFERED BY MR. TRAFICANT

Mr. TRAFICANT. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 23 offered by Mr. TRAFICANT: Page 46, after line 2, insert the following section:

SEC. 4. BUY AMERICAN PROVISIONS.

(a) COMPLIANCE WITH BUY AMERICAN ACT.—No funds authorized pursuant to this Act may be expended by an entity unless the entity agrees that in expending the assistance the entity will comply with sections 2 through 4 of the Act of March 3, 1933 (41 U.S.C. 10a–10c, popularly known as the ''Buy American Act'').

(b) SENSE OF CONGRESS; REQUIREMENT REGARDING NOTICE.—

(1) PURCHASE OF AMERICAN-MADE EQUIPMENT AND PRODUCTS.—In the case of any equipment or products that may be authorized to be purchased with financial assistance provided under this Act, it is the sense of the Congress that entities receiving such assistance should, in expending the assistance, purchase only American-made equipment and products.

(2) NOTICE TO RECIPIENTS OF ASSISTANCE.—In providing financial assistance under this Act, the Secretary of Health and Human Services shall provide to each recipient of the assistance a notice describing the statement made in paragraph (1) by the Congress.

Mr. TRAFICANT. Mr. Chairman, I would like to start out by commending the gentleman from Florida (Mr. BILIRAKIS), a fellow graduate of the University of Pittsburgh and a dear friend, for his work on health care. I believe if the Congress would work with the gentleman from Florida (Mr. BILIRAKIS), we would continue to have improvements such as these that will incrementally improve the health-care system of America.

I also want to commend the gentleman from Ohio (Mr. BROWN), my neighbor, for working with our chairman and for aggressively working on problems of health-care needs for all the people of America. But I do want to encourage the Congress to continue to work carefully with the chairman. The health-care program that he is espousing makes a lot of sense.

Mr. Chairman, this is a very simple amendment. It says people who get the money from this bill in the form of grants shall abide by the ''buy American'' law which many of them forget to do, and they have to be prosecuted for such evasion. At least we can remind them and encourage them when expending these funds, where at all possible and practicable, to expend those funds in the purchases of American-made goods and services.

It makes sense. It is common sense. I would ask that it would be included in the bill.

Mr. BILIRAKIS. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, before I respond to the gentleman's amendment, I would like to take this opportunity to thank and commend the staffs, the people who really make all of this possible. We get the accolades, but they are really the ones who have done all the work: Jason Lee, a member of the committee staff; Tom Giles, another member of the majority staff; Ann Esposito from my personal staff; minority staff John Ford and Ellie Dahoney; and Pete Goodloe, legislative counsel. I really commend them and thank them. This has been a good piece of legislation. It has been very beneficial, I think.

Mr. Chairman, the majority has had an opportunity to review the amendment by the Buy-American Congressman, the great Buy-American Congressman here in the Congress, and his amendment would require that the agency or any entity that expends funds authorized pursuant to this act comply with the Buy American Act. He is already very diligent in doing that.

We are prepared to accept his amendment.

Mr. BROWN of Ohio. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I rise in support of the Traficant amendment. I commend the gentleman from Ohio (Mr. TRAFICANT), with whom I share a county, Trumbull County in eastern Ohio, and thank him for his work on this amendment. I thank the gentleman from Florida (Mr. BILIRAKIS) for his good work on this bill and so many other pieces of legislation in our committee. Also Mr. Ford, Mr. Schooler, and the majority staff, and Ellie Dahoney also in my office.

This amendment, as the amendments of the gentleman from Ohio (Mr. TRAFICANT) typically are on this, on several bills on buy America, makes sense. It will improve the bill. I commend him for his work. I ask for support of the amendment.

The CHAIRMAN pro tempore. The question is on the amendment offered by the gentleman from Ohio (Mr. TRAFICANT).

The amendment was agreed to.

Are there any further amendments on the bill?

If not, the question is on the committee amendment in the nature of a substitute, as amended.

The committee amendment in the nature of a substitute, as amended, was agreed to.

The CHAIRMAN pro tempore. Under the rule, the Committee rises.

Accordingly, the Committee rose; and the Speaker pro tempore (Mr. MCHUGH) having assumed the chair, Mr. QUINN, Chairman pro tempore of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 2506) a bill to amend title IX of the Public Health Service Act to revise and extend the Agency for Health Care Policy and Research, pursuant to House Resolution 299, he reported the bill back to the House with an amendment adopted by the Committee of the Whole.

The SPEAKER pro tempore. Under the rule, the previous question is ordered.

Is a separate vote demanded on any amendments to the committee amendment in the nature of a substitute adopted by the Committee of the Whole? If not, the question is on the amendment.

The amendment was agreed to.

The SPEAKER pro tempore. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. BILIRAKIS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The vote was taken by electronic device, and there were—yeas 417, nays 7, not voting 9, as follows:

[Roll No. 457]

YEAS—417

Abercrombie
Ackerman
Aderholt
Allen
Andrews
Armey
Bachus
Baird
Baker
Baldacci
Baldwin
Ballenger
Barcia
Barr
Barrett (NE)
Barrett (WI)
Bartlett
Barton
Bass
Bateman
Becerra
Bentsen
Bereuter
Berkley
Berman
Berry
Biggert
Bilbray
Bilirakis
Bishop
Blagojevich
Bliley
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonior
Bono
Borski
Boswell
Boucher
Boyd
Brady (PA)
Brady (TX)
Brown (FL)
Brown (OH)
Bryant
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Cannon
Capps
Capuano
Cardin
Carson
Castle
Chabot
Chambliss
Clay
Clayton
Clement
Clyburn
Coble
Collins
Combest
Condit
Conyers
Cook
Cooksey
Costello
Cox
Coyne
Cramer
Crane
Crowley
Cubin
Cummings
Cunningham
Danner
Davis (FL)
Davis (IL)
Davis (VA)
Deal
DeFazio
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart
Dickey
Dicks
Dingell
Dixon
Doggett
Dooley
Doolittle
Doyle
Dreier
Dunn
Edwards
Ehlers
Ehrlich
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Ewing
Farr
Fattah
Filner
Fletcher
Foley
Forbes
Ford
Fossella
Fowler
Frank (MA)
Franks (NJ)
Frelinghuysen
Frost
Gallegly
Ganske
Gejdenson
Gekas
Gephardt
Gibbons
Gilchrest
Gillmor
Gilman
Gonzalez
Goode
Goodlatte
Goodling
Gordon
Goss
Graham
Granger
Green (TX)
Green (WI)
Greenwood
Gutierrez
Gutknecht
Hall (OH)
Hall (TX)
Hansen
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Herger
Hill (IN)
Hill (MT)
Hilleary
Hilliard
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Hooley
Horn
Houghton
Hoyer
Hulshof
Hunter
Hutchinson
Hyde
Inslee
Isakson
Istook
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Jenkins
John
Johnson (CT)
Johnson, E. B.
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Kasich
Kelly
Kennedy
Kildee
Kilpatrick
Kind (WI)
King (NY)
Kingston
Kleczka
Klink
Knollenberg
Kolbe
Kucinich
Kuykendall
LaFalce
LaHood
Lampson
Lantos
Largent
Larson
Latham
LaTourette
Lazio
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Luther
Maloney (CT)
Maloney (NY)
Manzullo
Markey
Martinez
Mascara
Matsui
McCarthy (MO)
McCollum
McCrery
McDermott
McGovern
McHugh
McInnis
McIntosh
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Metcalf
Mica
Millender-McDonald
Miller (FL)
Miller, Gary
Miller, George
Minge
Mink
Moakley
Mollohan
Moore
Moran (KS)
Moran (VA)
Morella
Murtha
Myrick
Nadler
Napolitano
Neal
Nethercutt
Ney
Northup
Norwood
Nussle
Oberstar
Obey
Olver
Ortiz
Ose
Owens
Oxley
Packard
Pallone
Pascrell
Pastor
Payne
Pease
Pelosi
Peterson (MN)
Peterson (PA)
Petri
Phelps
Pickering
Pickett
Pitts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Quinn
Radanovich
Rahall
Ramstad
Rangel
Regula
Reyes
Reynolds
Rivers
Rodriguez
Roemer
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Rothman
Roukema
Roybal-Allard
Rush
Ryan (WI)
Ryun (KS)
Sabo
Salmon
Sanchez
Sanders
Sandlin
Sawyer
Saxton
Schaffer
Schakowsky
Scott
Sensenbrenner
Serrano
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shows
Shuster
Simpson
Sisisky
Skeen
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Souder
Spence
Spratt
Stabenow
Stark
Stearns
Stenholm
Strickland
Stump
Stupak
Sununu
Sweeney
Talent
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thompson (CA)
Thompson (MS)
Thornberry
Thune
Thurman
Tiahrt
Tierney
Toomey
Towns
Traficant
Turner
Udall (CO)
Udall (NM)
Upton
Velazquez
Vento
Visclosky
Vitter
Walden
Walsh
Wamp
Waters
Watkins
Watt (NC)
Watts (OK)
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Wexler
Weygand
Whitfield
Wicker
Wilson
Wise
Wolf
Woolsey
Wynn
Young (AK)
Young (FL)

NAYS—7

Chenoweth
Coburn
Duncan
Hostettler
Johnson, Sam
Paul
Royce

NOT VOTING—9

Archer
McCarthy (NY)
McKinney
Riley
Sanford
Scarborough
Sessions
Thomas
Wu

☐ 1804

Mr. ROYCE changed his vote from ''yea'' to ''nay.''

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mr. THOMAS. Mr. Speaker, on rollcall No. 457, had I been present, I would have voted "yea."

GENERAL LEAVE

Mr. BILIRAKIS. Madam Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and to include extraneous material on H.R. 2506, the bill just passed.

The SPEAKER pro tempore (Mrs. BIGGERT). Is there objection to the request of the gentleman from Florida?

There was no objection.

AUTHORIZING CLERK TO MAKE CHANGES IN THE ENGROSSMENT OF H.R. 2506, HEALTH RESEARCH AND QUALITY ACT OF 1999

Mr. BILIRAKIS. Madam Speaker, I ask unanimous consent that, in the engrossment of the bill, H.R. 2506, the Clerk be authorized to correct section numbers, punctuation, and cross references and to make such other technical and conforming changes as may be necessary to reflect the actions of the House.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Florida?

There was no objection.

DISTRICT OF COLUMBIA APPROPRIATIONS ACT, 2000—VETO MESSAGE FROM THE PRESIDENT OF THE UNITED STATES (H. DOC. NO. 106–135)

The SPEAKER pro tempore laid before the House the following veto message from the President of the United States; which was read and, without objection, referred to the Committee on Appropriations and ordered to be printed:

To the House of Representatives:

I am returning herewith without my approval, H.R. 2587, the ''District of Columbia Appropriations Act, 2000.'' Although the bill provides important funding for the District of Columbia, I am vetoing this bill because it includes a number of highly objectionable provisions that are unwarranted intrusions into local citizens' decisions about local matters.