Gina exemplified compassion, family values, and dedication. She gleamed with joy at the thought of her children and would go to the ends of the earth to ensure their security and comfort. She never questioned the needs of others and was always willing to help out where ever she could. She was and will remain such a tremendous person in our thoughts and in our memories.

Gina was never the type of parent to push her children, but instead offer her support. Her eldest child, Raquel, blind from birth, was blessed with a voice from heaven and has used that voice for the good or her culture. Since the age of 14, Raquel has been singing with the Inland Empire Mariachi Youth Foundation and has plans to someday teach children just like herself. Raquel could not have done this without the devotion of her mother. Gina devoted her time and efforts to the success of her daughter as well as the success of the group.

This past May, in an effort to expose Washington to the culture of Mariachi music as well as provide an opportunity for the children to experience our Nation's Capitol, I brought these talented children here to Washington, DC. Gina gave up her opportunity to go on the trip so she could stay at home to take care of her other children and prepare the group for their journey.

This is exactly the type of person Gina was. She never complained and was willing to give up large portions of herself to the needs of her children as well as the needs of the entire group as a whole.

Gina lived a fulfilling life graced by her husband and her children. Not only was she blessed with Raquel, but she was blessed with five other children that are just as talented and beautiful as the first. Vanessa—age 16, Tatiana—age 14, the twins Felipe and David—age 11, and the youngest Steven—age 5, all stand as a reminder of the excellence and selflessness that was Gina.

I join with all of those who loved Gina in extending our prayers to the family and hope they find peace and comfort during this time of sorrow.

God Bless.

COMMENDING IRVINGTON HIGH SCHOOL FOR RECEIVING THE NEW AMERICAN HIGH SCHOOL AWARD FROM THE UNITED STATES DEPARTMENT OF EDUCATION

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, December 14, 2000

Mr. STARK. Mr. Speaker, today I commend and congratulate Irvington High School in Fremont, California for receiving a New American High School Award from the United States Department of Education.

The U.S. Department of Education New American High School Award is given to high schools that demonstrate a commitment to ensuring that all students meet challenging academic standards and are prepared for colleges and careers. This program is part of the Department of Education's effort to reform our schools.

Irvington High School was one of only 27 schools in the country to win this award for 2000. Irvington High School won this award by making a schoolwide effort to refuse to accept subpar schoolwork from any student. To make sure all students can earn good grades, the school offers extra help to pupils with academic difficulties. To aid these students, the teachers help the student identify their weaknesses and develop a pact for rectifying them. The school also fosters responsibility to one's community by requiring students to complete a minimum of 40 hours of community service as a requirement for graduation.

Finally, the school requires that all seniors participate in a ''personal quest'' by doing a research project and oral presentation on a subject that fascinates them. Students have embarked on ''personal quests'' to learn about careers that they want to pursue after graduation. These quests have ranged from one student learning about becoming a photographer to another learning about becoming a marine biologist. Each student must work with a school advisor and must gain actual work experience in the occupation in which they are interested.

This combination of innovative teaching and emphasis on public service has made Irvington High School a shining example to other schools across America on how to educate our students to thrive in the 21st century. Again, I want to extend the highest commendation and congratulations to Irvington High School for its outstanding performance in educating our children. This award recognizes what the citizens of Fremont, California have always known, that the faculty and students of Irvington High School are first rate in every aspect.

ELIMINATE RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, December 14, 2000

Mr. STARK. Mr. Speaker, Medical Care Research & Review recently released a special issue, compiling ten articles from our nation's leading researchers in the area of racial and ethnic health disparities. Taken altogether, these investigations add to a growing body of evidence that leaves little doubt as to the pervasive and persistent presence of racial and ethnic disparities in health insurance coverage and access to care.

Many variables are thought to contribute to racial and ethnic disparities in health care, such as status of health care coverage and income level. Yet across each investigation, regardless of outcome measured, racial and ethnic disparities persisted—even when the effects of income, health care coverage status, and other individual characteristics were controlled.

As our country continues to diversity, with growing populations of African Americans, Latinos, Asians & Pacific Islanders, and Native Americans, we, as a nation, must be responsive to the needs of all citizens. As reflected in the following findings, this special issue of Medical Care Research & Review highlights areas that need to be addressed to ensure equitable health care access for everyone.

People of color are far more likely to lack health care coverage as compared to whites, primarily due to lower rates of private health insurance coverage, especially employment-based coverage. In 1996, people of color comprised only one quarter of the non-elderly population, yet they represented 41% of the uninsured.

The effects of race and ethnicity extend beyond insurance coverage to encompass the entire treatment process. For example, the referral process for invasive cardiac procedures involves multiple steps and decisions. At every step, ranging from the initial recognition of symptoms by the patient to obtaining referrals for coronary angioplasty or coronary artery bypass surgery, race and ethnicity issues can (and often do) enter into the equation.

Hispanics and African Americans are much more likely to lack a usual source of health care and less likely to use ambulatory care as compared to whites. The disparities are greatest for Hispanics—for whom the probability of lacking a usual resource of care increased from 19.9% in 1977 to 29.5% in 1996. By way of contrast, this figure represents twice the risk faced by whites in 1996.

Race and ethnicity are also factors in the likelihood of being hospitalized for a preventable condition, which is an indicator of limited access to primary care. When preventable hospitalizations are compared across minority groups and whites, those that fare the worst are Hispanic children, African American adults, and Hispanic and African American elderly. Even among elderly Medicare beneficiaries, all of whom have equal health insurance coverage, the odds of minority beneficiaries requiring a preventable hospitalization are 6 to 21% greater than for white beneficiaries.

These many differences are not simply due to unresponsive attitudes of a few individual physicians, but the health care delivery system as a whole. People of color are twice as likely to say that racism is a major problem in health care. Two-thirds of African Americans and more than half of Latinos believe they receive lower quality care than whites, but most whites believe everyone receives the same quality of care. Not surprisingly, those patients who perceive more racism and who are more distrustful of the medical system are less satisfied with their health care.

These findings illustrate the importance of delivering culturally competent health care at the provider level and throughout the health care delivery. One model, presented in this special issue of Medical Care Research & Review, illustrates how cultural competency is comprised of nine major components, including interpreter services, recruitment and retention of bilingual and bicultural health care professionals, and the inclusion of family and community members throughout treatment. As a result of these techniques, positive changes in clinician and patient behavior, such as improved communication, increased trust, and expanded understanding of how cultural and environmental factors affect patient behavior, can occur. Such positive changes can lead to the provision of more appropriate health care services and better outcomes—not just in health status but also in quality of life, well being, and satisfaction across all ethnic groups.

These findings further support the need for eliminating disparities that persist in health care and treatment. In order to truly be an inclusive society, we must continue to work toward an equitable and fair health care system. The Minority Health and Health Disparities Research and Education Act (S. 1880), which was signed into law this year, along with health disparities provisions in the possible Balanced Budget Act relief legislation are two positive steps in that direction. I hope we can build on these successes in the upcoming Congress and I look forward to working with my colleagues on this important endeavor.