S. 2789 establishes within the current Congressional Award Act a Congressional Recognition for Excellence in Arts and Education awards board, made up of nine members, four members from the House of Representatives, and four from the Senate, plus the director of the board who shall serve as a nonvoting member.

Additionally, an advisory board shall be established to assist and advise the congressional board with respect to its duties and shall consist of 15 members from among recommendations received from outside arts organizations.

Membership on the advisory board shall represent a balance of artistic and education professionals and must include at least one representative who teaches in each of the four disciplines of music, theater, visual arts, and dance.

By recognizing the importance of arts instruction and granting them an award from this body, it is our hope that arts classes in schools will be as common as English or math.

Finally, I am pleased that Senator COCHRAN worked with me on strengthening the role of arts educators on the advisory board. Their strong participation is vital for this program.

In conclusion, I urge my colleagues to join the other body and support this important piece of legislation.

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

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

First of all, it is great to be defending a bill with the gentleman from California (Mr. MCKEON), my good friend, as we did 2 years ago with the higher education bill. It is a pleasure to be working with him. He is one who I number among my friends.

Mr. Speaker, I rise in support of S. 2789, the Congressional Recognition for Excellence in Arts Education Act. This legislation was introduced by Senator COCHRAN and passed the Senate on October 27 by unanimous consent. This bill amends the Congressional Award Act, which is authorized until fiscal year 2005, to establish a board towards schools and students for excellence in the arts and in arts education.

The legislation would also set up a trust fund and allow board members to seek and accept from sources other than the Federal Government funds to carry out activities for the award program. This would be done at little, if any, direct expense to the taxpayers.

This bill supports arts education for our most important population, our children. Studies have shown that arts education stimulates, develops, and refines many cognitive and creative skills in children and young adults. Emphasizing high-quality art and art curriculum through this award will further these worthwhile objectives.

Mr. Speaker, I urge Members to support this legislation.

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

Mr. MCKEON. Mr. Speaker, I want to thank the gentleman from Michigan (Mr. KILDEE), my good friend, and tell him that I also appreciate the opportunity of working together on this bill with him.

Mr. Speaker, I have no more speakers; but I do have some thanks I would like to give at this time, to Karen Weiss, my legislative director; Jo Marie St. Martin, our legal counsel; Rich Stombres with the majority staff; Alex Nock with the minority staff; and Kirk Boyle with the majority leader's office, for their great help in bringing this bill to this point.

Mr. GILMAN. Mr. Speaker, I rise today in support of S. 2789, the Congressional Recognition for Excellence in Arts Education Act and I commend the House Speaker, the gentleman from California, Mr. MCKEON.

Over the past 30 years, our quality of life has been improved by the arts. Support for the arts illustrates our Nation's commitment to freedom of expression, one of the basic principles on which our Nation is founded.

We must understand and appreciate the importance of the arts on our Nation's children. Whether it is music or drama or dance, children are drawn to the arts. By giving children something to be proud of and passionate about, they can make good choices and avoid following the crowd down dark paths.

S. 2789 establishes the sense of Congress that arts literacy is a fundamental purpose of schooling for all students. Arts education stimulates, develops, and refines many cognitive and creative skills, critical thinking and nimbleness in judgment, creativity and imagination, cooperative decisionmaking, leadership, high-level literacy, and communication, and the capacity for problem-posing and problem-solving.

As chairman of the International Relations Committee, I recognize the importance of the arts on an international level, as they help foster a common appreciation of history and culture that are so essential to our humanity.

Accordingly, I urge all my colleagues to support this measure, to recognize the importance of arts literacy in our Nation's schools.

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

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from California (Mr. MCKEON) that the House suspend the rules and pass the Senate bill, S. 2789.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the Senate bill was passed.

A motion to reconsider was laid on the table.

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MINORITY HEALTH AND HEALTH DISPARITIES RESEARCH AND EDUCATION ACT OF 2000

Mr. NORWOOD. Mr. Speaker, I move to suspend the rules and pass the Senate bill (S. 1880) to amend the Public Health Service Act to improve the health of minority individuals.

The Clerk read as follows:

S. 1880

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Minority Health and Health Disparities Research and Education Act of 2000''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Findings.

TITLE I—IMPROVING MINORITY HEALTH AND REDUCING HEALTH DISPARITIES THROUGH NATIONAL INSTITUTES OF HEALTH; ESTABLISHMENT OF NATIONAL CENTER

Sec. 101. Establishment of National Center on Minority Health and Health Disparities.
Sec. 102. Centers of excellence for research education and training.
Sec. 103. Extramural loan repayment program for minority health disparities research.
Sec. 104. General provisions regarding the Center.
Sec. 105. Report regarding resources of National Institutes of Health dedicated to minority and other health disparities research.

TITLE II—HEALTH DISPARITIES RESEARCH BY AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Sec. 201. Health disparities research by Agency for Healthcare Research and Quality.

TITLE III—DATA COLLECTION RELATING TO RACE OR ETHNICITY

Sec. 301. Study and report by National Academy of Sciences.

TITLE IV—HEALTH PROFESSIONS EDUCATION

Sec. 401. Health professions education in health disparities.
Sec. 402. National conference on health professions education and health disparities.
Sec. 403. Advisory responsibilities in health professions education in health disparities and cultural competency.

TITLE V—PUBLIC AWARENESS AND DISSEMINATION OF INFORMATION ON HEALTH DISPARITIES

Sec. 501. Public awareness and information dissemination.

TITLE VI—MISCELLANEOUS PROVISIONS

Sec. 601. Departmental definition regarding minority individuals.
Sec. 602. Conforming provision regarding definitions.
Sec. 603. Effective date.

SEC. 2. FINDINGS.

The Congress finds as follows:

(1) Despite notable progress in the overall health of the Nation, there are continuing disparities in the burden of illness and death experienced by African Americans, Hispanics, Native Americans, Alaska Natives, and Asian Pacific Islanders, compared to the United States population as a whole.

(2) The largest numbers of the medically underserved are white individuals, and many of them have the same health care access problems as do members of minority groups. Nearly 20,000,000 white individuals live below the poverty line with many living in non-metropolitan, rural areas such as Appalachia, where the high percentage of counties designated as health professional shortage areas (47 percent) and the high rate of poverty contribute to disparity outcomes. However, there is a higher proportion of racial and ethnic minorities in the United States represented among the medically underserved.

(3) There is a national need for minority scientists in the fields of biomedical, clinical, behavioral, and health services research. Ninety percent of minority physicians educated at Historically Black Medical Colleges live and serve in minority communities.

(4) Demographic trends inspire concern about the Nation's ability to meet its future scientific, technological and engineering workforce needs. Historically, non-Hispanic white males have made up the majority of the United States scientific, technological, and engineering workers.

(5) The Hispanic and Black population will increase significantly in the next 50 years. The scientific, technological, and engineering workforce may decrease if participation by underepresented minorities remains the same.

(6) Increasing rates of Black and Hispanic workers can help ensure strong scientific, technological, and engineering workforce.

(7) Individuals such as underepresented minorities and women in the scientific, technological, and engineering workforce enable society to address its diverse needs.

(8) If there had not been a substantial increase in the number of science and engineering degrees awarded to women and underepresented minorities over the past few decades, the United States would be facing even greater shortages in scientific, technological, and engineering workers.

(9) In order to effectively promote a diverse and strong 21st Century scientific, technological, and engineering workforce, Federal agencies should expand or add programs that effectively overcome barriers such as educational transition from one level to the next and student requirements for financial resources.

(10) Federal agencies should work in concert with the private nonprofit sector to emphasize the recruitment and retention of qualified individuals from ethnic and gender groups that are currently underrepresented in the scientific, technological, and engineering workforce.

(11) 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. These factors have the potential to then be modified to help close the health disparities gap among ethnic minority populations. In addition, there is a shortage of minority behavioral science researchers and behavioral health care professionals. According to the National Science Foundation, only 15.5 percent of behavioral research-oriented psychology doctorate degrees were awarded to minority students in 1997. In addition, only 17.9 percent of practice-oriented psychology doctorate degrees were awarded to ethnic minorities.

TITLE I—IMPROVING MINORITY HEALTH AND REDUCING HEALTH DISPARITIES THROUGH NATIONAL INSTITUTES OF HEALTH; ESTABLISHMENT OF NATIONAL CENTER

SEC. 101. ESTABLISHMENT OF NATIONAL CENTER ON MINORITY HEALTH AND HEALTH DISPARITIES.

(a) IN GENERAL.—Part E of title IV of the Public Health Service Act (42 U.S.C. 287 et seq.) is amended by adding at the end the following subpart:

''Subpart 6—National Center on Minority Health and Health Disparities

''SEC. 485E. PURPOSE OF CENTER.

''(a) IN GENERAL.—The general purpose of the National Center on Minority Health and Health Disparities (in this subpart referred to as the 'Center') is the conduct and support of research, training, dissemination of information, and other programs with respect to minority health conditions and other populations with health disparities.

''(b) PRIORITIES.—The Director of the Center shall in expending amounts appropriated under this subpart give priority to conducting and supporting minority health disparities research.

''(c) MINORITY HEALTH DISPARITIES RESEARCH.—For purposes of this subpart:

''(1) The term 'minority health disparities research' means basic, clinical, and behavioral research on minority health conditions (as defined in paragraph (2)), including research to prevent, diagnose, and treat such conditions.

''(2) The term 'minority health conditions', with respect to individuals who are members of minority groups, means all diseases, disorders, and conditions (including with respect to mental health and substance abuse)—

''(A) unique to, more serious, or more prevalent in such individuals;

''(B) for which the factors of medical risk or types of medical intervention may be different for such individuals, or for which it is unknown whether such factors or types are different for such individuals; or

''(C) with respect to which there has been insufficient research involving such individuals as subjects or insufficient data on such individuals.

''(3) The term 'minority group' has the meaning given the term 'racial and ethnic minority group' in section 1707.

''(4) The terms 'minority' and 'minorities' refer to individuals from a minority group.

''(d) HEALTH DISPARITY POPULATIONS.—For purposes of this subpart:

''(1) A population is a health disparity population if, as determined by the Director of the Center after consultation with the Director of the Agency for Healthcare Research and Quality, there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in the population as compared to the health status of the general population.

''(2) The Director shall give priority consideration to determining whether minority groups qualify as health disparity populations under paragraph (1).

''(3) The term 'health disparities research' means basic, clinical, and behavioral research on health disparity populations (including individual members and communities of such populations) that relates to health disparities as defined under paragraph (1), including the causes of such disparities and methods to prevent, diagnose, and treat such disparities.

''(e) COORDINATION OF ACTIVITIES.—The Director of the Center shall act as the primary Federal official with responsibility for coordinating all minority health disparities research and other health disparities research conducted or supported by the National Institutes of Health, and—

''(1) shall represent the health disparities research program of the National Institutes of Health, including the minority health disparities research program, at all relevant Executive branch task forces, committees and planning activities; and

''(2) shall maintain communications with all relevant Public Health Service agencies, including the Indian Health Service, and various other departments of the Federal Government to ensure the timely transmission of information concerning advances in minority health disparities research and other health disparities research between these various agencies for dissemination to affected communities and health care providers.

''(f) COLLABORATIVE COMPREHENSIVE PLAN AND BUDGET.—

''(1) IN GENERAL.—Subject to the provisions of this section and other applicable law, the Director of NIH, the Director of the Center, and the directors of the other agencies of the National Institutes of Health in collaboration (and in consultation with the advisory council for the Center) shall—

''(A) establish a comprehensive plan and budget for the conduct and support of all minority health disparities research and other health disparities research activities of the agencies of the National Institutes of Health (which plan and budget shall be first established under this subsection not later than 12 months after the date of the enactment of this subpart);

''(B) ensure that the plan and budget establish priorities among the health disparities research activities that such agencies are authorized to carry out;

''(C) ensure that the plan and budget establish objectives regarding such activities, describes the means for achieving the objectives, and designates the date by which the objectives are expected to be achieved;

''(D) ensure that, with respect to amounts appropriated for activities of the Center, the plan and budget give priority in the expenditure of funds to conducting and supporting minority health disparities research;

''(E) ensure that all amounts appropriated for such activities are expended in accordance with the plan and budget;

''(F) review the plan and budget not less than annually, and revise the plan and budget as appropriate;

''(G) ensure that the plan and budget serve as a broad, binding statement of policies regarding minority health disparities research and other health disparities research activities of the agencies, but do not remove the responsibility of the heads of the agencies for the approval of specific programs or projects, or for other details of the daily administration of such activities, in accordance with the plan and budget; and

''(H) promote coordination and collaboration among the agencies conducting or supporting minority health or other health disparities research.

''(2) CERTAIN COMPONENTS OF PLAN AND BUDGET.—With respect to health disparities research activities of the agencies of the National Institutes of Health, the Director of the Center shall ensure that the plan and budget under paragraph (1) provide for—

''(A) basic research and applied research, including research and development with respect to products;

''(B) research that is conducted by the agencies;

''(C) research that is supported by the agencies;

''(D) proposals developed pursuant to solicitations by the agencies and for proposals developed independently of such solicitations; and

''(E) behavioral research and social sciences research, which may include cultural and linguistic research in each of the agencies.

''(3) MINORITY HEALTH DISPARITIES RESEARCH.—The plan and budget under paragraph (1) shall include a separate statement of the plan and budget for minority health disparities research.

''(g) PARTICIPATION IN CLINICAL RESEARCH.—The Director of the Center shall work with the Director of NIH and the directors of the agencies of the National Institutes of Health to carry out the provisions of section 492B that relate to minority groups.

''(h) RESEARCH ENDOWMENTS.—

''(1) IN GENERAL.—The Director of the Center may carry out a program to facilitate minority health disparities research and

other health disparities research by providing for research endowments at centers of excellence under section 736.

''(2) ELIGIBILITY.—The Director of the Center may provide for a research endowment under paragraph (1) only if the institution involved meets the following conditions:

''(A) The institution does not have an endowment that is worth in excess of an amount equal to 50 percent of the national average of endowment funds at institutions that conduct similar biomedical research or training of health professionals.

''(B) The application of the institution under paragraph (1) regarding a research endowment has been recommended pursuant to technical and scientific peer review and has been approved by the advisory council under subsection (j).

''(i) CERTAIN ACTIVITIES.—In carrying out subsection (a), the Director of the Center—

''(1) shall assist the Director of the National Center for Research Resources in carrying out section 481(c)(3) and in committing resources for construction at Institutions of Emerging Excellence;

''(2) shall establish projects to promote cooperation among Federal agencies, State, local, tribal, and regional public health agencies, and private entities in health disparities research; and

''(3) may utilize information from previous health initiatives concerning minorities and other health disparity populations.

''(j) ADVISORY COUNCIL.—

''(1) IN GENERAL.—The Secretary shall, in accordance with section 406, establish an advisory council to advise, assist, consult with, and make recommendations to the Director of the Center on matters relating to the activities described in subsection (a), and with respect to such activities to carry out any other functions described in section 406 for advisory councils under such section. Functions under the preceding sentence shall include making recommendations on budgetary allocations made in the plan under subsection (f), and shall include reviewing reports under subsection (k) before the reports are submitted under such subsection.

''(2) MEMBERSHIP.—With respect to the membership of the advisory council under paragraph (1), a majority of the members shall be individuals with demonstrated expertise regarding minority health disparity and other health disparity issues; representatives of communities impacted by minority and other health disparities shall be included; and a diversity of health professionals shall be represented. The membership shall in addition include a representative of the Office of Behavioral and Social Sciences Research under section 404A.

''(k) ANNUAL REPORT.—The Director of the Center shall prepare an annual report on the activities carried out or to be carried out by the Center, and shall submit each such report to the Committee on Health, Education, Labor, and Pensions of the Senate, the Committee on Commerce of the House of Representatives, the Secretary, and the Director of NIH. With respect to the fiscal year involved, the report shall—

''(1) describe and evaluate the progress made in health disparities research conducted or supported by the national research institutes;

''(2) summarize and analyze expenditures made for activities with respect to health disparities research conducted or supported by the National Institutes of Health;

''(3) include a separate statement applying the requirements of paragraphs (1) and (2) specifically to minority health disparities research; and

''(4) contain such recommendations as the Director considers appropriate.

''(l) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this subpart, there are authorized to be appropriated $100,000,000 for fiscal year 2001, and such sums as may be necessary for each of the fiscal years 2002 through 2005. Such authorization of appropriations is in addition to other authorizations of appropriations that are available for the conduct and support of minority health disparities research or other health disparities research by the agencies of the National Institutes of Health.''.

(b) CONFORMING AMENDMENT.—Part A of title IV of the Public Health Service Act (42 U.S.C. 281 et seq.) is amended—

(1) in section 401(b)(2)—

(A) in subparagraph (F), by moving the subparagraph two ems to the left; and

(B) by adding at the end the following subparagraph:

''(G) The National Center on Minority Health and Health Disparities.''; and

(2) by striking section 404.

SEC. 102. CENTERS OF EXCELLENCE FOR RESEARCH EDUCATION AND TRAINING.

Subpart 6 of part E of title IV of the Public Health Service Act, as added by section 101(a) of this Act, is amended by adding at the end the following section:

''SEC. 485F. CENTERS OF EXCELLENCE FOR RESEARCH EDUCATION AND TRAINING.

''(a) IN GENERAL.—The Director of the Center shall make awards of grants or contracts to designated biomedical and behavioral research institutions under paragraph (1) of subsection (c), or to consortia under paragraph (2) of such subsection, for the purpose of assisting the institutions in supporting programs of excellence in biomedical and behavioral research training for individuals who are members of minority health disparity populations or other health disparity populations.

''(b) REQUIRED USE OF FUNDS.—An award may be made under subsection (a) only if the applicant involved agrees that the grant will be expended—

''(1) to train members of minority health disparity populations or other health disparity populations as professionals in the area of biomedical or behavioral research or both; or

''(2) to expand, remodel, renovate, or alter existing research facilities or construct new research facilities for the purpose of conducting minority health disparities research and other health disparities research.

''(c) CENTERS OF EXCELLENCE.—

''(1) IN GENERAL.—For purposes of this section, a designated biomedical and behavioral research institution is a biomedical and behavioral research institution that—

''(A) has a significant number of members of minority health disparity populations or other health disparity populations enrolled as students in the institution (including individuals accepted for enrollment in the institution);

''(B) has been effective in assisting such students of the institution to complete the program of education or training and receive the degree involved;

''(C) has made significant efforts to recruit minority students to enroll in and graduate from the institution, which may include providing means-tested scholarships and other financial assistance as appropriate; and

''(D) has made significant recruitment efforts to increase the number of minority or other members of health disparity populations serving in faculty or administrative positions at the institution.

''(2) CONSORTIUM.—Any designated biomedical and behavioral research institution involved may, with other biomedical and behavioral institutions (designated or otherwise), including tribal health programs, form a consortium to receive an award under subsection (a).

''(3) APPLICATION OF CRITERIA TO OTHER PROGRAMS.—In the case of any criteria established by the Director of the Center for purposes of determining whether institutions meet the conditions described in paragraph (1), this section may not, with respect to minority health disparity populations or other health disparity populations, be construed to authorize, require, or prohibit the use of such criteria in any program other than the program established in this section.

''(d) DURATION OF GRANT.—The period during which payments are made under a grant under subsection (a) may not exceed 5 years. Such payments shall be subject to annual approval by the Director of the Center and to the availability of appropriations for the fiscal year involved to make the payments.

''(e) MAINTENANCE OF EFFORT.—

''(1) IN GENERAL.—With respect to activities for which an award under subsection (a) is authorized to be expended, the Director of the Center may not make such an award to a designated research institution or consortium for any fiscal year unless the institution, or institutions in the consortium, as the case may be, agree to maintain expenditures of non-Federal amounts for such activities at a level that is not less than the level of such expenditures maintained by the institutions involved for the fiscal year preceding the fiscal year for which such institutions receive such an award.

''(2) USE OF FEDERAL FUNDS.—With respect to any Federal amounts received by a designated research institution or consortium and available for carrying out activities for which an award under subsection (a) is authorized to be expended, the Director of the Center may make such an award only if the institutions involved agree that the institutions will, before expending the award, expend the Federal amounts obtained from sources other than the award.

''(f) CERTAIN EXPENDITURES.—The Director of the Center may authorize a designated biomedical and behavioral research institution to expend a portion of an award under subsection (a) for research endowments.

''(g) DEFINITIONS.—For purposes of this section:

''(1) The term 'designated biomedical and behavioral research institution' has the meaning indicated for such term in subsection (c)(1). Such term includes any health professions school receiving an award of a grant or contract under section 736.

''(2) The term 'program of excellence' means any program carried out by a designated biomedical and behavioral research institution with an award under subsection (a), if the program is for purposes for which the institution involved is authorized in subsection (b) to expend the grant.

''(h) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of making grants under subsection (a), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

SEC. 103. EXTRAMURAL LOAN REPAYMENT PROGRAM FOR MINORITY HEALTH DISPARITIES RESEARCH.

Subpart 6 of part E of title IV of the Public Health Service Act, as amended by section 102 of this Act, is amended by adding at the end the following section:

''SEC. 485G. LOAN REPAYMENT PROGRAM FOR MINORITY HEALTH DISPARITIES RESEARCH.

''(a) IN GENERAL.—The Director of the Center shall establish a program of entering into contracts with qualified health professionals under which such health professionals agree to engage in minority health disparities research or other health disparities research in consideration of the Federal Government

agreeing to repay, for each year of engaging in such research, not more than $35,000 of the principal and interest of the educational loans of such health professionals.

''(b) SERVICE PROVISIONS.—The provisions of sections 338B, 338C, and 338E shall, except as inconsistent with subsection (a), apply to the program established in such subsection to the same extent and in the same manner as such provisions apply to the National Health Service Corps Loan Repayment Program established in subpart III of part D of title III.

''(c) REQUIREMENT REGARDING HEALTH DISPARITY POPULATIONS.—The Director of the Center shall ensure that not fewer than 50 percent of the contracts entered into under subsection (a) are for appropriately qualified health professionals who are members of a health disparity population.

''(d) PRIORITY.—With respect to minority health disparities research and other health disparities research under subsection (a), the Secretary shall ensure that priority is given to conducting projects of biomedical research.

''(e) FUNDING.—

''(1) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.

''(2) AVAILABILITY OF APPROPRIATIONS.—Amounts available for carrying out this section shall remain available until the expiration of the second fiscal year beginning after the fiscal year for which the amounts were made available.''.

SEC. 104. GENERAL PROVISIONS REGARDING THE CENTER.

Subpart 6 of part E of title IV of the Public Health Service Act, as amended by section 103 of this Act, is amended by adding at the end the following section:

''SEC. 485H. GENERAL PROVISIONS REGARDING THE CENTER.

''(a) ADMINISTRATIVE SUPPORT FOR CENTER.—The Secretary, acting through the Director of the National Institutes of Health, shall provide administrative support and support services to the Director of the Center and shall ensure that such support takes maximum advantage of existing administrative structures at the agencies of the National Institutes of Health.

''(b) EVALUATION AND REPORT.—

''(1) EVALUATION.—Not later than 5 years after the date of the enactment of this subpart, the Secretary shall conduct an evaluation to—

''(A) determine the effect of this subpart on the planning and coordination of health disparities research programs at the agencies of the National Institutes of Health;

''(B) evaluate the extent to which this subpart has eliminated the duplication of administrative resources among such Institutes, centers and divisions; and

''(C) provide, to the extent determined by the Secretary to be appropriate, recommendations concerning future legislative modifications with respect to this subpart, for both minority health disparities research and other health disparities research.

''(2) MINORITY HEALTH DISPARITIES RESEARCH.—The evaluation under paragraph (1) shall include a separate statement that applies subparagraphs (A) and (B) of such paragraph to minority health disparities research.

''(3) REPORT.—Not later than 1 year after the date on which the evaluation is commenced under paragraph (1), the Secretary shall prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Commerce of the House of Representatives, a report concerning the results of such evaluation.''.

SEC. 105. REPORT REGARDING RESOURCES OF NATIONAL INSTITUTES OF HEALTH DEDICATED TO MINORITY AND OTHER HEALTH DISPARITIES RESEARCH.

Not later than December 1, 2003, the Director of the National Center on Minority Health and Health Disparities (established by the amendment made by section 101(a)), after consultation with the advisory council for such Center, shall submit to the Congress, the Secretary of Health and Human Services, and the Director of the National Institutes of Health a report that provides the following:

(1) Recommendations for the methodology that should be used to determine the extent of the resources of the National Institutes of Health that are dedicated to minority health disparities research and other health disparities research, including determining the amount of funds that are used to conduct and support such research. With respect to such methodology, the report shall address any discrepancies between the methodology used by such Institutes as of the date of the enactment of this Act and the methodology used by the Institute of Medicine as of such date.

(2) A determination of whether and to what extent, relative to fiscal year 1999, there has been an increase in the level of resources of the National Institutes of Health that are dedicated to minority health disparities research, including the amount of funds used to conduct and support such research. The report shall include provisions describing whether and to what extent there have been increases in the number and amount of awards to minority serving institutions.

TITLE II—HEALTH DISPARITIES RESEARCH BY AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

SEC. 201. HEALTH DISPARITIES RESEARCH BY AGENCY FOR HEALTHCARE RESEARCH AND QUALITY.

(a) GENERAL.—Part A of title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended—

(1) in section 902, by striking subsection (g); and

(2) by adding at the end the following:

''SEC. 903. RESEARCH ON HEALTH DISPARITIES.

''(a) IN GENERAL.—The Director shall—

''(1) conduct and support research to identify populations for which there is a significant disparity in the quality, outcomes, cost, or use of health care services or access to and satisfaction with such services, as compared to the general population;

''(2) conduct and support research on the causes of and barriers to reducing the health disparities identified in paragraph (1), taking into account such factors as socioeconomic status, attitudes toward health, the language spoken, the extent of formal education, the area or community in which the population resides, and other factors the Director determines to be appropriate;

''(3) conduct and support research and support demonstration projects to identify, test, and evaluate strategies for reducing or eliminating health disparities, including development or identification of effective service delivery models, and disseminate effective strategies and models;

''(4) develop measures and tools for the assessment and improvement of the outcomes, quality, and appropriateness of health care services provided to health disparity populations;

''(5) in carrying out section 902(c), provide support to increase the number of researchers who are members of health disparity populations, and the health services research capacity of institutions that train such researchers; and

''(6) beginning with fiscal year 2003, annually submit to the Congress a report regarding prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors in priority populations.

''(b) RESEARCH AND DEMONSTRATION PROJECTS.—

''(1) IN GENERAL.—In carrying out subsection (a), the Director shall conduct and support research and support demonstrations to—

''(A) identify the clinical, cultural, socioeconomic, geographic, and organizational factors that contribute to health disparities, including minority health disparity populations, which research shall include behavioral research, such as examination of patterns of clinical decisionmaking, and research on access, outreach, and the availability of related support services (such as cultural and linguistic services);

''(B) identify and evaluate clinical and organizational strategies to improve the quality, outcomes, and access to care for health disparity populations, including minority health disparity populations;

''(C) test such strategies and widely disseminate those strategies for which there is scientific evidence of effectiveness; and

''(D) determine the most effective approaches for disseminating research findings to health disparity populations, including minority populations.

''(2) USE OF CERTAIN STRATEGIES.—In carrying out this section, the Director shall implement research strategies and mechanisms that will enhance the involvement of individuals who are members of minority health disparity populations or other health disparity populations, health services researchers who are such individuals, institutions that train such individuals as researchers, members of minority health disparity populations or other health disparity populations for whom the Agency is attempting to improve the quality and outcomes of care, and representatives of appropriate tribal or other community-based organizations with respect to health disparity populations. Such research strategies and mechanisms may include the use of—

''(A) centers of excellence that can demonstrate, either individually or through consortia, a combination of multi-disciplinary expertise in outcomes or quality improvement research, linkages to relevant sites of care, and a demonstrated capacity to involve members and communities of health disparity populations, including minority health disparity populations, in the planning, conduct, dissemination, and translation of research;

''(B) provider-based research networks, including health plans, facilities, or delivery system sites of care (especially primary care), that make extensive use of health care providers who are members of health disparity populations or who serve patients in such populations and have the capacity to evaluate and promote quality improvement;

''(C) service delivery models (such as health centers under section 330 and the Indian Health Service) to reduce health disparities; and

''(D) innovative mechanisms or strategies that will facilitate the translation of past research investments into clinical practices that can reasonably be expected to benefit these populations.

''(c) QUALITY MEASUREMENT DEVELOPMENT.—

''(1) IN GENERAL.—To ensure that health disparity populations, including minority health disparity populations, benefit from the progress made in the ability of individuals to measure the quality of health care

delivery, the Director shall support the development of quality of health care measures that assess the experience of such populations with health care systems, such as measures that assess the access of such populations to health care, the cultural competence of the care provided, the quality of the care provided, the outcomes of care, or other aspects of health care practice that the Director determines to be important.

''(2) EXAMINATION OF CERTAIN PRACTICES.—The Director shall examine the practices of providers that have a record of reducing health disparities or have experience in providing culturally competent health services to minority health disparity populations or other health disparity populations. In examining such practices of providers funded under the authorities of this Act, the Director shall consult with the heads of the relevant agencies of the Public Health Service.

''(3) REPORT.—Not later than 36 months after the date of the enactment of this section, the Secretary, acting through the Director, shall prepare and submit to the appropriate committees of Congress a report describing the state-of-the-art of quality measurement for minority and other health disparity populations that will identify critical unmet needs, the current activities of the Department to address those needs, and a description of related activities in the private sector.

''(d) DEFINITION.—For purposes of this section:

''(1) The term 'health disparity population' has the meaning given such term in section 485E, except that in addition to the meaning so given, the Director may determine that such term includes populations for which there is a significant disparity in the quality, outcomes, cost, or use of health care services or access to or satisfaction with such services as compared to the general population.

''(2) The term 'minority', with respect to populations, refers to racial and ethnic minority groups as defined in section 1707.''.

(b) FUNDING.—Section 927 of the Public Health Service Act (42 U.S.C. 299c–6) is amended by adding at the end the following:

''(d) HEALTH DISPARITIES RESEARCH.—For the purpose of carrying out the activities under section 903, there are authorized to be appropriated $50,000,000 for fiscal year 2001, and such sums as may be necessary for each of the fiscal years 2002 through 2005.''.

TITLE III—DATA COLLECTION RELATING TO RACE OR ETHNICITY

SEC. 301. STUDY AND REPORT BY NATIONAL ACADEMY OF SCIENCES.

(a) STUDY.—The National Academy of Sciences shall conduct a comprehensive study of the Department of Health and Human Services' data collection systems and practices, and any data collection or reporting systems required under any of the programs or activities of the Department, relating to the collection of data on race or ethnicity, including other Federal data collection systems (such as the Social Security Administration) with which the Department interacts to collect relevant data on race and ethnicity.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the National Academy of Sciences shall prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Commerce of the House of Representatives, a report that—

(1) identifies the data needed to support efforts to evaluate the effects of socioeconomic status, race and ethnicity on access to health care and other services and on disparity in health and other social outcomes and the data needed to enforce existing protections for equal access to health care;

(2) examines the effectiveness of the systems and practices of the Department of Health and Human Services described in subsection (a), including pilot and demonstration projects of the Department, and the effectiveness of selected systems and practices of other Federal, State, and tribal agencies and the private sector, in collecting and analyzing such data;

(3) contains recommendations for ensuring that the Department of Health and Human Services, in administering its entire array of programs and activities, collects, or causes to be collected, reliable and complete information relating to race and ethnicity; and

(4) includes projections about the costs associated with the implementation of the recommendations described in paragraph (3), and the possible effects of the costs on program operations.

(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for fiscal year 2001.

TITLE IV—HEALTH PROFESSIONS EDUCATION

SEC. 401. HEALTH PROFESSIONS EDUCATION IN HEALTH DISPARITIES.

(a) IN GENERAL.—Part B of title VII of the Public Health Service Act (42 U.S.C. 293 et seq.) is amended by inserting after section 740 the following:

''SEC. 741. GRANTS FOR HEALTH PROFESSIONS EDUCATION.

''(a) GRANTS FOR HEALTH PROFESSIONS EDUCATION IN HEALTH DISPARITIES AND CULTURAL COMPETENCY.—

''(1) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may make awards of grants, contracts, or cooperative agreements to public and nonprofit private entities (including tribal entities) for the purpose of carrying out research and demonstration projects (including research and demonstration projects for continuing health professions education) for training and education of health professionals for the reduction of disparities in health care outcomes and the provision of culturally competent health care.

''(2) ELIGIBLE ENTITIES.—Unless specifically required otherwise in this title, the Secretary shall accept applications for grants or contracts under this section from health professions schools, academic health centers, State or local governments, or other appropriate public or private nonprofit entities (or consortia of entities, including entities promoting multidisciplinary approaches) for funding and participation in health professions training activities. The Secretary may accept applications from for-profit private entities as determined appropriate by the Secretary.

''(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out subsection (a), $3,500,000 for fiscal year 2001, $7,000,000 for fiscal year 2002, $7,000,000 for fiscal year 2003, and $3,500,000 for fiscal year 2004.''.

(b) NURSING EDUCATION.—Part A of title VIII of the Public Health Service Act (42 U.S.C. 296 et seq.) is amended—

(1) by redesignating section 807 as section 808; and

(2) by inserting after section 806 the following:

''SEC. 807. GRANTS FOR HEALTH PROFESSIONS EDUCATION.

''(a) GRANTS FOR HEALTH PROFESSIONS EDUCATION IN HEALTH DISPARITIES AND CULTURAL COMPETENCY.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may make awards of grants, contracts, or cooperative agreements to eligible entities for the purpose of carrying out research and demonstration projects (including research and demonstration projects for continuing health professions education) for training and education for the reduction of disparities in health care outcomes and the provision of culturally competent health care. Grants under this section shall be the same as provided in section 741.''.

''(b) AUTHORIZATION OF APPROPRIATIONS.—There are to be appropriated to carry out subsection (a) such sums as may be necessary for each of the fiscal years 2001 through 2004.''.

SEC. 402. NATIONAL CONFERENCE ON HEALTH PROFESSIONS EDUCATION AND HEALTH DISPARITIES.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary''), acting through the Administrator of the Health Resources and Services Administration, shall convene a national conference on health professions education as a method for reducing disparities in health outcomes.

(b) PARTICIPANTS.—The Secretary shall include in the national conference convened under subsection (a) advocacy groups and educational entities as described in section 741 of the Public Health Service Act (as added by section 401), tribal health programs, health centers under section 330 of such Act, and other interested parties.

(c) ISSUES.—The national conference convened under subsection (a) shall include, but is not limited to, issues that address the role and impact of health professions education on the reduction of disparities in health outcomes, including the role of education on cultural competency. The conference shall focus on methods to achieve reductions in disparities in health outcomes through health professions education (including continuing education programs) and strategies for outcomes measurement to assess the effectiveness of education in reducing disparities.

(d) PUBLICATION OF FINDINGS.—Not later than 6 months after the national conference under subsection (a) has convened, the Secretary shall publish in the Federal Register a summary of the proceedings and findings of the conference.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 403. ADVISORY RESPONSIBILITIES IN HEALTH PROFESSIONS EDUCATION IN HEALTH DISPARITIES AND CULTURAL COMPETENCY.

Section 1707 of the Public Health Service Act (42 U.S.C. 300u–6) is amended—

(1) in subsection (b), by adding at the end the following paragraph:

''(10) Advise in matters related to the development, implementation, and evaluation of health professions education in decreasing disparities in health care outcomes, including cultural competency as a method of eliminating health disparities.'';

(2) in subsection (c)(2), by striking ''paragraphs (1) through (9)'' and inserting ''paragraphs (1) through (10)''; and

(3) in subsection (d), by amending paragraph (1) to read as follows:

''(1) RECOMMENDATIONS REGARDING LANGUAGE.—

''(A) PROFICIENCY IN SPEAKING ENGLISH.—The Deputy Assistant Secretary shall consult with the Director of the Office of International and Refugee Health, the Director of the Office of Civil Rights, and the Directors of other appropriate departmental entities

regarding recommendations for carrying out activities under subsection (b)(9).

''(B) HEALTH PROFESSIONS EDUCATION REGARDING HEALTH DISPARITIES.—The Deputy Assistant Secretary shall carry out the duties under subsection (b)(10) in collaboration with appropriate personnel of the Department of Health of Human Services, other Federal agencies, and other offices, centers, and institutions, as appropriate, that have responsibilities under the Minority Health and Health Disparities Research and Education Act of 2000.''.

TITLE V—PUBLIC AWARENESS AND DISSEMINATION OF INFORMATION ON HEALTH DISPARITIES

SEC. 501. PUBLIC AWARENESS AND INFORMATION DISSEMINATION.

(a) PUBLIC AWARENESS ON HEALTH DISPARITIES.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a national campaign to inform the public and health care professionals about health disparities in minority and other underserved populations by disseminating information and materials available on specific diseases affecting these populations and programs and activities to address these disparities. The campaign shall—

(1) have a specific focus on minority and other underserved communities with health disparities; and

(2) include an evaluation component to assess the impact of the national campaign in raising awareness of health disparities and information on available resources.

(b) DISSEMINATION OF INFORMATION ON HEALTH DISPARITIES.—The Secretary shall develop and implement a plan for the dissemination of information and findings with respect to health disparities under titles I, II, III, and IV of this Act. The plan shall—

(1) include the participation of all agencies of the Department of Health and Human Services that are responsible for serving populations included in the health disparities research; and

(2) have agency-specific strategies for disseminating relevant findings and information on health disparities and improving health care services to affected communities.

TITLE VI—MISCELLANEOUS PROVISIONS

SEC. 601. DEPARTMENTAL DEFINITION REGARDING MINORITY INDIVIDUALS.

Section 1707(g)(1) of the Public Health Service Act (42 U.S.C. 300u–6) is amended—

(1) by striking ''Asian Americans and'' and inserting ''Asian Americans;''; and

(2) by inserting ''Native Hawaiians and other'' before ''Pacific Islanders;''.

SEC. 602. CONFORMING PROVISION REGARDING DEFINITIONS.

For purposes of this Act, the term ''racial and ethnic minority group'' has the meaning given such term in section 1707 of the Public Health Service Act.

SEC. 603. EFFECTIVE DATE.

This Act and the amendments made by this Act take effect October 1, 2000, or upon the date of the enactment of this Act, whichever occurs later.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Ohio (Mr. STRICKLAND) each will control 20 minutes.

The Chair recognizes the gentleman from Georgia (Mr. NORWOOD).

GENERAL LEAVE

Mr. NORWOOD. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on S. 1880.

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

There was no objection.

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

Mr. Speaker, whether we care to admit it or not, there are disparities in health care in America today. In the minority health community, there are clearly significant disparities in health outcomes.

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In the African-American community, the Asian-American community, and the Hispanic-American community, there are disproportionate incidences of cardiovascular disease and certain forms of cancer. This also holds true for certain nonminority, low-income, rural communities as well.

Mr. Speaker, the two questions we must have the courage and the determination to answer are why, and what can be done about it? It takes courage because the admission of the problem moves us all out of our comfort zone, in which we are all too content to just let racial and ethnic and class disparities improve on their own and work themselves out over time.

It takes determination, because there is no easy answer. In fact, many health care experts sharply disagree on all the underlying causes of health disparities.

Mr. Speaker, all of this takes determination, because there is no easy answer. In fact, many health care experts sharply disagree on all the underlying causes of health disparities. Many point to the role of continued income disparities, others to discrimination in diagnosis and prescribed treatments. Some point out a lack of training in our medical schools concerning racial, gender and ethnic differences in symptoms presented by patients when seeking treatment.

All of these points make for good debate, but they in no way justify doing nothing while patients lives are on the line. There are solutions that can be identified right now as providing relief, and the Health Care Fairness Act is one of those remedies.

For this reason, I am proud to cosponsor very similar legislation in this body with the gentleman from Georgia (Mr. LEWIS) and the gentleman from Oklahoma (Mr. WATTS), my good friend, and the gentleman from Kentucky (Mr. WHITFIELD).

This bill creates a Center for Health Disparities at the National Institutes of Health, provides increased funding and incentives for minority health and health disparities research and new support for educating both our health professionals and patients on common sense approaches to increasing the number of positive health outcomes for minorities and other health disparity patients.

Mr. Speaker, I want to draw particular attention to the bill's emphasis on education. The bill will provide access to critical funding for those schools that are researching health disparities and educating the health professionals that will bring treatment to minority and health disparity communities. We can wait to do anything unless we address each cause or we can move immediately to repair those things that we can.

Mr. Speaker, since we are dealing with the life and health of Americans, we have no choice but the latter, and I urge all of my colleagues to support this bill.

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

Mr. STRICKLAND. Mr. Speaker, I yield myself 2 minutes.

Mr. Speaker, I am very pleased that the House is considering the Minority Health and Health Disparities Research and Education Act this evening. This is legislation that will improve the health status of many Americans who suffer the inequity of health disparities. I think the need for this bill is demonstrated by the tragic fact that minorities in America lag behind other Americans in nearly every health indicator, including health care coverage, access to care, life expectancy and disease rates.

Minorities suffer disproportionately from cancer, cardiovascular disease, HIV and AIDS and diabetes. Some of these disparities in health status are linked to problems of access to care and low levels of health care coverage.

These characteristics also describe my Appalachian constituents from rural Ohio, even though my district has very few minorities. Not surprisingly, my constituents suffer from some of the same disparities in disease and mortality rates, particularly for cancer and diabetes.

S. 1880 is the result of months of bipartisan, bicameral work to craft solutions to this complex problem. The bill will create a Center for Research on Minority Health and Health Disparities at the National Institutes of Health, where research into the causes of and solutions to this health crisis will be prompted. It will also create opportunities for researchers who are members of health disparity populations.

Mr. Speaker, I would like to thank several Members for their hard work on this piece of legislation, the gentleman from Georgia (Mr. LEWIS); the gentleman from Illinois (Mr. JACKSON); the gentleman from Mississippi (Mr. THOMPSON); the gentleman from New York (Mr. TOWNS); the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN); and the gentleman from Michigan (Mr. DINGELL), the ranking member. And I would especially like to thank the sponsors of this bill for their willingness to work with me and the gentleman from Kentucky (Mr. WHITFIELD) to include our constituencies in this important bill.

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

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

Mr. STRICKLAND. Mr. Speaker, I yield 3 minutes to the gentleman from Georgia (Mr. LEWIS), the primary sponsor of this bill.

Mr. LEWIS of Georgia. Mr. Speaker, I want to thank the gentleman from Ohio (Mr. STRICKLAND), my good friend, for yielding me the time and for all of his help. I also want to thank the gentleman from Georgia (Mr. NORWOOD), my colleague and my friend, for all of his help to bring this bill before us tonight.

Mr. Speaker, I, along with the gentleman from Oklahoma (Mr. WATTS), the gentleman from Mississippi (Mr. THOMPSON), the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Illinois (Mr. JACKSON) introduced H.R. 3250, the House companion bill to S. 1880.

H.R. 3250 passed out of the Committee on Commerce on July the 26.

As one of the original authors of H.R. 3250, I want to take this opportunity to thank my colleagues tonight on both sides of the aisle for their dedication and hard work to pass H.R. 3250 and S. 1880.

Over the past few decades, we have made great advances as a Nation in science and medicine. However, all of our citizens have not shared in the benefits of these advances. Minority Americans lag behind the rest of the country on nearly every health indicator, including health care coverage, access to care, life expectancy and disease rates.

Some striking examples include the African-American infant mortality rate, which is twice that all of U.S. infants; and nearly twice as many Hispanic adults report they do not have a regular doctor compared to white adults. However, health disparities are not limited to minority communities. Nearly 20 million white Americans live below the poverty line and many live in rural areas where high rates of poverty contribute to health disparity outcomes.

In the Appalachian regions of Kentucky, Tennessee and West Virginia, the rates of the five top causes of death in the United States all exceeded the national average in 1997. Mr. Speaker, we have a moral obligation, a duty and responsibility to find effective ways to eliminate these health disparities. Equal access to health care is not a privilege, it is a fundamental right. That is why S. 1880 is a good bill.

This legislation will take the necessary step to bridge the health disparity gap. The Minority Health and Health Disparities Research and Education Act is a comprehensive approach to addressing the complex set of factors which surround health disparity.

Mr. Speaker, let me close by saying the last century saw our Nation make great strides. We passed laws to address that right, like equal opportunity in employment, education and housing. We also passed the Voting Rights Act of 1965 and the Civil Rights Act of 1964. However, until now, our country has not given health care the same attention.

We must focus our attention on bridging the health disparity gap.

Mr. Speaker, I urge all of my colleagues to vote to pass S. 1880, the Minority Health and Health Disparities Research and Education Act.

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

Mr. STRICKLAND. Mr. Speaker, I yield 3 minutes to the gentleman from Illinois (Mr. RUSH), a member of the Committee on Commerce.

Mr. RUSH. Mr. Speaker, I want to, first of all, commend the gentleman from Georgia (Mr. LEWIS) and the gentleman from Georgia (Mr. NORWOOD), the gentleman from Ohio (Mr. STRICKLAND), the gentleman from Mississippi (Mr. THOMPSON), and the gentleman from Oklahoma (Mr. WATTS) for their outstanding work on this bill.

It is with great pride that I support S. 1880, the Minority Health and Health Disparities Research and Education Act of 2000.

The disparities in health care as they relate to ethnic minorities is alarming. Consider these statistics, the infant mortality rate among African Americans is still more than double that of white citizens.

African-American children are significantly more likely than whites to experience childhood asthma.

Heart disease death rates are more than 40 percent higher for African Americans than for whites.

For prostate cancer, it is more than double the rates for whites.

African-American women have a higher death rate from breast cancer, despite having mammography screening rates that is higher than for white women.

The death rate from HIV/AIDS for African Americans is more than 7 times that for whites. The rate for homicide is 6 times that for whites. The suicide right among young African-American men has doubled since 1980.

Many whites living in medically underserved areas suffer from the same health care access problems as do members of minority groups. In rural Appalachia, 46 percent of counties are designated as health professions shortage areas and high rates of poverty contribute to health disparity outcomes.

White Appalachian males between the ages of 35 and 46 are 19 percent more likely to die of health disease than their counterparts elsewhere in the country, and white Appalachian women are 20 percent more likely to die of heart disease.

Mr. Speaker, this bill addresses this critical problem, and we do need to do more to correct these alarming disparities, and the creation of the Center for Research on Minority Health and Health Disparities within the National Institutes of Health is an excellent step forward.

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

(Mr. JACKSON of Illinois asked and was given permission to revise and extend his remarks.)

Mr. JACKSON of Illinois. Mr. Speaker, I rise in strong support of S. 1880, the Minority Health and Health Disparities Research and Education Act. This bipartisan legislation holds great promise for reducing the health status gap between our Nation's majority populations and our ethnic minority and medically underserved communities, helping to ensure that no American is left behind.

Mr. Speaker, the bill's most central feature, section 1, which was H.R. 2391, which I proposed a year and a half ago, elevates the Office of Research on Minority Health at the National Institutes of Health to ''Center'' status and puts these health disparities on the exact same parity that exists with other prioritized health disparity issues at the National Institutes of Health.

Despite the national economic prosperity and double digit growth for NIH, the health status gap amongst African Americans and other underserved populations is getting worse and not better.

As a member of the Subcommittee on Labor, Health and Human Services and Education, I had the opportunity during our hearings to carefully review the program activities and priorities of the NIH and to question the researchers who carry out such vital work.

The unsung hero of today's legislation, who is not a Member of Congress, but certainly the former Secretary of Health and Human Services, Dr. Louis Sullivan was before the Subcommittee on Appropriations in the Senate, and Dr. Sullivan shared with me testimony that he had recently presented to that Subcommittee on the Institute of Medicine study that demonstrated a disturbingly low level of support that is funding support for cancer research among minorities through the National Cancer Institute. To improve the response to minority health, Dr. Sullivan recommended that the Office of Research of Minority Health should be elevated to ''Center'' status because the existing structure at NIH did not adequately address or prioritize the issue of health disparities.

After asking scores of questions to the NIH director and the directors of the Institutes and Centers during the last year's hearings about these disparities, I became more convinced than ever that the Office of Research and Minority Health needed to be elevated to ''Center'' status.

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Consequently, I worked with Dr. Sullivan and other health care professionals to fashion a bill that would do just that. And so, Mr. Speaker, today S. 1880, among other vital provisions of the bill, authorizes the director of the National Center, in collaboration with other NIH institutes and centers, to establish a comprehensive plan and budget for the conduct and support of all

minority health and other health disparities research at NIH.

Mr. Speaker, as I said earlier, passage of this bill is an important first step, and I would like to thank all of my colleagues on both sides of the aisle who played an important leadership role, including Senators KENNEDY and FRIST, the gentleman from Georgia (Mr. NORWOOD), the gentleman from Oklahoma (Mr. WATTS), the gentleman from Georgia (Mr. LEWIS), the gentleman from Mississippi (Mr. THOMPSON), the gentleman from Virginia (Chairman BLILEY), the unsung hero on the legislative side of this, the gentleman from Florida (Mr. BILIRAKIS), who walked this bill through a number of hurdles, the gentleman from Michigan (Mr. DINGELL), and the gentleman from Ohio (Mr. BROWN).

Mr. Speaker, I ask all of my colleagues to support this important measure.

Mr. NORWOOD. Mr. Speaker, I yield such time as he might consume to the gentleman from Florida (Mr. BILIRAKIS), chairman of the Commerce Subcommittee on Health and Environment.

Mr. BILIRAKIS. Mr. Speaker, I thank the gentleman from Georgia (Mr. NORWOOD) for yielding me this time. Obviously, I support S. 1880, the Minority Health Disparities Research and Education Act of 2000.

This proposal encompasses H.R. 3250, which is the Health Care Finance Act of 2000 which was reported from the Committee on Commerce. The gentleman from Illinois (Mr. JACKSON) and so many others were so very much responsible for that.

The bill addresses disparities in biomedical and behavioral research and health professional education for minority medically underserved Americans. There is ample evidence, Mr. Speaker, that some populations suffer disproportionately from certain diseases. For example, African Americans have a 70 percent higher rate of diabetes than whites. Hispanics suffer a rate that is nearly double the rate for whites. Vietnamese women suffer from cervical cancer five times the rate of white women.

Mr. Speaker, we need to know why this is the case, and I hope this legislation will help. The proposal will create a new National Center on Minority Health and Health Disparities at NIH which will be charged with coordinating biomedical and behavioral health disparities research.

The bill strengthens research into health care quality and access by funding studies at the Agency for Health Care Research and Quality. And, finally, the bill provides additional funds for loan repayment programs in the Health Resources and Services Administration for health professional training and education programs focusing in the causes and potential solutions to health disparities among Americans.

S. 1880 includes some important changes to H.R. 3250 that improve the underlying bill. These changes reflect bipartisan efforts to address concerns expressed by Members of Congress and the administration. Chief among these is the recognition of health disparities in medically underserved populations as well as in racial and ethnic minorities.

Additional changes were made to the bill to address concerns raised by the Department of Justice and some Members with potential constitutional problems with the bill as introduced. These are all positive changes that ensure Americans who suffer from disease and death disproportionately to the population at large benefit from the research and education provisions in this legislation.

This is an important piece of legislation, Mr. Speaker, and I urge all of my colleagues to join us in a ''yes'' vote.

Mr. STRICKLAND. Mr. Speaker, I yield 2 minutes to the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN).

Mrs. CHRISTENSEN. Mr. Speaker, I thank the gentleman from Ohio (Mr. STRICKLAND) for yielding me this time. I also want to thank the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Michigan (Mr. DINGELL), the ranking member, for their leadership and work in getting S. 1880 to the floor today.

Mr. Speaker, I also want to applaud the gentleman from Georgia (Mr. LEWIS), the gentleman from Mississippi (Mr. THOMPSON), the gentleman from Illinois (Mr. JACKSON), the gentleman from Oklahoma (Mr. WATTS), and Senator EDWARD KENNEDY who sponsored the bill in the other body for shepherding this bill through the entire process, as well as all of our staff. I thank the leadership in the committee and the House on both sides of the aisle.

Mr. Speaker, health care disparities in people of color, those of low socioeconomic status, and in our rural areas should cause us all concern in this country which boasts of the best in medical expertise and the most advanced medical technology. But they exist, and even as we turn the page into a new century, the gaps are not closing but getting wider.

Heart disease, cancer, infant mortality, stroke, diabetes, HIV/AIDS and mental illnesses are among the diseases which represent the most glaring disparities.

Surely, lack of insurance, deficiencies in the health delivery system and the lack of culturally and linguistically competent providers are some of the factors responsible. It has been proven that bias and prejudice has a significant role as well.

But there remains much that we do not know, and without more in-depth knowledge we will never be able to develop the appropriate remedies. Therefore, S. 1880, though long overdue, comes at a critical time, but also at a time when this country has the resources and I think the will to right the wrongs, to close the gaps, and to bring fairness and equity to the system and access to quality health care for all of our citizens and residents.

I am proud, Mr. Speaker, of the role that the Health Brain Trust of the Congressional Black Caucus played in this bill's development. I want to be proud of this body tomorrow, and so I ask all of my colleagues to vote ''yes'' for S. 1880, to vote ''yes'' to the research and related activities that will usher in a millennium of health and wellness for many who, until now, have been left behind, and to vote ''yes'' to a healthy and a better America.

Mr. STRICKLAND. Mr. Speaker, I yield 2 minutes to the gentleman from Mississippi (Mr. THOMPSON), who was an original cosponsor in the fashioning of this legislation.

Mr. THOMPSON of Mississippi. Mr. Speaker, first let me compliment the gentleman from Georgia (Mr. NORWOOD), my colleague, for his leadership in helping shepherd this bill to the floor this evening for consideration. I would also like to recognize the gentleman from Illinois (Mr. JACKSON), the gentleman from Oklahoma (Mr. WATTS), and the gentleman from Georgia (Mr. LEWIS), who also cosponsored this legislation.

Mr. Speaker, I am pleased to come before you in support of S. 1880, the Minority Health and Health Disparities Research and Education Act of 2000.

Nearly 1 year ago, on November 8, 1999, I introduced H.R. 3250, a bill to amend the Public Health Service Act to improve the health of minority individuals. I thank Senator EDWARD KENNEDY for introducing S. 1880, and I am extremely proud to see this bill come to the floor for consideration.

Mr. Speaker, the statistics are alarming when comparing the disparity between whites and minorities, alarming when we speak of infant mortality rates, alarming when we speak of heart disease death rates, alarming when we speak of prostate cancer and breast cancer, and most alarming of all, HIV/AIDS infection and death rates for African Americans.

Mr. Speaker, I say for all of us now to come forward in a bipartisan manner and pass this bill and take the first step toward correcting these alarming disparities for African Americans and all other underserved communities. Let us have a quality health care system for everyone in the 21st century.

Mr. STRICKLAND. Mr. Speaker, I yield 1 minute to the gentlewoman from North Carolina (Mrs. CLAYTON).

Mrs. CLAYTON. Mr. Speaker, I thank the gentleman from Ohio for yielding me this time. I want to also commend the sponsors and also commend this House in a bipartisan way, recognizing this is an excellent opportunity to begin to close the gap between those who have access to quality health and those who indeed have not been considered in the research.

I live in rural North Carolina, but I also live in an area called the ''Stroke

Belt.'' And the Stroke Belt indeed affects those persons who are African American perhaps a little more than it does other individuals. But if we begin to look at the Stroke Belt, it also includes white Americans in there. So there is a disparity related to poverty, isolation, and ruralness of the community.

So I want to commend the sponsors of this, because it does, indeed, bring a more healthy America and allows the research to work with those entities and look at those disparities in ways that will reduce the incidence of disease and encourage prevention. I support this bill 100 percent.

The bill will be considered under suspension of the rules; 40 minutes of debate; not subject to amendment; two-thirds majority vote required for passage. The measure will be managed by Chairman Bliley, R-Va., or Rep. Bilirakis, R-Fla. The Democratic manager will be Rep. Dingell, D-Mich., or Rep. Brown, D-Ohio.

The Senate passed the bill on Oct. 26 by unanimous consent. The Commerce Committee did not act on the measure.

Following is a summary of the bill as passed by the Senate. As of press time, it was not known whether the floor manager will move to suspend the rules and agree to the Senate-passed bill, thereby clearing the measure for the president, or whether he would include an amendment, thus sending the bill back to the Senate.

The Senate passed bill establishes a National Center on Minority Health and Health Disparities in the National Institutes of Health (NIH) to conduct and support research on minority health conditions and disparities between the health of the overall population and the health of minority groups. The measure authorizes $100 million in FY 2001, and such sums as may be necessary for fiscal years 2002 through 2005, for these activities.

The bill authorizes such sums as may be necessary in fiscal years 2001 through 2005 for centers of excellence for research and training, which would support training in biomedical and behavioral research for members of minority populations.

The measure authorizes such sums as may be necessary in each of fiscal years 2001 through 2005 for a program under which the federal government would repay certain education loans for individuals who agree to engage in minority health disparity research. Under the bill, the federal government would repay up to $35,000 of the principal and interest on educational loans of such individuals for each year the engage in such research.

The bill also authorizes $50 million in FY 2001, and such sums as may be necessary for each of fiscal years 2002 through 2005, for the Agency for Healthcare Research and Quality to conduct and support research on health disparities.

This measure is an authorization measure and is not covered by spending limitations in the Budget Act or any budget resolution because it does not directly result in expenditures. As of press time, the Congressional Budget Office had not completed a cost estimate for the bill. In many cases, however, Congress does not appropriate the full amount contained in authorization measures.

Mr. STRICKLAND. Mr. Speaker, I yield 2 minutes to the gentlewoman from Texas (Ms. JACKSON-LEE).

(Ms. JACKSON-LEE of Texas asked and was given permission to revise and extend her remarks.)

Ms. JACKSON-LEE of Texas. Mr. Speaker, this is an excellent piece of legislation. I thank the gentleman from Ohio (Mr. STRICKLAND), my good friend, for yielding me this time. I thank the gentleman from Georgia (Mr. LEWIS), the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN), the gentleman from Mississippi (Mr. THOMPSON), the gentleman from Illinois (Mr. JACKSON), and the gentleman from Oklahoma (Mr. WATTS) for their leadership, along with the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Florida (Mr. BILIRAKIS) for their leadership as well.

Mr. Speaker, if my colleagues would take a journey with me and realize how far we have come on a cure for breast cancer, and part of the effort behind that cure was utilizing women in clinicals in the National Institutes of Health. This Minority Health and Health Disparities Research and Education Act has the same focus; it is to concentrate on the enormous disparities that are found with minorities in the health care system. In particular, African Americans, Hispanics, Asian Americans, Pacific Islanders, Native Americans all have found themselves without access to health care, including rural white Americans as well.

It is important that this legislation strengthens research into health care quality and access. It examines collection of data on race or ethnicity. It addresses the role of health professionals so that they will be culturally sensitive to be sure that they understand what is occurring. It is very important to educate our health care professionals so they can ask the kinds of sensitive questions to ensure that if they are speaking to a particular minority group, that they can secure from them the information that will allow the physician or the health care professional to treat them correctly.

It is very important that we focus on diet and nutrition and immunization for children and find out whether there is an intimidation or some concern about why minorities do not have the access, why they are not interacting with our health care professionals.

Mr. Speaker, let me just briefly, as I close, share a story, and I will certainly point to this as a cultural concerns of an elderly person going into a medical office of a doctor. Happened to be a minority, in particular African American. This person was accused of taking a bar of soap. Of course that would discourage a particular African American or minority, because of some cultural bias to go to that particular office again or go to any doctor.

Mr. Speaker, I think this bill is a good bill to study what will help us ensure that all Americans have equal access to health care. This is a good bill, and I ask my colleagues to support it.

Ms. PELOSI. Mr. Speaker, will the gentlewoman yield?

Ms. JACKSON-LEE of Texas. I yield to the gentlewoman from California.

Ms. PELOSI. Mr. Speaker, I wish to, in the course of this debate, associate myself with the comments of our colleagues who spoke in favor of that.

I would first like to thank the gentleman from Georgia (Mr. LEWIS) for his tremendous leadership in initiating this legislation, the gentleman from Illinois (Mr. JACKSON), with whom I serve on the Subcommittee on Labor, Health and Human Services, and Education on the Committee on Appropriations, who has been a relentless supporter in ending the disparity and access to quality health care research and prevention, and the gentleman from Mississippi (Mr. THOMPSON), who has been a leader on this issue, as well as the gentlewoman from North Carolina (Mrs. CLAYTON).

I thank them all for their tremendous work on this issue. They have been great leaders in the effort to reduce health disparities, and this bill is a testament to their hard work and commitment.

Mr. Speaker, numerous studies have shown that minority communities suffer disproportionately from many severe health problems and have higher mortality rates than whites for many treatable health conditions. Although we have seen giant leaps in scientific knowledge, particularly in recent years, as we have increased our investment in the National Institutes of Health, the benefits of those advances are not clearly reaching all segments of our society.

At this point, I would like to recognize the tremendous work of the gentleman from Pennsylvania (Mr. GEKAS). He and I are co-chairs of the Biomedical Research Caucus, but he is our leader in having monthly meetings where Members and staff can be made aware of the scientific opportunities in the biomedical community. He is a giant on that issue in this Congress.

During our NIH hearings in the Subcommittee on Labor, Health and Human Services, and Education, we have heard many alarming statistics on racial and ethnic health disparities, including significantly higher rates of death from cancer and heart disease, as well as higher rates of HIV/AIDS, diabetes, and other health problems.

HIV/AIDS has been particularly devastating in minority communities. African Americans and Hispanics, who represent 12 and 11 percent respectively of our Nation's population, now account for 70 percent of new HIV cases and nearly 60 percent of new AIDS cases. And African-American and Hispanic women account for 78 percent of the newly reported infections among women.

Not enough research is being done to understand and eliminate racial and ethnic health disparities. According to an Institute of Medicine study published in February 1999, Federal efforts to research cancer in minority communities are insufficient. The IOM recommended an increase in resources in development of a strategic plan to coordinate this research.

I commend the administration for responding to this need by implementing

the initiative to eliminate racial and ethnic disparities in health. The initiative identifies the steps necessary to eliminate disparities in the areas of cardiovascular disease, cancer screening and management, diabetes, infant mortality, HIV/AIDS and immunizations by 2010.

At this point, I would also like to commend the gentlewoman from California (Ms. WATERS) for her relentless efforts ongoing but especially when she was Chair of the Congressional Black Caucus in getting the minority initiative passed and funded. It made a drastic difference, but it is still not enough.

Fulfilling the goals of this initiative must be a top priority. Next decade, however, these goals cannot be met without a comprehensive effort to improve research on the health of my minority communities and develop the interventions capable of reducing these disparities.

The Center for Minority Health and Health Disparities created by the Minority Health and Health Disparities Research and Education Act and the full grant-making authority conferred upon it is an important step toward this effort. And while I am pleased that this critical issue is finally gaining the attention it deserves and again commend the gentleman from Georgia (Mr. LEWIS) for his leadership, the next step forward must be full institute status. This creates a center. It does have full grant-making authority, and that is an important distinction. Usually an institute gives full grant-making. But I do not know why we cannot make this a full institute at the National Institutes of Health.

It is imperative that, as we continue to increase NIH funding, we provide this ongoing issue the permanent attention necessary to eliminate current health disparities and prevent future health disparities from emerging.

All Americans deserve a healthy future. I urge my colleagues to vote yes on the Minority Health and Health Disparities Research and Education Act.

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

Mr. Speaker, have no other speakers. I would just like to close by thanking the gentleman from Georgia (Mr. NORWOOD) for his wonderful leadership in this House on health matters. I also thank the gentleman from Georgia (Mr. LEWIS) and all those who have had a part in the fashioning and the passage of this wonderful piece of legislation.

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

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

Mr. Speaker, I want to take just a minute to close this up and thank really everybody that has been involved with this over the past 6 months. I am sorry the gentleman from Oklahoma (Mr. WATTS), my good friend, is not here. He has worked very hard and worked with me long to help us get to this point. He has done things way upstairs back there that the rest of us could not do, and I am grateful to him.

This bill is, in my view, pretty meaningful. It has some very interesting prospects for America, one of which is the research. The biomedical research that we are talking about under the auspices of NIH is going to reveal to us, I believe, some anomalies in health care and in medicine that we are not aware of today. At least I hope that is where the research takes us.

Second, and maybe we had not talked about it as much and it is equally important to me, is the education factor of this bill. I readily admit to anyone who asked, very selfishly I hope a lot of this goes to Morehouse Medical School. I hope they do a lot of the education and the research right there. And to continue to be selfish, it is for a very simple reason. The graduates, the doctors, health care professionals that they put out are the people that go into my counties and my communities and treat rural Georgia. That is what I am after here as much as anything else.

So I thank all that have been involved. And I know that we will all follow this, the research and the education aspects of it, very carefully over the coming years and hope and pray that this does what we all intend for it to do.

Mr. ENGEL. Mr. Speaker, I want to commend the authors of this legislation and express my strong support for this bill. Historically, minorities have been under-represented in health research.

It is my hope that establishing a National Center for Research on Minority Health and Health Disparities at the National Institutes of Health will provide the means necessary to meet the health challenges many minorities face. With the unique health problems affecting different racial and ethnic communities, it is essential that this National Center be established to research and develop treatments and cures for afflictions that are more prevalent in minorities.

One of my concerns throughout my tenure in Congress has been the effects of smog and pollution that inner-city residents are exposed to on a daily basis. Within inner-cities, minorities comprise a large portion of the population. I have been a strong advocate on behalf of inner-city communities, including my own district, that have been unfairly burdened by environmental hazards.

I included an amendment in the House version of this bill which simply stated that the Administrator of Health Care Policy, within the National Center for Research on Minority Health and Health Disparities, take into account environmental factors when researching the cause of health disparities for minority populations. While the Senate version of the bill that we are considering today does not include the exact language of my amendment, it does accomplish the goal I intended to address.

The legislation clearly states that when researching barriers many minorities face in obtaining proper health care, the Administrator of Health Care Policy is specifically directed to take into account the socioeconomic status, attitudes toward health, the language spoken, the extent of formal education, the area or community in which the population resides, and other factors the Director determines to be appropriate. It is my hope that by identifying health problems caused by environmental factors, we can begin to address the issue and enhance the quality of life for our urban residents.

Mr. Speaker, I want to reiterate my support for this bill, and I urge my colleagues to vote in favor of this important legislation.

Mr. TOWNS. Mr. Speaker, I rise in support of the Health Care Fairness Act. As a senior member of the Commerce Committee's Subcommittee on Health and Environment, I have long been concerned about the pervasive inequality of health services endured by America's minority populations.

At a recent hearing before my subcommittee, we confronted the compelling evidence that race and ethnicity correlate with persistent, and often increasing, health disparities among U.S. populations. Despite notable progress in the overall health of the nation, there are continuing disparities in the burden of illness and death experienced by African Americans, Hispanics, and others compared to the U.S. population as a whole. In fact, current information about the biologic and genetic characteristics of racial and ethnic groups does not explain the health disparities experienced by these groups compared with the white, non-Hispanic population. Given the demographic projections for the U.S. population in 2030, I believe that it is imperative that Congress establishes a forward-looking strategy to address health disparities in minority communities.

For example, research shows that the AIDS epidemic is disproportionately affecting minorities. According to the Centers for Disease Control, African Americans, who comprise 13 percent of the U.S. population, account for 49 percent of AIDS deaths in 1998. In March 2000, an audit conducted by the U.S. General Accounting Office assessed how government funding on AIDS programs was spent. The audit concluded that African Americans and Hispanics were receiving substandard care relative to whites in areas such as doctor visits, emergency room care, hospitalizations, and drug therapies.

In order to identify and rectify health disparities that occur among minorities, I agreed to cosponsor H.R. 3250, the House companion to S. 1880, the Health Care Fairness Act. Among other things, this legislation would create a new National Center for Research on Minority Health and Health Disparities. This center would support basic and clinical research, training and the dissemination of information with respect to minority health.

I believe the new National Center will enable us to make real progress toward eliminating the daunting gap in health status between minorities and the rest of America, and I encourage my colleagues to support its passage.

Mr. CUMMINGS. Mr. Speaker, I rise this evening in support of The Minority Health and Health Disparities Research and Education Act.

During his radio address on February 21st, 1998, President Clinton committed the Nation to an ambitious goal by the year 2010:

To eliminate the disparities in six areas of health status experienced by racial and ethnic minority populations while continuing

the progress we have made in improving the overall health of the American people.

Achieveing the President's vision will require a major national commitment to identify and address the underlying causes of higher levels of disease and disability in racial and ethnic minority communities.

Contrary to what some may say, this legislation is not a ''quota'' bill.

This legislation that opens the door of fairness and equality for a healthy nation.

Eliminating racial and ethnic disparities in health will require enhanced efforts at preventing disease, promoting health, and delivering appropriate care.

This will necessitate improved collection and use of standardized data to correctly identify all high risk populations and monitor the effectiveness of health interventions targeting these groups.

Research dedicated to a better understanding of the relationships between health status and different racial and ethnic minority backgrounds will help us acquire new insights into eliminating the disparities and developing new ways to apply our existing knowledge toward this goal.

Improving access to quality health care and the delivery of preventive and treatment services will require working more closely with communities to identify culturally-sensitive implementation strategies.

At my request, the Committee on Government Reform held a Congressional hearing entitled, ''Ethnic Minority Disparities in Cancer Treatment: Why the Unequal Burden?''

The hearing gave us the opportunity to engage in a more exhaustive investigation of the disparity issue as it related to ''conventional'' treatments for cancer.

I requested this hearing in response to a study published by the New England Journal of Medicine in October 1999, which reported that African American patients with early stage lung cancer are less likely than whites to undergo life-saving surgery, and as a result are more likely to die of their disease.

The treatment disparities revealed in the study were of great concern to me, particularly when considered along with other data regarding cancer incidence and mortality rates among minorities as compared to the majority population.

In fact, disturbingly:

The incidence rate for lung cancer in African American and Native Hawaiian men is higher than in white men; Hispanics suffer elevated rates of cervical and liver cancer; and Alaskan Native and African American women have the first and second highest all-cancer and lung cancer mortality rates among females;

Cancer has also surpassed heart disease as the leading cause of death for Japanese, Korean, and Vietnamese populations;

Further, while surgery is the treatment option for lung cancer in its early stages, only 64 percent of African Americans had surgery at this stage, as compared to 76.7 percent of white Americans; and

Paralleling recommended treatment options, cancer death rates among African Americans are about 35 percent higher than that for whites, and in my district of Baltimore City, 251 African Americans per every 100,000 die of cancer as compared to 194 of whites.

Our Nation is in a ''race for the cure.'' However, we must be mindful that this race for a healthy America must be run by and for all Americans. The entry into this contest should not be dependent on your race, but must be based on your humanity. And winning the race for a quality, healthy life must be a victory for every citizen, no matter their race, ethnicity, or socioeconomic status.

As we move closer to crossing that victory line, we must all work toward a meaningful improvement in the lives of minorities who now suffer disproportionately from the burden of disease and disability.

I will remain committed to the bioethical principles of justice and fairness which call for one standard of health in this country for all Americans, not an acceptable level of disease for minorities and another for the majority population.

Mr. WATTS of Oklahoma. Mr. Speaker, I would like to begin by thanking my House colleagues JOHN LEWIS, BENNIE THOMPSON, CHARLIE NORWOOD, and JESSE JACKSON, Jr., who are champions in this important effort to address the issue of minority health disparities. This is a matter of deep concern to not only African-Americans, but also to Hispanic-Americans, Native-Americans and other minorities who are clearly underserved by the American health care system.

Despite continuing advances in research and medicine, disparities in American health care are a growing problem. This is evidenced by the fact that minority Americans lag behind in nearly every single measure of heath quality. Those measures include life expectancy, health care coverage, access to care, and disease rates. Ethnic minorities and individuals in medically underserved rural communities continue to suffer disproportionately from many diseases such as cancer, diabetes, and cardiovascular diseases. There have been numerous studies in scientific journals showing the severity of racial and ethnic disparities and the need for action in order to remedy this grave problem.

For these and countless other reasons, it is time for the nation to focus on this problem and to work to bring fairness to our minority citizens in the nation's public and private health care systems. There is no better place to start this effort than the focal point for federal research, the renowned and highly respected National Institutes of Health.

Since 1996, Congress has increased funding for basic medical research at NIH from $12 billion to over $18 billion—over a 50% increase. These funds support 50,000 scientists working at 2,000 institutions across the United States. I have been proud to support these increases, but I think it is now time that we target some portion of those funds on the nation's most acute health problems among our minority citizens—and I might add, minority taxpayers.

Let me say that I am delighted to be a cosponsor of this legislation. Among other provisions, this legislation will elevate the existing office of Research on Minority Health at NIH to a National Center for Research on Minority Health. This upgrade to the level of National Center would in itself underscore the importance of this work, and along with expanded research and education, improved data systems and strengthened public awareness, we will be taking a great leap forward in addressing this critical national problem.

The Minority Health and Health Disparities Research and Education Act will increase our knowledge of the nature and causes of health disparities, improve the quality and outcomes of health care services for minority populations, and aid in bringing us closer to our mutual goal of closing the long-standing gap in health care.

I am deeply committed to this legislation, and I urge you to support my colleagues and me in our effort to rectify this inequality in health care.

Mr. DINGELL. Mr. Speaker, I strongly support S. 1880, the Minority Health and Health Disparities Research and Education Act of 2000. I urge all of my colleagues to approve this much needed and long overdue legislation.

We have before us a bill aimed at one of the most significant challenges in health care research and education. The existence of disparities in all aspects of health care is well documented. Reports published by the Institute of Medicine and in the New England Journal of Medicine and the Journal of the American Medical Association are just a few of many that point clearly to the need for quick enactment and implementation of the legislation that is before us today. The Commerce Committee's hearing on this subject highlighted the fact that there are massive differences in the frequency, severity, and survivability of many health conditions among different members of our diverse population. Unfortunately, where you live, what you earn, and the color of your skin make a big difference in health care quality and access.

Great care has been taken in drafting this legislation so that it responds to the panoply of disparities issues without running afoul of the equal protection clause of the Constitution. Indeed, the Department of Justice has concluded that the bill does not trigger strict scrutiny under applicable tests for the validity of laws and programs aimed at addressing inequities that fall, in some cases, along racial and ethnic lines.

Disparities occur for a variety of reasons, so it is not surprising that legislation aimed at identifying and eliminating disparities has several facets. First, S. 1880 addresses biomedical issues through the establishment of a National Center on Minority Health and Health Disparities at the National Institutes of Health. Next, this bill directs the Agency for Health Care Research and Quality to carry out activities to address disparities in health care quality and access. S. 1880 also addresses quality and access issues through the Public Health Service Act's health professions programs.

This legislation enjoys broad bipartisan support. I wish to take particular note of the fine work of my colleagues, Representatives LEWIS, JACKSON, THOMPSON, TOWNS, STRICKLAND, NORWOOD, WATTS, and WHITFIELD. I know that many other of my colleagues on both sides of the aisle contributed to the effort of getting this bill before us today and I am greatful to all of them. Our colleagues in the Senate, particularly Senators KENNEDY and FRIST, also made significant contributions to this bill.

I urge my colleagues to join me in support of this bill.

Mr. STARK. Mr. Speaker, one of America's most important assets is the diversity of our residents, and this diversity is growing rapidly. Between 1991 and 2000, the population of Asians and Pacific Islanders increased by 46 percent, Latinos by 40 percent, American Indians by 16 percent, and African Americans by 14 percent.

Unfortunately, vestiges of racism—both conscious and unconscious—still exist, permeating our society and our institutions. Last month, I highlighted research findings that demonstrate people of color disproportionately lack access to health care, vital treatments, and preventive screening measures. In addition, a recent New England Journal of Medicine study found that unconscious perceptions and biases can be revealed in differential physician recommendations for minority individuals seeking heart disease treatment. Taken together, these findings underscore the urgency of supporting legislation to improve health care quality for diverse communities.

So far, very little has been done to address these tremendous disparities. For example, people of color are disproportionately affected by certain types of cancers—Vietnamese American women are five times more likely to contract cervical cancer than white women and Africa Americans are 35 percent more likely to die from cancer than whites. Despite these alarming statistics, the Institute of Medicine concluded that federal funding for cancer research among communities of color remains insufficient.

S. 1880, The Health Care Fairness Act is an opportunity to positively improve the health care of all Americans by working toward reducing these disparities. It is a bipartisan effort that contains many important provisions, including an increased commitment to research on health disparities, improved data systems, and enhanced quality of care for health disparity populations, including low-income, medically underserved, racial and ethnic minority, and rural individuals.

This legislation ensures a prominent focus in our nation's premier research agencies—the National Institutes of Health and the Agency for Health Care Policy Research—in improving health outcomes for populations that have a significant disparity in the rate of disease incidence, prevalence, morbidity, mortality, or survival as compared to the general population. It also provides grants to our medical, public health, dental, nursing, and other health professional schools so that curricula to promote improved health care quality can be developed for these populations. Furthermore, it designates opportunities for training so that our current and future medical providers are equipped to join the fight against health disparities due to geography, the lack of medical services, race and ethnicity, and socioeconomic status.

Our country has made phenomenal advancements in science and medicine. It is time to ensure that all of our communities share in these rewards. This is a chance to help ensure our health care system is just, equitable, and equal for all Americans. Support fairness in health care, and vote for S. 1880.

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

The SPEAKER pro tempore (Mr. SUNUNU). The question is on the motion offered by the gentleman from Georgia (Mr. NORWOOD) that the House suspend the rules and pass the Senate bill, S. 1880.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the Senate bill was passed.

A motion to reconsider was laid on the table.

□

FEDERAL PHYSICIANS COMPARABILITY ALLOWANCE AMENDMENTS OF 2000

Mrs. MORELLA. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 207) to amend title 5, United States Code, to provide that physicians comparability allowances be treated as part of basic pay for retirement purposes, as amended.

The Clerk read as follows:

H.R. 207

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Federal Physicians Comparability Allowance Amendments of 2000''.

SEC. 2. AUTHORITY MADE PERMANENT.

(a) IN GENERAL.—

(1) AMENDMENT TO TITLE 5, UNITED STATES CODE.—The second sentence of section 5948(d) of title 5, United States Code, is repealed.

(2) AMENDMENT TO THE FEDERAL PHYSICIANS COMPARABILITY ALLOWANCE ACT OF 1978.—Section 3 of the Federal Physicians Comparability Allowance Act of 1978 (5 U.S.C. 5948 note) is repealed.

(b) TECHNICAL AND CONFORMING AMENDMENTS.—Section 5948 of title 5, United States Code, is amended—

(1) by repealing paragraph (2) of subsection (j); and

(2) in subsection (j)(1)—

(A) by striking ''(j)(1)'' and inserting ''(j)'';

(B) by redesignating subparagraphs (A) through (E) as paragraphs (1) through (5), respectively; and

(C) in paragraph (5) (as so redesignated by this paragraph) by striking ''subparagraph (B)'' and inserting ''paragraph (2)''.

SEC. 3. TREATMENT OF ALLOWANCES AS PART OF BASIC PAY FOR RETIREMENT PURPOSES.

(a) DEFINITION OF BASIC PAY.—Section 8331(3) of title 5, United States Code, is amended—

(1) in subparagraph (F) by striking ''and'' after the semicolon;

(2) in subparagraph (G) by inserting ''and'' after the semicolon;

(3) by inserting after subparagraph (G) the following:

''(H) any amount received under section 5948 (relating to physicians comparability allowances);''; and

(4) in the matter following subparagraph (H) (as added by paragraph (3)) by striking ''through (G)'' and inserting ''through (H)''.

(b) CIVIL SERVICE RETIREMENT SYSTEM.—

(1) COMPUTATION RULES.—Section 8339 of title 5, United States Code, is amended by adding at the end the following:

''(s)(1) For purposes of this subsection, the term 'physicians comparability allowance' refers to an amount described in section 8331(3)(H).

''(2) Except as otherwise provided in this subsection, no part of a physicians comparability allowance shall be treated as basic pay for purposes of any computation under this section unless, before the date of the separation on which entitlement to annuity is based, the separating individual has completed at least 15 years of service as a Government physician (whether performed before, on, or after the date of enactment of this subsection).

''(3) If the condition under paragraph (2) is met, then, any amounts received by the individual in the form of a physicians comparability allowance shall (for the purposes referred to in paragraph (2)) be treated as basic pay, but only to the extent that such amounts are attributable to service performed on or after the date of enactment of this subsection, and only to the extent of the percentage allowable, which shall be determined as follows:

''If the total amount of service performed, on or after the date of enactment of this subsection, allowable is: as a Government physician is:	Then, the percentage allowable is:
Less than 2 years	0
At least 2 but less than 4 years	25
At least 4 but less than 6 years	50
At least 6 but less than 8 years	75
At least 8 years	100.

''(4) Notwithstanding any other provision of this subsection, 100 percent of all amounts received as a physicians comparability allowance shall, to the extent attributable to service performed on or after the date of enactment of this subsection, be treated as basic pay (without regard to any of the preceding provisions of this subsection) for purposes of computing—

''(A) an annuity under subsection (g); and

''(B) a survivor annuity under section 8341, if based on the service of an individual who dies before separating from service.''.

(2) GOVERNMENT PHYSICIAN DEFINED.—Section 8331 of title 5, United States Code, is amended by striking ''and'' at the end of paragraph (26), by striking the period at the end of paragraph (27) and inserting ''; and'', and by adding at the end the following:

''(28) 'Government physician' has the meaning given that term under section 5948.''.

(c) FEDERAL EMPLOYEES' RETIREMENT SYSTEM.—

(1) COMPUTATION RULES.—Section 8415 of title 5, United States Code, is amended by adding at the end the following:

''(i)(1) For purposes of this subsection, the term 'physicians comparability allowance' refers to an amount described in section 8331(3)(H).

''(2) Except as otherwise provided in this subsection, no part of a physicians comparability allowance shall be treated as basic pay for purposes of any computation under this section unless, before the date of the separation on which entitlement to annuity is based, the separating individual has completed at least 15 years of service as a Government physician (whether performed before, on, or after the date of enactment of this subsection).

''(3) If the condition under paragraph (2) is met, then, any amounts received by the individual in the form of a physicians comparability allowance shall (for the purposes referred to in paragraph (2)) be treated as basic pay, but only to the extent that such amounts are attributable to service performed on or after the date of enactment of this subsection, and only to the extent of the percentage allowable, which shall be determined as follows: