

Peter to pay Paul. Unfortunately, both Peter and Paul are starving.

If we are going to lead, and especially if we are going to ask others to do more, we are going to have to stop playing shell games with the foreign aid budget. Leadership is good policy. Leadership means resources. Leadership means ideas. Leadership is not a press release.

Senator FEINSTEIN, Senator HAGEL, Senator SMITH, and so many others, Democrats and Republicans, have spoken out about the need for substantially more resources to protect America's interests abroad. When are we going to stop talking and start acting?

As I have told the President before, I would strongly support him on these issues. But, I am not going to support empty rhetoric. I want to see the money. It is one thing to go on foreign trips and talk to leaders and say: Look at this AIDS authorization bill I have. But, it does not make much sense if the money is not there. And, in this budget, the money is not there.

I call on the President: Let's forget the politics. Let's come up with the right ideas on AIDS. Let's come up with the right ideas on the Millennium Challenge Account. But, once we have the right policies, let's put real resources behind these policies. And, to pay for these increases, we should not cut programs for global health, disaster assistance, refugees, food aid, development assistance, and immunizations.

Let's get rid of the rhetoric. Let's put some reality in there. If we do that, then the United States can show the promise and the moral leadership a great Nation should show.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2003

Mr. FRIST. Mr. President, last Wednesday marked an important day in the progress of medicine and national policy. I am pleased to note that on that day the Health, Education, Labor, and Pensions Committee voted unanimously to report out S. 1053, the Genetic Information Nondiscrimination Act of 2003.

For more than 6 years, I have had the opportunity to work with Senators SNOWE, JEFFORDS, ENZI, GREGG, HAGEL, COLLINS, and DEWINE on this important legislation. I believe with the invaluable contributions of Senators DASCHLE and KENNEDY that we brought to the forefront of the congressional agenda solid legislation that will provide patients with real protection against ge-

netic discrimination in health insurance.

I will first express how much I appreciate the work of my colleague on this issue, the Senator from New Hampshire, Mr. JUDD GREGG, who is chairman of the Health, Education, Labor and Pensions Committee. It is his commitment and dedication to this issue that is primarily responsible for getting us to this point of reporting out this Genetic Information Nondiscrimination Act.

At this juncture, I also commend President Bush for his commitment to ensuring strong protections against genetic discrimination and for calling attention to this critical matter.

We began work on this issue many years ago. It was interesting when we started this work—well, not many years, about 5 years ago. But when we started this work, it was way off in the future that we anticipated decoding of the human genome would actually occur, but we were able to identify the problem, recognizing that the advances in technology, this unraveling of the genetic code, which was so revolutionary in thought at the time, would indeed introduce new challenges to the way we handled health information.

So we jump a few years later and now we can look back, and over the last few weeks the complete decoding of the human genome has been announced. That is about three billion bits of information that we did not know about a year ago. Now we know.

Just last month, America celebrated two wonderful milestones in medical science. Scientists working in collaboration with the National Human Genome Research Institute at the NIH, National Institutes of Health, published a final draft documenting that entire sequence of the human genetic code. The publication occurred more than 2 years ahead of schedule. I should also add, it came under budget. There are very few things we do in Washington that are completed ahead of schedule and under budget. This tremendous discovery, this unraveling of the genetic code of the human genome, is one of them.

The publication of this occurred more than 2 years ahead of schedule, as I mentioned, but also almost 50 years to the day from the historic publication by two icons in terms of science, Dr. James Watson and Dr. Francis Crick. The helix, called the DNA, which is a double helix—all of us have seen pictures of almost a figure 8, a three dimensional helix which was described now a little over 50 years ago. The dazzling accomplishment of this decoding of the human genome has ushered in a new era which we will see unfold over the next few years, next 5, 10 years, which will enable us to better understand diseases, how the human body functions but, importantly, how diseases affect that functioning of the human body.

This decoding has also begun to expand our understanding of human de-

velopment throughout life, health, and disease processes. Specifically, the discovery of disease genes—that is, variations in the genetic code that can be associated with the manifestation of symptoms and what becomes disease—brings promises for hope for ultimately not just prevention of those diseases but also treatment and cure. Scientists very likely will be able to design drugs to treat specific genes or the manifestation of these genes. In my own field of heart and lung transplantation and other types of transplantation of tissues, organs may be specifically engineered for use in the field of transplantation. Even preventive care, where we are woefully inadequate in terms of knowledge but also in application of that knowledge today, may potentially be based in large part to genetic testing.

This potential explosion of knowledge, which is exciting to me as a scientist and as a physician, is also associated with risk. When I first joined my distinguished colleague from Maine, Senator SNOWE, in this effort several years ago, almost one-third of women who were offered a test for breast cancer risk—and this is a genetic test—at the National Institutes of Health declined. They said, no. They say: I understand that test may be able to tell whether I will get breast cancer but I decline.

You ask why. They say: The only reason, and the reason I say no, is the risk that information will be used by a health insurance company or an employer against me. What if that information got out?

I strongly believe then, as I do now, that we have an obligation, a responsibility, to protect people from the threat that their genetic information can be used against them in any way. I would say that from a medical standpoint, and from a societal standpoint, this is a moral responsibility. It is a practical responsibility. If unchecked, the fear of genetic discrimination will prevent individuals from participating, whether it is in research studies, or in the gathering of information that can be used and applied more broadly to people, either in this country or indeed across the globe. It will prevent people from taking advantage of the new technologies which can be and, in fact, almost certainly will be lifesaving. It will keep people from getting tests, even from discovering that they are not at risk for genetically related diseases. Also, the fear of genetic discrimination has the potential to prevent citizens from making informed health decisions.

If one does not have that information, they simply are not going to be able to make informed health care decisions, whether it is in lifestyle or to determine whether or not they need an annual cardiac or heart catheterization once a year, or if they have the gene for breast cancer so that they would go and get mammographies more often. If they refused to get the test because of

the fear of the discrimination, clearly they are not able to make informed health decisions for themselves.

In the past, Congress has taken on the battle against broad discrimination in all sorts of legislation. We think back to the 1964 Civil Rights Act; to 1990, the American with Disabilities Act; more recently to the Health Insurance Portability and Accountability Act.

Today, we extend those protections to citizens with genetic markers, a move that has the power, I would argue, to save lives.

As I have implied, this whole field of genetic research and testing will undoubtedly unleash thrilling advances and better health care. It will lead almost certainly to cures for diseases that we cannot even imagine can be cured today. The potential medical advances that emerge from our knowledge and our understanding and that definition of the human genome that was spelled out just a couple of months ago, I know will be more dramatic than the changes I have seen in over 20 years practicing medicine, that I witnessed in my own medical career. Clearly, there will be much more advancing and pioneering than my dad saw after 55 years practicing medicine from about the 1930s to the 1980s.

As we greet the future, the excitement, the thrill of discovering what emerges from this new body of information, this definition of the human genetic code, we have a responsibility in this body to protect our body politic. I am pleased by the progress we have made thus far.

I come to the floor to speak today because I have watched this debate, I have watched this discussion, and I have seen in a bipartisan way in the Health, Education, Labor, and Pensions Committee tremendous progress being made this past week, and hopefully it can be made in the Senate as we look at discrimination in genetic testing.

I congratulate my colleagues on their persistence and dedication to the issue. It gives us an opportunity, in advance of there being a problem, in advance of the new genetic tests, to address that potential for discrimination which, in turn, if it occurred—and I believe there is a high likelihood unless we act—would be a disservice to mankind.

This legislation stands squarely on our time-tested civil rights laws establishing comprehensive, consistent, practical, reasonable, and fair protections. I strongly support this compromise bill. I am speaking today primarily because it is a compromise bill taking the very best out of the pieces of legislation that have been proposed in the past. I strongly support this compromise bill. I look forward to its swift passage.

EQUALITY IN HEALTH CARE

Mr. FRIST. Mr. President, I speak for a moment on the issue of equality in

health care and what I have personally been able to observe, which we as a body have tried to address—in fact, have taken some major steps forward—but which stands as a major challenge which I believe we can address in this body. That is the subject of health care disparities.

In the 21st century, Americans are among the healthiest, the longest living, and robust citizens in the history of the world. We have conquered diseases that were once untreatable. Our remarkable scientists continue to develop new drugs, therapies, treatments, and procedures that every day are bringing new hope and, indeed, saving the lives of millions around the country and millions around the world. We have much of which to be proud.

At the same time, there is something we should be ashamed of because despite the dazzling medical and social progress of the last century, there remains wide health disparities and inequalities between minority and non-minority citizens. I will cite a few examples. Infant mortality rates are twice as high among African Americans versus Whites. The prevalence of HIV/AIDS in Latino populations is four times higher. And the prevalence of AIDS among African Americans is nine times higher than among Whites. African-American children are twice as likely to have asthma. They are six times more likely to die from asthma than others. And mortality rates related to diabetes are more than twice as high among African Americans and Native Americans.

The question is, why? We have made progress in understanding why, but we cannot answer that question. Why? Even when we control our access to medical services and we control for other socioeconomic factors, Americans from minority backgrounds still receive unequal care. They suffer lower quality care and, consequently, worse health outcomes. That is the challenge. The response to that challenge is we can eliminate that. We can reverse these health care disparities.

Progress has been made in recent years to close the health gap between minority and White patients. We are boosting Federal research into the cause of health disparities. We are identifying barriers to care in our communities. We are expanding the number of health professionals who have a strong commitment to the needs of minority and underserved patients. Much more, however, needs to be done.

That is why I am proposing the Health Care Gap Act of 2003. This legislation, which I plan to introduce later this year, builds on successful prior legislation to ultimately eliminate such disparities in health care. This legislation will address key areas necessary to close the health care gap in America. These include expanding access to quality health care, improving national leadership and coordination, increasing the diversity of health professionals, promoting more aggressive

professional education, promoting research to identify sources of racial and ethnic disparities, identifying promising interventions, and improving and expanding programs to prevent, too manage, and to treat diseases and conditions that disproportionately impact minority and underserved populations. As I mentioned in the data I quoted, these include asthma, they include HIV/AIDS, prostate cancer, and other types of cancer.

Last weekend, I have the privilege, as so many Members—in fact, many Members departed an hour or so ago to deliver commencement speeches at high schools, elementary schools, secondary schools, colleges, and graduate schools all over the country.

I had the privilege last week of speaking at two commencement ceremonies. One was for the School of Medicine at Morehouse College in Atlanta, and also the George Washington School of Medicine here in the Washington area. In my address, I challenged these hard-working and young people—our future doctors, our future health professionals, our scientists—to become active, to actively shape and mold our profession. I told them that in this day and time in the field of medicine, we simply can no longer, as health professionals, solely practice medicine. They must lead in medicine. The same is true of us.

This bill on health care disparities, this legislation which will be introduced later this year, will do just that. In the Senate, we must help to create a medical system that treats all patients equitably. Our national creed, that all are created equal, dictates that we must.

HONORING BOB HOPE

Mr. FRIST. Mr. President, I take a moment to honor a great American who is celebrating his 100th birthday. Bob Hope was born one of six boys in a London suburb on May 29, 1903. His family made their way to America when he was 3, and they settled in Cleveland, OH. We can only be grateful to the Hope family for making that journey.

Growing up, Bob Hope was a shoeshine boy, butcher's mate, stock boy, newspaper boy, golf caddie, shoe salesman, and even a prizefighter—all of these things before he became one of America's most beloved and successful entertainers.

As a performer, Bob Hope had the rare and miraculous gift of being able to touch our common humanity. His famous road pictures with Big Crosby and Dorothy Lamour were the quintessential expressions of the adventure of being an American.

But he is most loved, of course, for the thousands of hours and millions, literally millions of miles he spent in selfless devotion to our troops. World War II, South Korea, Vietnam, from the Far East to Northern Africa, the Indonesian peninsula to the heart of