Mr. Speaker, in closing, I would just like again to thank the gentleman from Florida (Mr. BILIRAKIS) for his leadership. He is one of the newest members of the Health Hearing Caucus. We are delighted that he is and we urge him to continue his important leadership.

Mr. DINGELL. Mr. Speaker, for 75 years, May has been designated Better Hearing and Speech Month. With an estimated 42 million Americans affected by speech, language, and hearing disorders, audiologist and speech language pathologist have made a special effort during this month to inform, educate, and raise awareness about this critical health care issue.

It is estimated that one in six Americans has a hearing, speech, or language problem—a condition that makes it difficult to communicate with others. An impairment of the ability to hear, speak, or understand effectively can affect anyone, of any age, at any time. If left untreated these problems can limit a person at home, school, and work. With proper treatment, however, the isolating effects of communication disorders can be minimized or completely eliminated.

As with most health care conditions, it is critical that communication disorders be diagnosed early. As the most common congenital birth defect, hearing loss can severely affect a child's social, emotional, and academic development. That is why I urge all 50 states to follow the example of my home state of Michigan, and implement routine hearing screens for every newborn before they leave the hospital. Also, hearing loss among Americans age 65 and over affects one out of three people, but without effective screening, many are condemned to suffer in silence. We must seek comprehensive hearing screening for all Americans.

Therefore, I support this resolution recognizing May as Better Hearing and Speech Month and urge the people of the United States to focus on preventing, mitigating, and curing communication disorders.

Mrs. MCCARTHY of New York. Mr. Speaker, I rise today in support of H. Con. Res. 358 and in celebration of May, National Better Hearing and Speech Month.

Did you know that 28 million people in the United States today suffer from hearing loss, and 16 million people have a speech or language disorder? 42 million people have a speech, language, voice or hearing impediment. Hearing loss is the most common congenital disorder found in newborns, and ten percent of children entering the first grade suffer from mild speech disorders like stuttering.

As a nurse, I know the issue of speech and hearing health affects many different people, from infants to adults to senior citizens. You can be born with a disorder, or you can develop one later in life due to late onset of a specific impediment, a stroke or traumatic event. But many Americans don't realize the extent to which our society deals with speech and hearing disorders. That is why, since 1927, the speech and hearing community has celebrated May as a month to increase national awareness of this health problem.

As a nurse, I understand the importance of getting the right healthcare immediately, especially when it comes to our children. Deafness is the most common birth defect; that out of the 12,000 babies born in the U.S. each year with hearing loss, 4,000 of them are profoundly deaf and need a cochlear implant, and 8,000 need hearing aids. Unless a child gets medical attention by the time they are two, permanent damage is done to his or her language and speech.

A newborn hearing test is simple and easy, and only costs $35. Our babies are subjected to batteries of other tests, and I think it's crucial for this one to be included.

As a founding member of the Congressional Hearing Caucus, I am extremely proud of H. Con. Res. 358. Not only does this resolution support the goals and ideals of National Better Hearing and Speech Month, it calls attention to and commends the 41 states that have implemented routine hearing screenings of every newborn before the baby leaves the hospital.

The resolution also supports the efforts of speech and hearing professionals to improve the speech and hearing development of children and encourages all Americans to have their hearing checked regularly and to avoid environmental noise that can lead to hearing loss.

All across the United States, people are trying to make a difference. I commend everyone in the speech and hearing community for their education and awareness efforts, as well as the extraordinary level of care and medical attention they give to their patients.

Mr. BROWN of Ohio. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. BILIRAKIS. Mr. Speaker, I do not have any further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore (Mr. WALDEN of Oregon). The question is on the motion offered by the gentleman from Florida (Mr. BILIRAKIS) that the House suspend the rules and agree to the concurrent resolution, H. Con. Res. 358.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the concurrent resolution was agreed to.

A motion to reconsider was laid on the table.

ESTABLISHING A NATIONAL MINORITY HEALTH AND HEALTH DISPARITIES MONTH

Mr. BILIRAKIS. Mr. Speaker, I move to suspend the rules and agree to the concurrent resolution (H. Con. Res. 388) expressing the sense of the Congress that there should be established a National Minority Health and Health Disparities Month, and for other purposes.

The Clerk read as follows:

H. CON. RES. 388

Whereas in 2000, the Surgeon General of the Public Health Service announced as a goal the elimination by 2010 of health disparities experienced by racial and ethnic minorities in health access and outcome in 6 areas: infant mortality, cancer screening, cardiovascular disease, diabetes, acquired immunodeficiency syndrome and human immunodeficiency virus infection, and immunizations;

Whereas despite notable progress in the overall health of the Nation there are continuing health disparities in the burden of illness and death experienced by African-Americans, Hispanics, Native Americans, Alaska Natives, Asians, and Pacific Islanders, compared to the United States population as a whole;

Whereas minorities are more likely to die from cancer, cardiovascular disease, stroke, chemical dependency, diabetes, infant mortality, violence, and, in recent years, acquired immunodeficiency syndrome;

Whereas there is a national need for scientists in the fields of biomedical, clinical, behavioral, and health services research to focus on how best to eliminate health disparities;

Whereas individuals such as underrepresented minorities and women in the workforce enable society to address its diverse needs; and

Whereas behavioral and social sciences research has increased awareness and understanding of factors associated with health care utilization and access, patient attitudes toward health services, and risk and protective behaviors that affect health and illness, and these factors have the potential to be modified to help close the health disparities gap among ethnic minority populations: Now, therefore, be it

Resolved by the House of Representatives (the Senate concurring), That it is the sense of the Congress that—

(1) a National Minority Health and Health Disparities Month should be established to promote educational efforts on the health problems currently facing minorities and other health disparity populations;

(2) the Secretary of Health and Human services should, as authorized by the Minority Health and Health Disparities Research and Education Act of 2000, present public service announcements on health promotion and disease prevention among minorities and other health disparity populations in the United States and educate the public and health care professionals about health disparities;

(3) the President should issue a proclamation recognizing the immediate need to reduce health disparities in the United States and encouraging all health organizations and Americans to conduct appropriate programs and activities to promote healthfulness in minority and other health disparity communities;

(4) Federal, State, and local governments should work in concert with the private and nonprofit sector to emphasize the recruitment and retention of qualified individuals from racial, ethnic, and gender groups that are currently underrepresented in health care professions;

(5) the Agency for Healthcare Research and Quality should continue to collect and report data on health care access and utilization on patients by race, ethnicity, socioeconomic status, and where possible, primary language, as authorized by the Minority Health and Health Disparities Research and Education Act of 2000, to monitor the Nation's progress toward the elimination of health care disparities; and

(6) the information gained from research about factors associated with health care utilization and access, patient attitudes toward health services, and risk and protective behaviors that affect health and illness, should be disseminated to all health care professionals so that they may better communicate with all patients, regardless of race or ethnicity, without bias or prejudice.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Florida (Mr. BILIRAKIS) and the gentleman from Ohio (Mr. BROWN) each will control 20 minutes.

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

GENERAL LEAVE

Mr. BILIRAKIS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H. Con. Res. 388.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Florida?

There was no objection.

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

Mr. Speaker, today I rise in support of H. Con. Res. 388. Thanks to numerous medical advances, Americans are healthier than they have ever been before.

Unfortunately, not all Americans have equally shared in this progress. During the 106th Congress, the Committee on Commerce, Subcommittee on Health and Environment, which I chaired, reviewed the health disparities that persist between minority groups and the non-Hispanic white population. Hepatitis C, heart disease, diabetes, lupus, lung cancer and cervical cancer are but a few of the diseases that disproportionately affect minorities in this country.

Congress took an important step forward in addressing health disparities when it passed the Minority Health and Health Disparities Research and Education Act of 2000 late in the 106th Congress. This important legislation created a new National Center on Minority Health and Health Disparities which coordinates biomedical and behavioral research on these issues at the National Institutes of Health. I was pleased to move this legislation through my subcommittee and support it on the House floor.

Among other things, the resolution we are considering today would call for the establishment of a National Minority Health and Health Disparities Month to focus educational efforts on the health problems disproportionately affecting minorities. It also calls on the Secretary of Health and Human Services to develop public service announcements on health promotion and disease prevention. Finally, H. Con. Res. 388 calls for dissemination of information that would help health care professionals communicate in a culturally sensitive manner with all of their patients.

Raising awareness of existing health disparities is necessary to improving the overall health and well-being of the American people. Mr. Speaker, I urge my colleagues to support H. Con. Res. 388.

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

Mr. BROWN of Ohio. Mr. Speaker, I yield myself 2 minutes.

I rise in support of the Christensen resolution. Our values and success as a Nation are a function of multiple races, multiple ethnicities and multiple cultures. The Nation's health care system, our medical research, our medical education and our medical care, should reflect that fact, but we have major work to do.

Minority populations have higher rates of cancer, higher rates of heart disease, especially higher rates of diabetes, higher rates of HIV/AIDS. Minorities have shorter life expectancies, higher infant mortality rates and a high, much too high, incidence of premature death. Minorities are less likely in this health care system to receive cancer screening and monitoring. Minorities are less likely to receive childhood and adult vaccinations.

Unless we initiate changes explicitly aimed at reducing disparities in health and health care, those disparities will persist. This resolution is a good start. Among other things, it would encourage the establishment of the Minority Health and Health Disparities Month. It asks the Secretary to deliver public service announcements on health promotion and disease prevention among minorities. It encourages governments to work with the private sector to recruit and to retain qualified individuals from racial and ethnic and gender groups underrepresented in health care professions.

Mr. Speaker, I want to thank the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN) for sponsoring this resolution. I urge my colleagues to support it.

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

Mr. BILIRAKIS. Mr. Speaker, I am pleased to yield such time as he may consume to the gentleman from Oklahoma (Mr. WATTS), one of our Republican leaders who has been so very much involved in this legislation but also the legislation we passed in the last Congress.

Mr. WATTS of Oklahoma. Mr. Speaker, I appreciate the gentleman from Florida (Mr. BILIRAKIS) yielding me the time.

Mr. Speaker, I rise to support and increase the awareness of a very serious problem in our Nation today. Despite so much progress in the field of medicine, there is a significant discrepancy in the health of ethnic minorities compared to the rest of our American population. The silent reality should spur more than indignation. The facts and statistics that make up this crisis must be a wake-up call to all of us, regardless of the color of our skin.

The resolution before the House today aims to raise the level of awareness to the disparity of health care concerning members of minority communities. It calls for a dedicated month of minority health care recognition, urges the Secretary of Health and Human Services to develop public service announcements on health promotion and disease prevention among minorities, requests the President to issue a proclamation on minority health care, and encourages better use of data and statistics in order to help eliminate health disparities.

Hispanics, black Americans, Indians and other members of racial minorities have had higher levels of cancer, cardiovascular disease, stroke, diabetes and infant mortality. This is more than a misfortune. It is a systemic emergency that we must view as a call to action.

Hippocrates recognized the importance of quality health care over 2400 years ago when he said, ''A wise man should consider that health is the greatest of human blessings.'' Let us make sure that all Americans have access to the care they need to sustain a healthy life.

I thank the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN) for sponsoring this resolution with me, and I urge my colleagues to support our legislation to increase the level of attention America pays to minority health disparities. With a heightened level of awareness, we can make our country a healthier Nation and better the lives of all her citizens.

Mr. BROWN of Ohio. Mr. Speaker, I yield 5 minutes to the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN) who is the sponsor of this resolution.

(Mrs. CHRISTENSEN asked and was given permission to revise and extend her remarks.)

Mrs. CHRISTENSEN. Mr. Speaker, I thank the gentleman from Ohio (Mr. BROWN) for yielding me the time.

I am pleased to rise in support of H. Con. Res. 388, expressing the sense of Congress that there should be established a National Minority Health and Disparities Month, and I want to begin by expressing my gratitude to my cosponsors of the resolution, my colleagues, Chairman of the House Republican Conference, the gentleman from Oklahoma (Mr. WATTS), and chairman of the Subcommittee on Workforce Protections of the Committee on Education and the Workforce, the gentleman from Georgia (Mr. NORWOOD) for their willingness to join me in putting this important resolution forward.

I also want to thank the gentleman from Florida (Mr. BILIRAKIS) and the gentleman from Ohio (Mr. BROWN) for their support in making it possible to bring this resolution to the floor of the House today.

Mr. Speaker, pick any minority community across our great Nation or any of our Nation's rural areas and the reports will be the same. Minorities and people living in those rural areas, of all races and ethnicities, are dying of preventable diseases in alarmingly excessive numbers. Heart disease, hypertension, HIV/AIDS, cancer, diabetes, stroke and kidney disease predominate as the leading causes of death in these groups in far greater numbers than that of white suburban or urban America.

In addition, substance abuse and diminished mental health continue to take a staggering toll on many individuals in this group and undermine the well-being of our communities.

This resolution in establishing a special month of focus on this national

tragedy will hopefully forge a national resolve to close these gaps through increasing the awareness that gross disparities in health care continue to exist for people of color and those in our rural areas, which disrupt families, damage community and threaten our national security.

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While this resolution is only a beginning, I am pleased and honored to have had a role in bringing it to the floor today, because the existence and the impact of the centuries of disparities in health is a dark blot on this country's legacy, and it must be erased.

Achieving this important goal will not only take a strong and unwavering commitment, but also a significant investment, which would yield immeasurable dividends in terms of the health of our constituents and our Nation. To do otherwise would result in dire consequences of monumental and far-reaching threats, not only to the financial stability of this Nation, but also to our collective productivity, global competitiveness, and our defense capacity. These are risks we cannot afford and must not take.

While health is influenced by only three factors, genetics, environment and behavior, it is my belief that there has been too much focus on the behavior as individuals and not enough on the behavior of institutions that are supposed to serve us and the system that is supposed to provide us with health care. Just this past spring, following on three other important reports, failure to collect needed health data by race and ethnicity by Summit Health, a health care quality survey by the Commonwealth Fund, and another on language interpretation in health care settings by the National Health Law Program, the Institutes of Medicine, following on those, released a hard-hitting eye-opening report entitled Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.

Mr. Speaker, I am grateful for the opportunity that H. Con. Res. 388 provides to highlight the disparities in health care experienced by racial and ethnic minorities in our country and in our rural communities. The importance of such a month cannot be overestimated. Again, I want to thank my colleagues for their cosponsorship and support, and I urge everyone to support its passage and hope in doing so it will serve as a catalyst to recommit all of us to the creation of a health care system in this country where there are disparities for none and equity in access for all.

Mr. Speaker, I am pleased to rise in support of H. Con. Res. 388, expressing the sense of Congress that there should be established a national Minority Health and Health Disparities Month.

I want to begin by expressing my gratitude to my cosponsors of the resolution, my colleagues, the Chairman of the House Republican Conference, JC WATTS and the Chairman of the Workforce Protections Subcommittee of the Education and the Workforce Committee, CHARLIE NORWOOD, for their willingness to join me in putting this important resolution forward.

I also want to thank the Chairman and Ranking Member of the Energy and Commerce Committee for their support in making it possible for the resolution to be on the floor of the House today.

Mr. Speaker, pick any minority community across our great country, whether it be California or Virginia, New York or Texas, the U.S. Virgin Islands or Illinois or any of our nation's rural areas and the reports will all be the same: Minorities and people living in our rural areas, of all races and ethnicities, are dying of preventable diseases in alarmingly excessive numbers. Heart disease, hypertension, HIV/AIDS, cancer, diabetes, stroke and kidney disease predominate as the leading causes on the death certificates these groups in far greater numbers than that of white suburban or urban America.

In addition, substance abuse and diminished mental health continue to take a staggering toll on many individuals in this group, and undermine the well-being of our communities.

This resolution in establishing a special month of focus on this national tragedy, will hopefully forge a national resolve to close these gaps through increasing the awareness that gross disparities in health care continue to exist for people of color and those in our rural areas, which disrupt families damage communities and threaten our national security.

While this resolution is only a beginning, I am pleased and honored to have had a role in bringing it to the floor today, because the existence and impact of the centuries of disparities in health is a dark blot on this country's legacy, and must be erased.

Achieving this important goal will not only take strong, and unwavering commitment, but also a significant investment, which would yield immeasurable dividends, in terms of the health of our constituents and of our nation. To do otherwise would result in dire consequences of monumental and far reaching threats not only to the financial stability of this nation, but also to our collective productivity, global competitiveness, and our defense capacity—Risks we cannot afford and must not take.

Let me share some statistics, but let us never forget that each number represents a real person, who is a part of a real and living family and a community that needs him to her to be a part;

Around 40 million Americans have no health insurance of which 50% are minorities.

Rural populations which are disproportionately poor, uninsured and underserved compared to urban populations, and whose residents are often eligible but unenrolled in publicly sponsored programs are also at particular risk.

This lack of coverage alone, results in 83,000 deaths every year.

HIV/AIDS has become primarily a disease and epidemic of communities of color: In 2002 the rate of reported AIDS cases among African Americans was 8 times the rate for whites and 2 times the rate for Hispanics, which was about three times that of whites.

All minorities except Alaska Natives have a prevalence of type 2 diabetes that is 2 to 6 times greater than that of the white population.

Native American elders are 173% more likely to experience diabetes than the general population;

African Americans and other people of color are likely to seek care later and die in greater numbers from cancer.

This is particularly true for African Americans, whose men, for example, are 2 to 3 times as likely to die of prostate cancer as white men.

According to the national Kidney Foundation, African Americans, Asian and Pacific Islanders and Hispanics are three-times more likely to suffer from end-stage renal disease—complete failure of the kidneys to function—than whites.

In my own district, the U.S. Virgin Islands, we have the highest adjusted mortality rate for circulatory disease (namely heart disease and hypertension) in the Americas.

Our nation's poor, who are more likely to be rural or of color are more likely to be living with mental illness, and be untreated.

These are just a few of many areas where disparities are rampant.

Why is this so? One leading health expert at the National Institutes of Health has repeatedly pointed out that health or lack of it is influenced by three factors, behavior, genetics and environment.

While there is much in the news today about the role of genetics in the diseases that we all face, the evidence is that it plays only a small part.

Today, we are learning more about the relationship between health and the environment, which requires more attention as we can directly seek redress of those issues. And while some point to the fact that many of us in communities of color wait too long to seek treatment, eat the wrong foods, don't exercise or that we continue to smoke or engage in high risk behavior, there are other significant factors, which continue to lead to early death in our families which until now have largely been ignored.

It is my belief that there has been too much focus on our behavior as individuals and as a community and not enough focus on the behavior of the institutions that are supposed to help to serve us, and the system that is supposed to provide us with healthcare.

Just this last spring, following on three other important reports, on failure to collect needed health data by race and ethnicity by SHIRE, and a Health Care quality survey by the Commonwealth Fund, and one on the need for language interpretation in health care settings by the National Health Law Program, the Institutes of Medicine at the National Academy of Sciences released a hard hitting, eye opening report entitled; Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare.

Mr. Speaker, I ask to submit testimony and summaries of these reports and one from the Kaiser Family foundation, which expand on these issues into my statement, into the record.

In this review of all current research and reports on health care delivery in this country tells an ugly story of health care deferred and denied simply because of race, ethnicity and language.

Mr. Speaker, I am greatful for the opportunity that H. Con. Res. 388 provides to highlight the disparities in health care experienced by racial and ethnic minorities in our country.

The importance of such a month and the need to have one is underscored by the reminder just today at a briefing on the hill from Dr. Brian Smedley of the Institute of Medicine that the issue of disparities is one of life and death, and testimony from Dr. Marsha Lillie Blanton, Vice President for Health Policy of the Henry J. Kaiser Family Foundation at our recent hearing, who stated in a representative survey sample, that most Americans, including people of color did not know that Blacks generally fare worse than whites in terms of infant mortality or that Latinos are less likely than Whites to have health insurance as well as other important facts about health disparities. To further aggravate an already bad condition, some of the same misperceptions are shared by health care providers.

Again I want to thank my colleagues for their cosponsorship and support.

I urge my colleagues to support its passage and hope that in so doing it will serve as the catalyst to recommit all of us to the creation of a health care system where there are disparities for none and equity in access for all.

Mr. Speaker, I submit the summary report I referred to earlier for the RECORD.

ELIMINATING RACIAL/ETHNIC DISPARITIES IN MEDICAL CARE: PROGRESS AND CHALLENGES

MARSHA LILLIE-BLANTON, DRPH, VICE-PRESIDENT, HEALTH POLICY, THE HENRY J. KAISER FAMILY FOUNDATION, FOR HEARING ON THE STATUS AND PROGRESS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES INITIATIVE TO ELIMINATE RACIAL AND ETHNIC HEALTH DISPARITIES

THE CONGRESSIONAL BLACK CAUCUS, THE CONGRESSIONAL HISPANIC CAUCUS, AND THE CONGRESSIONAL ASIAN PACIFIC AMERICAN CAUCUS

APRIL 12, 2002

Good morning. First, I'd like to thank the members of the Congressional Black Caucus (CBC), the Congressional Hispanic Caucus (CHC), and the Congressional Asian Pacific American Caucus (CAPAC) for holding today's hearing on the status and progress of the Department of Health and Human Services' initiative to eliminate racial and ethnic health disparities. I am Marsha Lillie-Blanton, a vice-president of the Henry J. Kaiser Family Foundation and director of the Foundation's work on access to care for vulnerable populations.

The recently released IOM report, Unequal Treatment, has helped to refocus the nation's attention on racial and ethnic disparities in medical care. The problem is by no means new, but seldom gets priority attention in public policy discussions around the health care system. Few would disagree that for most of this nation's history, race has been a major factor in determining if and where medical care was obtained; however, its influence today has become more subtle. Public policy efforts, most notably the enactment of Medicaid and Medicare and enforcement of the 1964 Civil Rights Act, have made an enormous difference in reducing the health care divides for some of this nation's most vulnerable populations. So much progress has been achieved that many tend to think that the problems that remain are inconsequential.

The IOW report provides compelling evidence to the contrary. After an extensive review of the research, IOM concluded that there is a ''preponderance'' of evidence that racial and ethnic disparities in medical care persist for a number of health conditions and services, some of which may contribute to the poorer health outcomes of people of color. The findings are consistent with those of a comprehensive review of the literature by Robert Mayberry and colleagues from the Morehouse School of Medicine, undertaken about a year ago with funding support from the Foundation.

While there are some who will question whether the racial/ethnic differences in the studies cited by IOM are real or a function of factors not well-measured, the IOM report should help to shift the research focus from documenting disparities to investigating their underlying causes and the impact of interventions. Investigating the underlying causes will be a challenge in large part because the influence of race on the health care system is deeply intertwined with other forces—especially economic and educational opportunities—that shape life in America. Disentangling this web of interrelated factors should be helpful in developing more targeted interventions, but pursuing that research agenda need not delay efforts to address those factors now known to create a barrier in obtaining greater equity in access to quality medical care.

As noted in the IOM report, many factors likely contribute to racial/ethnic disparities in medical care, including patient, provider, and health system related factors. Differences in the extent of health insurance coverage (see Figure 1) are perhaps the most widely recognized of factors, other than health needs, that account for variations in the medical care obtained. The uninsured are less likely than those who are insured to get appropriate care. However, evidence of racial/ethnic differences among individuals who are similarly insured is particularly disturbing since health coverage is considered the ''great equalizer'' in the health system. In a recent study by Johns Hopkins University researchers Daumit and Powe, the racial disparity in cardiac procedures among men and women was sharply reduced when patients with chronic renal disease qualified for Medicare. However, this study also found that even after enrolling in Medicare, black men with chronic renal disease were less likely to undergo invasive cardiac procedures than white men who were of similar age, clinical characteristics, and other sociodemographic factors (see Figure 2). This study provides strong evidence that race—independent of other factors—is associated with the medical care obtained.

Why such a challenging problem to address

Efforts to address racial inequalities throughout varying sectors of society are challenging for many different reasons, including the troubling history of race relations in America. However, misperceptions about the nature and extent of the problem in the health care system adds a new level of complexity to efforts to eliminate health and health care disparities. The battle we are waging is with perceptions, as well as the reality of life in America. Two issues, in particular deserve note.

First, the public has a marginal, at best, awareness of racial/ethnic disparities in our health system. In a 1999 national survey of a representative sample of about 4,000 adults, we learned that most Americans, including people of color, didn't know that blacks generally fare worse than whites in terms of infant mortality, or that Latinos are less likely than whites to have health insurance—two indicators that have received considerable attention in the media. The survey also found that a significant majority of whites perceive that African Americans and Latinos get the same quality of care as they do; however, the majority of African Americans and Latinos perceive that they get lower quality care than whites (see Figure 3). These findings make it clear that the public's knowledge about disparities should not be assumed and the challenge we face is one of public perceptions as well as reality. Not surprisingly, some of the misperceptions of the public are also found among providers of care.

Second, there is a common perception that disparities in medical care are largely a result of patient characteristics (their financial resources, education, help-seeking behavior, preferences for care). This perception persists despite an abundance of studies that control for patient level characteristics (e.g., as measured by income, education, severity of health condition). There are fewer studies that have assessed patient preferences for care, but some offer insight on this issue. In a study of the quality of medical care provided for congestive heart failure and pneumonia—two common health problems in which the care is fairly low-tech and thus assumed to be influenced less by patient choice—Harvard University researchers, Ayanian and colleagues, found that elderly black patients with Medicare received lower quality care than whites based on defined clinical criteria. Similar findings were observed for women relative to men. The analysis adjusted for age, income, and hospital teaching status and used the Rand appropriateness criteria to assess health need.

Perceptions of a problem often influence the actions taken (or not taken) to change policy and practices. If the public is unaware that a problem exists or misunderstands the nature of the problem, it will be difficult to mount effective efforts to address that problem. Societal change requires a public understanding and willingness as well as the resources to address the problem.

Strengthening the Federal response

In 1999, the U.S. Department of Health and Human Services (DHHS), under the leadership of former Surgeon General, Dr. David Satcher, took a bold step in announcing a national initiative to eliminate health disparities in six health areas by 2010. The Congress provided important leadership to this effort by legislatively mandating the IOM study of health care disparities, creating in statute a Center on Minority Health and Health Disparities at the National Institutes on Health (NIH), and requiring DHHS in 2003 to annually produce a report on the nation's progress in reducing health care disparities as a companion to the National Healthcare Quality Report.

From the leadership of the former Surgeon General and the Congress have come a number of DHHS agency-wide related efforts, including the establishment of Healthy People 2010 goals that are the same for everyone, regardless of race/ethnic identity. Also, DHHS agencies have developed strategic plans for their efforts to eliminate disparities and have funded new initiatives—both research and interventions—to address disparities. Most relevant to eliminating health care disparities are the nine centers of excellence grants of the Agency of Healthcare Research and Quality (AHRQ), which are financed through funds of AHRQ and NIH. These initiative also have served as the catalyst for a number of foundation and other private sector efforts to reduce disparities.

These efforts are an incredibly important start. Government, however, can and should do more. The interventions recommended by the IOM report are critical next steps. Moreover, the DHHS initiative now appears to lack visible senior leadership to direct and garner support for the efforts underway in the various agencies. Such leadership is essential for such a controversial initiative. To strengthen the federal response the initiative also will require, at the very least:

First, a strategic linking of the work to existing Department efforts around improving the quality of medical care and patient safety.

Initiatives on quality and patient safety have new dollars and the attention of clinicians and policymakers. It would be a missed opportunity if the medical care needs and concerns of people of color are not well integrated into the plans for research and new interventions in these areas. Also, efforts regarding disparities appear to be competing for scare new resources. The view that focused efforts need new resources rather than an integration and allocation of some of the existing resources will hamper the short-term progress that can be achieved. This shift in direction will be no small feat to accomplish since DHHS staff and funded projects focused on quality issues and those focused on racial disparities generally are moving on separate tracks without much collaboration.

Second, an improvement of the information systems and the data used to answer questions about the health and medical care use of people of color.

DHHS has an important role to play in data collection and analysis. One reason we know so little about the health of Latinos, Asians, and Native Americans is that we simply have not collected the data. Even most national surveys that now over-sample African Americans and Latinos to produce reliable estimates are unable to provide estimates for Asian ethnic subgroups or Native Americans. Further complicating an assessment of disparities is that many health plans serving privately and publicly insured enrollees (whether in fee-for-service or managed care arrangements) do not collect data on the race and ethnicity of their patients. DHHS must encourage the collection of data in the private sector and collect and analyze the data on those who are publicly insured.

Third, a continuation of the Department's efforts to improve the public's awareness that the nation continues to be challenged in assuring that every American has timely access to high-quality medical care.

DHHS, through its partnerships and conferences, has already been engaged in efforts to promote dialogue and understanding about disparities. These efforts are extremely important. The Foundation, working in partnership with the medical community, is about to launch an initiative to raise physician awareness about racial disparities in medical care and encourage physicians to review the evidence and engage in a national dialogue about the issue. This is, at best, the beginning of national dialogue among one segment of the public—physicians. DHHS, working through respected and trusted leadership, should continue to improve awareness of disparities among the public generally. Whites need to be more aware of the real-life circumstances that face people of color. People of color need to be more aware of disparities so they can be more proactive in seeking needed care. This knowledge should result in greater acceptance of initiatives to remedy disparities.

In closing, let me say that race clearly matters in our health system, but so do many other factors—especially insurance coverage. Attention should be given to assuring that existing sources of coverage are not undermined. Medicaid, for example, is an essential source of coverage for about 1 in 5 non-elderly African Americans, Latinos, and Native Americans. In addition, people of color are disproportionately uninsured, and priority attention should be given to efforts to eliminate the insurance gap. It is also important to remember, however, that racial disparities among persons who are insured are an indication that expansions in coverage, though necessary, are not sufficient. The IOM report provides a blueprint for comprehensive reform to close the racial/ethnic divide in the health system.

Thank you for the opportunity to testify. I welcome any questions.

Mr. BILIRAKIS. Mr. Speaker, I continue to reserve the balance of my time.

Mr. BROWN of Ohio. Mr. Speaker, I yield 4 minutes to the gentlewoman from Texas (Ms. EDDIE BERNICE JOHNSON), Chair of the Congressional Black Caucus, who also is a nurse.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, let me express my appreciation for those who have helped to work on this resolution, because it is one that hopefully will start the ball rolling in getting some corrective action taken.

I stand before my colleagues today as a former health care professional to share really disturbing news. Sadly, in the year 2002, decades after the end of legal segregation, inequality based on race and ethnicity exists within our health care system. African Americans are 30 percent more likely to die of heart disease and cancer than Anglo Americans. Hispanics are more likely to be diagnosed with a chronic disease or a condition such as a heart attack, diabetes, or cancer than Anglo Americans. Infant mortality rates are more than twice as high for African Americans than Anglo Americans. In 2000, 47 percent of all HIV/AIDS cases reported in the U.S. were among African Americans and 21 percent among Hispanics.

Unfortunately, the bad news gets worse. Despite this glaring data revealing the health disparities between minorities and white Americans, the National Academy of Sciences tells us that minorities lag behind white Americans on nearly every measure of health care and treatment and are dying at higher rates. Minorities are less likely to be given appropriate cardiac medication or to undergo bypass surgery to treat a cardiovascular disease. Minorities are less likely to be placed on a waiting list for kidney transplants or to receive kidney dialysis or transplants.

My father was one of those. Minorities with HIV infection are less likely to receive antiretroviral therapy and other state-of-the-art treatments which could forestall the onset of AIDS. And minorities are less likely to receive appropriate cancer diagnostic tests and treatment.

There is really more bad news. Significantly, these disparities in treatment exist even when insurance status, income, age, and severity of conditions in minorities and whites are the same.

The good news is that we can address this problem by educating the public and the medical community about these disparities and take action to reduce them. House Concurrent Resolution 388 is a step in the right direction.

I agree with the gentleman, the chairman of the committee, it should not be a campaign issue. It is a serious issue that must be addressed. It would establish a National Minority Health and Health Disparities Month and calls for the government, private and nonprofit sectors, and the medical community to promote educational efforts, perform research, and conduct health care programs so that we may end health care disparities.

I urge my colleagues to support this resolution and work toward the elimination of racial and ethnic disparities in health care so that we can have some good news to share in the future.

Mr. BILIRAKIS. Mr. Speaker, I continue to reserve the balance of my time.

Mr. BROWN of Ohio. Mr. Speaker, I yield 3 minutes to the gentlewoman from the District of Columbia (Ms. NORTON).

Ms. NORTON. Mr. Speaker, I thank the gentleman for yielding me this time, and I want to congratulate the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN) for her continuing work as chair of the CBC Brain Trust and for bringing her practice of medicine, which she had to leave in order to become a Member of the House, right into this House in the way in which she fastens our attention on health care, and particularly for improved health care for minorities.

But I have to say, Mr. Speaker, when they give you a whole month, it is because of what you do not have. And what minorities in this country do not have is health. And that is like saying what you do not have is the difference between life and death.

The racial and ethnic disparities are quite intolerable. About 10 percent of whites in this country do not have health care; three times as many Hispanics; twice as many blacks. The fact is minorities have to do for themselves, because we know that a lot of health care is related to life-style. And I am a strong proponent, for example, of harnessing overweight and obesity. I am a race walker. You have to do what you can do to deal with your health care. But obesity and overweight is a national problem, and yet there are some folks who have some health care to get them some advice as to what to do about it.

The current recession and the consequences of September 11 and anthrax have simply exacerbated the health care crisis in our country. And we are not close to closing this intolerable gap with placebos like tax credits. Let me tell my colleagues something: Low-income people do not pay a lot of taxes because they do not have a lot of money. So tax credits, for example, is like throwing crumbs at people who are very hungry.

But let me tell my colleagues something else. The American middle class has a very sensitive barometer to health care. In the early 1990s, there were Members who lost their seats in this House and in the Senate over the single issue of health care. And the reason is that health care is always a

sleeper issue. And when we have the volatile mix of a recession and people losing their health care, watch out, Congress of the United States.

But we deserve to be called to account. The permanently uninsured are unable to raise the issue because they are the least powerful people in the society. It is only when there is a recession, when people who have a little bit of clout, the middle class, who lose their health care, that health care then rises to the top of the agenda. It is close to being there now.

In the 1990s, we were kind of creeping up on universal health care, going toward universal health care for children. And of course, there is universal health care for the very poor. But what about the working poor? What about the disincentive to go to work when you lose your health care? What about saying to welfare mothers you better go to work, and yet in the long run, lose your health care?

Poor health care in the United States has a disproportionately black and brown face, and yet in countries where there are nothing but black and brown faces, in many Third World countries, there is universal health care. Hey, what happened to the United States of America?

Some minimum of health care is what everybody deserves simply for being human. It is time we met that minimum standard in our own great country.

Mr. BILIRAKIS. Mr. Speaker, I yield myself such time as I may consume to advise the gentlewoman that in our Committee on Energy and Commerce, as the gentleman from Ohio (Mr. BROWN) knows, just last week we marked up a piece of welfare legislation which afforded transitional Medicaid assistance for those people, with a recognition that of course the words of the gentlewoman are so very true. And so, hopefully, we are helping towards that.

Mr. Speaker, I continue to reserve the balance of my time, but also make available to the gentleman from Ohio (Mr. BROWN) any additional time he may need for his speakers.

Mr. BROWN of Ohio. Mr. Speaker, I thank my friend for the generous offer. We have a couple more speakers. We may not need that time.

Mr. Speaker, I yield 3 minutes to the gentleman from Illinois (Mr. DAVIS).

Mr. DAVIS of Illinois. Mr. Speaker, I want to thank the gentleman for yielding me this time, and I also want to commend the gentlewoman from the Virgin Islands for her outstanding work on this issue and commend all of these who have been instrumental in bringing this matter to the floor.

I rise in enthusiastic support of H. Con. Res. 388, which expresses the sense of Congress that there should be established a National Minority Health and Health Disparities Month. Dr. W.E.B. Dubois suggested that the problem of the 20th Century would be that of the color line. Dr. Dubois was profound and prophetic in his analysis, but we still have not solved the problem of the color line in the 21st century and it is vivid in our health care delivery system.

The persistent problem of health disparities continues to be the reality; that there is serious separation in this Nation. I stand here today to suggest that as long as health disparities persist, we will remain a Nation divided; divided along the lines of those who have and those who have not.

According to the report that we have been discussing, issued by the Institute of Medicine last month, racial and ethnic minorities experience a lower quality of health services and are less likely to receive even routine medical procedures than whites. The report goes on to suggest that when it comes to diagnostic exams for heart disease, cancer, end-stage renal disease, and kidney transplantation, African Americans and other minority groups receive less care than whites.

This report suggests that African Americans and other racial minorities die early and often because of a lack of quality care. The report, which is extensive, entitled ''Unequal Treatment,'' really underscores the need to establish a National Minority Health and Disparities Month, a month that is set aside so that we can refocus, take a hard look, better understand, better realize the disparities, and then find the resources that are necessary to move us from the position of inequities to equality, to equal treatment, equal understanding, and equal recognition.

So again, I commend all of those who have been instrumental. I commend the chairman, the gentleman from Florida (Mr. BILIRAKIS), the gentleman from Ohio (Mr. BROWN), and certainly the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN) for all of their serious leadership on these matters.

Mr. BILIRAKIS. Mr. Speaker, I continue to reserve the balance of my time, but make available to the gentleman from Ohio (Mr. BROWN) any time he may need.

Mr. BROWN of Ohio. Mr. Speaker, I yield 3 minutes to the gentlewoman from Texas (Ms. JACKSON-LEE).

□ 1700

Ms. JACKSON-LEE of Texas. Mr. Speaker, I thank the ranking member, the gentleman from Ohio (Mr. BROWN), for his constant and persistent leadership as it relates to health issues in general. I thank the gentleman from Florida (Mr. BILIRAKIS) for his leadership, and I acknowledge the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN), the gentleman from Oklahoma (Mr. WATTS), and the gentleman from Georgia (Mr. NORWOOD) for bringing this resolution to our attention.

Clearly this is a resolution that will speak loudly in its passage to the American people. In my district, I am often spoken to by constituents of their caring and concern about those individuals far and wide that we have to address, such as the catastrophe in Afghanistan, the crisis in Africa with HIV–AIDS; and at the same time, they are clearly concerned with the home front.

This legislation deals with the importance of dealing with the questions of minority health. With some 50 percent of the minority community without insurance, with the impact on rural areas, with African Americans and Hispanics being impacted in large numbers by HIV–AIDS, and in particular with a study that was just recently issued that suggested that even when minorities access health care, the difficulty is that there is unequal treatment. There are determinations made as to whether or not the individual that accessed the health care should be treated long term for diabetes, should be given the opportunity for triple or quadruple bypass and surgery. We have a crisis.

What we want to do with this resolution is focus on changing the attitude. At the same time, let me acknowledge that I hope this legislation will encourage the Bush administration to not repeal the requirement of low-income children being tested for lead poisoning. That would put thousands of our children in minority communities at risk. My district happens to be a very multicultural district. It has people from all walks of life; but one of the most crowded places in my district is the Harris County Public Hospital system. It is because people desire health care, and do not have the ability to access private health coverage, so they are at our public hospital systems. Those institutions need assistance from the Federal Government to assist them in lead poisoning testing for our children. They need assistance in making sure that Medicaid payments are being paid, and making sure that if someone needs quadruple heart surgery, that they can be referred out to our very fine institutions in the medical center. The partnership is extremely important.

So this resolution is of utmost importance. I thank the members of the Committee on Energy and Commerce, the Congressional Black Caucus and the Hispanic Caucus Health Task Force, which the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN) and Congressman RODRIGUEZ lead, and I am a member of, and for the leadership behind educating both Congress and the American public.

Finally, racial and ethnic minorities tend to receive lower-quality health care than whites do, even when insurance status income, age, and severity of conditions are comparable according to the National Academies Institute of Health. Thousands of people suffer in America that is why we must pass this legislation to create a responsive and equal health system in America.

Mr. BROWN of Ohio. Mr. Speaker, I yield 2 minutes to the gentleman from Maryland (Mr. CUMMINGS).

Mr. BILIRAKIS. Mr. Speaker, I yield 2½ minutes to the gentleman from Maryland (Mr. CUMMINGS).

Mr. CUMMINGS. Mr. Speaker, this afternoon I rise in support of H. Con. Res. 388, a resolution to designate April as National Minority Health and Health Disparities Month.

In 2000, the Department of Health and Human Services and the U.S. Surgeon General established National Minority Health Month to promote national health and disease prevention. The goal was to build a public-private partnership, foster cultural competency among health care providers, encourage health education and training, and expand the use of state-of-the-art technology.

It is intended to be an inclusive initiative that addresses the health needs of African Americans, Hispanics, Asians, Native Americans, Pacific Islanders, Alaskan Natives and Native Hawaiians. Because the month will be nationally recognized, it will serve to raise awareness and reduce the problem of minority health disparity.

Mr. Speaker, a few weeks ago, the Congressional Black Caucus held its annual Health Braintrust. This year's focus was on minority health disparities. Testifying at the hearing from my district were Dr. Martha N. Hill, Dean of the Johns Hopkins School of Nursing; Professor Thomas E. Perez, who was the immediate past director of the Office on Civil Rights at HHS; and Dr. Thomas LaVeist, Johns Hopkins University, and an active health care researcher, including the role of race in health care services.

Also testifying were the authors of the Institute of Medicine's report, ''Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.'' The primary finding of this report publication, ''Unequal Treatment,'' states that due to disparities in health care treatment, blacks and other minorities do not live as long as Caucasians.

Why is that? Because according to the Institute of Medicine's publication of ''Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,'' even those of us who are fortunate enough to have health insurance receive inferior medical care compared to our caucasian counterparts, even when insurance coverages are the same.

I would like to cite some of the specific facts for the record, and I think my colleagues might find them very, very disturbing.

African Americans were 1.5 times more likely to be denied managed care authorization in an urban emergency room. For senior citizens, African American patients were four times less likely than Caucasians to receive needed coronary bypass surgery. Black male seniors were nearly two times less likely to receive treatment for prostate cancer. And this is incredible, but black seniors were 3.6 times more likely to have lower limbs amputated due to diabetes. Think about it. Due to poor health care, African Americans and other minorities do not live as long as Caucasians. Blacks are 24 percent less likely to receive life-preserving medications for HIV and AIDS; 20 percent of blacks and 33 percent of Hispanics lack health insurance. This is two and three times greater than the rate for Caucasians. These disparities permeate in minority communities.

For example, as a Social Security issue, blacks collect fewer retirement benefits because we die earlier. I guess on the upside, while we comprise about 12 percent of the United States population, we collect about 23 percent of the Social Security disability benefits. Think about it. This is not a Social Security issue; it is a health issue.

Mr. Speaker, if there were equity in health care, African Americans would be able to work longer and live longer. Think about it. The economic impact of poor health care created for all Americans is crucial.

Mr. Speaker, I urge all Members to vote in favor of this. I thank the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN), and I thank the other side for their courtesy and kindness.

Mr. DINGELL. Mr. Speaker, I rise to voice my strong support for H. Con. Res. 388, establishing a National Minority Health and Health Disparities Month. This resolution has been crafted by my good friend and colleague, Representative CHRISTENSEN. The resolution was reported unanimously by the Committee on Energy and Commerce last week.

Mr. Speaker, this resolution will help to keep our attention focused on a disturbing fact of life. That fact is that people of color face devastating disparities in research, quality, access, and other measures of health care. Women are particularly hard hit, as reflected in the statistics. The prestigious Institute of Medicine recently published yet another study that shows we still have a long way to go before we can say that all Americans share equally in the benefits of modern medicine.

Mr. Speaker, I am pleased that this resolution specifically mentions the Minority Health and Health Disparities Research and Education Act of 2000. I was proud to join my colleagues, including Representatives JOHN LEWIS and JESSE JACKSON, JR., in that effort. That bill recognized that disparities exist throughout the development and delivery of health care. It was a good step, but clearly much more needs to be done. The entire health care system, from ''bench to bedside,'' needs to be vigilant and to address disparities wherever and however they occur.

I applaud Representative CHRISTENSEN for bringing this resolution to the floor. I urge my colleagues to support her work and to support substantive efforts to eradicate health disparities in all programs that come before this body.

Ms. WATERS. Mr. Speaker, I rise to support H. Con. Res. 388, which would support the establishment of a National Minority Health and Health Disparities Month. The United States is a nation with a health system marked by its disparities. Too often, low-income Americans, racial minorities and individuals who lack health insurance find that quality health care is unavailable to them. At the request of Congress, the Institute of Medicine released a report this year confirming the existence of serious racial disparities in American health care.

Racial disparities in access to cancer screening contribute to higher cancer death rates for minorities. Black and Hispanic women are less likely to receive breast cancer screening with mammograms than white women, and black and Hispanic men are more likely to be diagnosed with more advanced forms of prostate cancer than white men. Last year, I introduced H.R. 3336, The Cancer Testing, Education, Screening and Treatment (Cancer TEST) Act, to provide cancer screening and treatment services for minorities and low-income populations. This bill now has 49 cosponsors.

Racial minorities have been disproportionately impacted by the HIV–AIDS epidemic. They now represent a majority of new AIDS cases and a majority of Americans living with AIDS. I am circulating a letter to the Chairman and Ranking Member of the House Subcommittee on Labor, Health and Human Services and Education Appropriations to request an appropriation of $540 million for the Minority AIDS Initiative in fiscal year 2003. Ninety Members of Congress have agreed to sign my letter.

Unfortunately, the problems in our nation's health system are only getting worse. A survey of California employers by the Kaiser Family Foundation shows that health insurance premiums increased by 9.9 percent in 2001. That is more than double California's 4.3 percent inflation rate. Furthermore, Calpers, the State of California's employee benefits system, plans to raise rates for its HMO premiums by 25 percent next year.

I urge my colleagues to vote in favor of H. Con. Res. 388 and support legislation that will guarantee every man, woman and child in America quality health care services, regardless of race, level of income or place or employment. Quality health care should be for everyone.

Mr. BILIRAKIS. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

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

The SPEAKER pro tempore (Mr. WHITFIELD). The question is on the motion offered by the gentleman from Florida (Mr. BILIRAKIS) that the House suspend the rules and agree to the concurrent resolution, H. Con. Res. 388.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the concurrent resolution was agreed to.

A motion to reconsider was laid on the table.

HEMATOLOGICAL CANCER RESEARCH INVESTMENT AND EDUCATION ACT OF 2001

Mr. BILIRAKIS. Mr. Speaker, I move to suspend the rules and pass the Senate bill (S. 1094) to amend the Public Health Service Act to provide for research, information, and education with respect to blood cancer.

The Clerk read as follows:

S. 1094

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