IN PRAISE OF IMMIGRANT CONTRIBUTION TO AMERICAN SOCIETY

HON. CHARLES B. RANGEL

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 28, 2005

Mr. RANGEL. Mr. Speaker, I rise today to recognize and praise the immigrant contribution to the United States. To say that immigration is a driving force in the American economy is to make an understatement. According to the 2005 Economic Report of the President immigration is shown as being a key to the growth of the labor force and has cemented the traditional belief that immigrants provide a positive net fiscal benefit to the American economy. Current governmental policies toward immigration, however, don't reflect the Report's findings.

Facts now point to the fact that today, 23 percent of the population is either foreign-born or children of someone who is. According to the most recent census, over 34 million people living in the U.S. were born outside of the U.S. with most of those coming from Latin America, about 25 percent hailing from Asia, nearly 15 percent from Europe and 8 percent coming from elsewhere including primarily Africa. Another 30 million are ''second generation'' Americans with one or both parents having been born elsewhere.

Immigrants play a vital role in American society. They are found in diverse occupations ranging from construction work and cooks to computer programmers and medical doctors. Their impact on American society can be seen in everything from musical icons such as Jennifer Lopez to our affinity for exotic cuisine.

It is the contributions of this wide and varying group that give America its diversity. Immigrants are our next-door neighbors, friends and colleagues. They are hardworking and diligent members of our society, who live, work, and pay U.S. taxes. In New York State alone, undocumented workers pay more than $1 billion in taxes a year.

Although it is true that we have unemployment among American citizens, we also have labor shortages, for example agricultural workers. Immigrants generally fill those jobs, which American citizens simply do not want to take.

America's continued economic growth requires a steady flow of immigration. It almost always has and will in the future, perhaps more than at any time in the past. Therefore, rather than placing up barriers we should embrace and celebrate the contributions of immigrants to our society.

I introduce in the RECORD an article from July 19, NYCarib reporting on the economic benefits of immigrant labor.

IMMIGRANTS AND MELTING POT ECONOMICS—THE FLOW OF FOREIGNERS INTO U.S. BOOST BUT DON'T IMPERIL THE NATION

(By Tony Best)

Call it a lesson in ''the melting pot economics 101,'' facts and figures that underscore an important reality of American society: immigration is a key element in the rejuvenation and the prosperity of the country.

Just as important, it's an essential cog in the economic wheel.

The latest data published by the U.S. Census Bureau not only showed that the United States is in the throes of what could be best described as a significant transformation of its demographic profile but that many of the claims the nativists are erroneous and that if their goals became nation's policy, they would be imperiling America's economic vitality.

''For those of us who believe that the melting pot is a vital and unique feature of American society, this finding that the new immigrants are integrating into our modern economy is highly re-assuring,'' stated Stephen Moore, a member of the Wall Street Journal's editorial board.

''Even more encouraging is the knowledge that a generous immigration policy can coexist with high rates of economic growth and low unemployment,'' he added in an OpEd commentary in the major business daily paper.'' The nativists have gotten this story wrong for at least the past 20 years; perhaps it would be wise to stop listening to them.''

We couldn't agree.

But what do the Census figures and other data show us that we may not have known before?

Here are some of the numbers that support the above contention:

Between 1980 and 2002, about 20 million immigrants entered the United States, most of them coming from the Caribbean, Asia and Central America.

The foreign-born now account for about 12 percent of the country's population, up from 6.2 per cent in 1980.

Housing and financial assets have grown four-fold in the past two decades, a time of great expansion of wealth and skyrocketing immigration.

As more and more people arrived, the unemployment rate declined between 1980–82. Joblessness among Blacks dropped by six per cent and Hispanics almost four per cent in the last 20 years.

The U.S. has been a leader in the industrialized world when it came to immigration, integrating twice the number of immigrants than other wealthy nations.

Median real family income rose about a fifth, going to $52,000 today. People at the bottom of the economic ladder have seen their median income jump as well between 1980–2000.

Immigrants in the U.S. for less than three years have a jobless rate of just eight percent but that rate fall to 6.7 percent after living here for a decade and 6 percent after 20 years.

The foreign born who recently landed on U.S. shores have a median family income of slightly less than $32,000 while those persons who arrived in the 1990's have incomes that surpass $38,000. If you had arrived in the early 1980's then chances are the income is in the vicinity of $38,395.

According to Dr. Richard Vedde, a labor economist at Ohio University, the states with the highest levels of immigration had the lowest levels of unemployment.

What then do we learn from the data?

The lessons are obvious.

While it is true that immigrants go up against American workers for their jobs in certain industries, such as driving taxis, working in textile mills and serving as field hands in the agricultural sector, ''there is no evidence,'' said Moore, that ''on a macro-level,'' that immigrants suppress wages because native born Americans have left too many of those jobs for better paying tasks any how.

The numbers also allay the fears of Blacks and Hispanics that immigrants take away their jobs. For as the foreign born population expanded, the nation's unemployment rate fell from 7.3 percent to 5.1 percent over 20 years. Black unemployment also slumped as the immigrant numbers expanded.

INTRODUCING A RESOLUTION SUPPORTING THE GOAL OF THE UNITED STATES ESTABLISHING A RESPONSIBLE ENERGY POLICY TOWARD THE GULF OF GUINEA REGION IN WESTERN AFRICA THAT ENCOURAGES LOCAL CONTENT DEVELOPMENT AND GREATER GOVERNMENTAL TRANSPARENCY

HON. ALCEE L. HASTINGS

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 28, 2005

Mr. HASTINGS of Florida. Mr. Speaker, I rise today to introduce a resolution supporting the goal of the United States establishing a responsible energy policy toward the Gulf of Guinea region in Western Africa that encourages local content development and greater governmental transparency.

The United States buys approximately 15 percent of its oil from the Gulf of Guinea region in Western Africa. Research indicates that in 10 years the United States will import 25 percent of its oil from the Gulf of Guinea region. The Gulf of Guinea region comprises the countries of Nigeria, Cameroon, Gabon, Equatorial Guinea, Angola, Congo-Brazzaville, Sao Tome and Principe, and the Democratic Republic of Congo.

With record-breaking prices for oil and gasoline products, reliance on a narrow range of the world to supply most of our oil has proven to be short-sighted as well as costly. We must now consider a broader range of fueling sources. By working as an active partner with the Gulf of Guinea region in Western Africa, the U.S. can positively guide changes that help develop West Africa's oil economy while securing economic growth, finding additional oil resources, and honoring human needs.

Mr. Speaker, I urge my colleagues to support this resolution. As Members of Congress, it is our moral responsibility to ensure that we establish a responsible energy policy toward the Gulf of Guinea region that is mutually beneficial and responsible. I look forward to working with my colleagues and moving this promising resolution forward.

RECOGNIZING MS. ROBBIE JACKMON

HON. HAROLD E. FORD, JR.

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 28, 2005

Mr. FORD. Mr. Speaker, I rise to recognize Ms. Robbie Jackmon, an individual whose continued commitment to public health has improved the lives of countless Tennesseans. Ms. Jackmon retires at the end of the year as the Executive Director of the Office of Minority Health for the Tennessee Department of Health.

Ms. Jackmon served communities within the state tirelessly for nearly 27 years. She has helped Tennesseans in every position she has held. As Director of Treatment Services for the Division of Alcohol and Drug Abuse Services, she proposed and implemented state policy pertaining to alcohol and drug treatment. As assistant commissioner for the Bureau of Alcohol and Drug Abuse Services, she directed

and oversaw a $30 million budget. As Clinical Coordinator for Meharry Medical College she specialized in case management, where she continued to help Tennesseans recover from the ravages of addiction.

Her commitment to the improvement of Tennessee public health has led her to serve on a number of committees and boards of State and National review. Among them are the Advisory Group for the Congressional Office of Technological Assessment, as chair for the Southeastern School on Alcohol & Drug Abuse and the Advisory Board for Blue Cross/Blue Shield of Tennessee.

In her position as Executive Director of the Office of Minority Health, she served with great stature as chief liaison between the state of Tennessee and the Department of Health and Human Services. She oversaw matters regarding health disparities and HIV/AIDS. In addition, she administered program design, project implementation, grant monitoring and evaluation, and health policy planning to ensure that effective measures are taken to provide Tennesseans with knowledge they need to develop healthier lifestyles.

Mr. Speaker, on behalf of all Tennesseans, I extend my deepest feelings of appreciation to Ms. Jackmon. I commend her long outstanding career, service and commitment to improving the public health of her fellow Tennesseans. I ask my colleagues to join me in recognizing the works of a distinguished woman, and a model citizen.

HEALTHCARE EQUALITY AND ACCOUNTABILITY ACT OF 2005

HON. DONNA M. CHRISTENSEN

OF THE VIRGIN ISLANDS

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 28, 2005

Mrs. CHRISTENSEN. Mr. Speaker, I rise today to discuss a critically important bill that is being introduced today: the Healthcare Equality and Accountability Act of 2005. Before I go into detail, I must profusely thank three people who were incredibly instrumental in helping us get this bill developed and introduced: Sharon Coleman of the Congressional Research Service, and Peter Goodloe and Warren Burke, of the House Legislative Counsel. Ms. Coleman, Mr. Goodloe and Mr. Burke, on behalf of the TriCaucus, I thank and applaud you for your efforts.

Over the last two decades, hundreds of studies—most which have been conducted by credible sources, like the Institutes of Medicine, academic institutions, including Harvard, Johns Hopkins, Morehouse College and University of California, in addition to non-partisan foundations and think tanks—have confirmed that racial and ethnic health disparities are a challenge to health care in this country. Here in America, the color of your skin, your ethnic background, and your geography can not only influence your health care access and quality; they can determine them.

We have all heard the numbers and statistics. We see grave racial and ethnic differences in health status and outcomes that are unacceptable in a country as wealthy as this one. For example:

African American and American Indian/Alaska Native infant mortality rates are more than two times higher than that for whites.

African American women are nearly four times more likely than white women to die during childbirth or from pregnancy complications.

The death rate from asthma is more than three times higher among African Americans than among whites.

The diabetes death rates among African Americans and Hispanics are about 2 times higher than that among whites.

The AIDS case rate among African Americans is more than ten times higher than that among whites. The AIDS case rate for Hispanics is more than four times higher than that among whites.

Until the conditions that disproportionately affect racial and ethnic minorities are addressed and an emphasis is put on prevention, as well as treatment and care, then racial and ethnic disparities in health will continue to plague minority Americans.

Mr. Speaker, far too many people assume that racial and ethnic minorities have poorer health status and die prematurely because of bad health decisions. And, making healthy decisions is one part of the equation. However, it is difficult to make healthy decisions and to preserve good health when you are uninsured. And, uninsurance disproportionately affects racial and ethnic minorities.

In fact, racial and ethnic minorities comprise about one third of the total U.S. population, yet are represented in more than half of this country's uninsured population. Uninsurance, Mr. Speaker, is a major factor that exacerbates racial and ethnic health disparities, and reducing the numbers of the uninsured must be an integral part of any strategy to reduce—and ultimately eliminate racial and ethnic health disparities.

And then, Mr. Speaker, there is something else that happens too often when racial and ethnic minorities go to the doctor. Even when they have an insurance card from the best companies, the quality of their health care is less than that of whites and often does not meet medical standards. These disparities, Mr. Chairman, are the most egregious and disturbing because they serve as a reminder that more than four decades after the Civil Rights Movement, racial and ethnic minorities still are not treated equally and fairly.

When I first heard about these types of disparities, I was shocked. As a physician who practiced for more than two decades, I cannot fathom discriminating against a patient because of their skin color, their ethnic background or sexual orientation. But, the studies documenting these disparities are extensive and robust, and have found that:

Despite having heart disease and stroke rates that are disproportionately higher than whites, African American women with health insurance are 40% less likely than whites with health insurance to be recommended for cardiac catheterization.

African-American diabetics are more nearly 3.5 times more likely than white diabetics to have a lower limb amputation procedure performed.

African Americans are 3 times more likely than whites to be hospitalized for asthma and about 2½ times more likely to visit an emergency room with an asthma attack. This is significant because hospitalization for asthma is an avoidable admission if the condition is adequately managed.

Mr. Speaker, last Congress, my colleagues and I in the TriCaucus introduced a bill that would reduce racial and ethnic disparities in health and in health care. This Congress, we decided to re-introduce that bill in a concerted effort to continue our commitment and work to ensure that racial and ethnic health disparities are eliminated from our health care system.

This bill, entitled the Healthcare Equality and Accountability Act of 2005, proposes solutions to the factors that exacerbate racial and ethnic health disparities by working to accomplish the following:

Remove barriers to health care access by expanding existing forms of health insurance coverage.

Improve cultural and linguistic competence in health care by removing language and cultural barriers to quality health care.

Improve the diversity of the health care workforce to reflect, understand and respect the backgrounds, experiences and perspectives of the people it serves.

Support and expand programs to reduce health disparities in diseases and conditions, especially diabetes, obesity, heart disease, asthma and HIV/AIDS.

Improve racial, ethnic, socioeconomic and language data collection to adequately identify, measure and find reasonable and innovative solutions for health disparities.

Ensure accountability of the Bush administration to ensure adequate funding of the Office of Minority Health, and the National Center for Minority Health and Health Disparities and the important work that they do.

Bolster the capacity of institutions that provide care in minority communities.

Mr. Speaker, these health disparities are not just minority issues. Because these health disparities often result in death, they are moral issues. Because these health disparities leave minorities with greater disease and disability burden, they are civil rights issues. Because these disparities burden the health care system, they are economic issues. And, because these disparities jeopardize the health and well being of the people in this country, they are an American issue.

I therefore urge my colleagues—on both sides of the fence—to support the Healthcare Equality and Accountability Act of 2005.

THE FINAL MISSION OF THE LATE OSSIE DAVIS

HON. CHARLES B. RANGEL

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 28, 2005

Mr. RANGEL. Mr. Speaker, I rise to pay tribute to an outstanding American actor, civil rights advocate, and highly regarded humanitarian—Ossie Davis. Throughout his distinguished career as an actor, he was simultaneously an activist who utilized the platform his celebrity status gave him to advocate for opportunity and justice for all Americans.

Ossie Davis passed away almost six months ago, leaving behind a legacy of determination, pride, and caring that will long be remembered and will continue to be an inspiration to all who were privileged to know him. Upon hearing of his death, I was deeply saddened but remembered his rich legacy of activism and leadership.

Ossie Davis fully participated in and led the great movements for civil rights and justice in