

110TH CONGRESS  
1ST SESSION

# H. R. 789

To amend the Public Health Service Act to establish an Office of Men's Health, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

JANUARY 31, 2007

Mr. TOWNS (for himself, Mrs. CHRISTENSEN, Mr. CONYERS, and Ms. LEE) introduced the following bill; which was referred to the Committee on Energy and Commerce

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## A BILL

To amend the Public Health Service Act to establish an Office of Men's Health, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Office of Men's Health  
5 Act of 2007".

6 **SEC. 2. FINDINGS.**

7 The Congress finds as follows:

8 (1) INTRODUCTION.—Men's health in the  
9 United States is in a state of crisis revealing a  
10 breadth of health inequities that warrant national

1 attention. This crisis has led to the need for an Of-  
2 fice of Men’s Health within the Department of  
3 Health and Human Services that coordinates the de-  
4 velopment of effective strategies and interventions  
5 designed to improve the health determinants as well  
6 as reduce and eliminate the widespread chronic dis-  
7 eases and health conditions that negatively affect the  
8 health of American men.

9 (A) According to Healthy People 2010, so-  
10 cial determinants of health include education,  
11 housing, labor, justice, transportation, agri-  
12 culture, and the environment.

13 (B) Improving the social determinants that  
14 affect men’s health could substantially improve  
15 their health and well-being, as well as the  
16 health and well-being of their families and com-  
17 munities over time.

18 (2) WOMEN’S HEALTH.—While the men’s  
19 health crisis concerns most if not all men, it also  
20 jeopardizes the lives of individuals in their families  
21 and social networks, particularly women. Women  
22 bear the direct and indirect caregiving burden for  
23 the family when male counterparts are unavailable  
24 due to declining health or premature death. Con-  
25 sequently, women’s overall well-being and health are

1 threatened by conditions that compromise the health  
2 and shorten the lives of their male loved ones.

3 (3) GENDER-RELATED HEALTH INEQUITIES.—  
4 Significant gender disparities exist in health that  
5 should be addressed to improve the overall health  
6 profile of the Nation. While the average life expect-  
7 ancy for the general population is 77.9 years of age,  
8 women on average live six years longer than men. In  
9 some cases, the life expectancy for men is 20 years  
10 less than women, especially within communities of  
11 color.

12 (A) Overall, men have higher death rates  
13 for the top 10 leading causes of death than  
14 women, including heart disease, cancer, chronic  
15 lower respiratory disease, unintentional injuries,  
16 suicide, chronic liver disease, homicide, and  
17 HIV/AIDS.

18 (B) In addition, men have a cardiovascular  
19 disease death rate 1.5 times higher than  
20 women, a lung cancer mortality rate 1.8 times  
21 higher than women, and an HIV/AIDS death  
22 rate that is roughly 3 times higher than women.

23 (C) Studies confirm that men are more  
24 likely than women to have less healthy life-  
25 styles, less likely to seek and obtain needed

1 medical attention, more likely to engage in risky  
2 behaviors, and less likely to recognize the value  
3 of and adhere to preventive health care prac-  
4 tices than women.

5 (D) Men are at least 25 percent less likely  
6 than women to visit a doctor, and are signifi-  
7 cantly less likely to have regular physician  
8 checkups and obtain preventive screening tests  
9 for serious acute and chronic diseases.

10 (4) RACIAL AND ETHNIC HEALTH INEQUAL-  
11 ITIES.—Racial and ethnic inequalities exist in men’s  
12 health with grave consequences for our most vulner-  
13 able populations.

14 (A) African American men have the high-  
15 est incidence and mortality rates of many forms  
16 of cancer, have the highest levels of high blood  
17 pressure in the world, and are twice as likely as  
18 White men to have diabetes, thus detrimentally  
19 affecting their health status and dramatically  
20 reducing their life expectancy.

21 (B) The life expectancy for African Amer-  
22 ican men is not only the lowest among all men,  
23 but is lower than that for African American  
24 women. Black urban men have the shortest life

1           expectancy (66.7 years of age), followed by  
2           Southern rural Black men, at 67.7 years of age.

3           (C) African American men are more likely  
4           to suffer serious side effects from chronic dis-  
5           eases and have higher mortality rates from  
6           heart disease and obesity than any other racial  
7           or ethnic group.

8           (D) African American men generally access  
9           medical facilities in later disease stages, thus  
10          reducing their chances for adequate treatment  
11          and recovery and increasing the cost of care.  
12          This affects mortality rates in a wide range of  
13          chronic diseases, including testicular disease  
14          and end-stage renal disease related to diabetes.

15          (E) American Indian and African Amer-  
16          ican men, 15 to 29 years of age, have higher  
17          overall death rates than Hispanic, White, and  
18          Asian American men of the same age group.

19          (F) Since 2001, the only men of color for  
20          whom HIV disease is a major cause of death  
21          are African Americans (fourth ranked) and  
22          Latinos (tenth ranked).

23          (G) Diabetes mellitus is the fifth ranked  
24          cause of death for American Indian and Alaska  
25          Native men, the sixth ranked cause among

1 Latino men and White men, and the seventh  
2 ranked cause among Asian and Pacific Islander  
3 men and African American men.

4 (5) ORAL HEALTH.—Oral diseases are preva-  
5 lent among men of color, particularly African Ameri-  
6 cans. Men suffer disproportionately from oral dis-  
7 eases, many of which can be treated and prevented  
8 with appropriate diagnosis and care.

9 (A) More than 50 percent of African  
10 American men have untreated dental decay  
11 compared to only 28 percent of White men.

12 (B) African American men have the high-  
13 est incidence of oral cancer and the lowest sur-  
14 vival rates of any group.

15 (6) MENTAL HEALTH.—Mental health is often  
16 ignored in discussions and intervention strategies re-  
17 lated to men’s health. However, mental health is an  
18 indispensable component of personal health and well-  
19 being. Mental health defines and affects inter-  
20 personal relationships, the ability to adapt and cope  
21 with adversity, and an individual’s relationship to his  
22 family, community, and society. The mental health  
23 status of men is a growing concern for this country  
24 and can have significant health consequences. From  
25 1980–1995, the suicide rate among African Amer-

1        ican males ages 10 to 14 increased 233 percent,  
2        compared to 120 percent of comparable non-His-  
3        panic White men. Additionally, research indicates  
4        that suicide death rates are more than four times  
5        higher among men than women.

6                (7) NATIONAL IMPACT.—Nationally, the men’s  
7        health crisis has a profound and often detrimental  
8        impact not only on the health, well-being, and pro-  
9        ductivity of men, but also on the strength and viabil-  
10       ity of the communities in which they live, work, and  
11       do business.

12                (A) This health crisis has had a negative  
13        impact on the national economy. As a con-  
14        sequence, substantial additional burdens have  
15        been placed upon a significant portion of our  
16        Nation’s labor force.

17                (B) The current men’s health crisis is a  
18        major concern for the private sector, labor  
19        unions, health providers, and government—  
20        from local governments to the Federal Govern-  
21        ment. Both the private sector and the public  
22        sector experience substantial additional costs  
23        related to absorbing the burden of health dis-  
24        parities related to men. These disparities are  
25        exacerbated even further in terms of men who

1 are unable to afford or gain access to reliable  
2 and appropriate care in their communities and  
3 men of color who bear a dual burden related to  
4 ethnicity and gender.

5 (C) The inequities in men's health are a  
6 core concern for employers, particularly those  
7 offering health benefits to employees and their  
8 dependants.

9 (i) Men's health issues challenge em-  
10 ployers' efforts to contain the direct and  
11 indirect costs associated with providing  
12 health care insurance for employees.

13 (ii) Disparities in men's health, par-  
14 ticularly in communities of color, leave  
15 men in the workforce in poorer health and  
16 at greater risk for the most costly chronic  
17 and acute conditions. These communities  
18 are especially at risk for increased rates of  
19 absenteeism and lower rates of productivity  
20 for health-only reasons.

21 (8) HEALTH INSURANCE.—Access to medical  
22 care in this country is largely predicated upon hav-  
23 ing health insurance coverage. Dramatically higher  
24 rates of uninsured men of color have had major con-  
25 sequences for the health of our Nation, our States,

1 and our communities. This lack of health insurance  
2 creates barriers to access to appropriate health care  
3 services and treatments and may have a profound  
4 impact on the health status and health outcomes of  
5 men, their families, and their communities. Health  
6 insurance is a primary source of health care for both  
7 prevention services and treatment of illnesses. Over-  
8 all, racial and ethnic minority men are dispropor-  
9 tionately more likely than White men to be unin-  
10 sured, as well as to suffer from chronic and acute  
11 conditions, and die prematurely from often prevent-  
12 able conditions during their most productive life  
13 years.

14 (A) More than half (56 percent) of all His-  
15 panic men, about 45 percent of all American  
16 Indian and Alaska Native men, 47 percent of  
17 all Native Hawaiian and Pacific Islander men,  
18 and 38 percent of all African American men, 18  
19 to 29 years of age, were uninsured in 2004,  
20 compared to 26 percent of all White men in the  
21 same age group.

22 (B) In 2004, the percentage of all unin-  
23 sured men of color, 30 to 44 years of age, was  
24 higher than that of white men of the same age  
25 group. The percentage of uninsured Hispanic

1 men, ages 30 to 44 was more than two and a  
2 half times higher than that of White men in the  
3 same age group. American Indian and Alaska  
4 Native men of the same age group had unin-  
5 sured rates that were two times higher than  
6 White men.

7 (9) HEALTH LITERACY AND EDUCATION.—Pro-  
8 viding a culturally competent and ethnically diverse  
9 health care workforce is likely to improve quality of  
10 health care and health outcomes for men. Addition-  
11 ally, finding ways to better educate men, their fami-  
12 lies, and health care providers about the importance  
13 of early detection of male health problems can result  
14 in reducing rates of mortality for male-specific dis-  
15 eases, as well as improve the health of America’s  
16 men and its overall economic well-being.

17 (A) A majority of men of color, most nota-  
18 bly those with lower levels of education, have  
19 difficulty understanding medical information.  
20 Men of color have reported limited medical lit-  
21 eracy. More than half of African American (54  
22 percent), Hispanic (59 percent), and Asian (63  
23 percent) men reported that they did not find in-  
24 formation from their doctor’s office easy to un-  
25 derstand. Others reported a similar difficulty

1 understanding the information written on pre-  
2 scription bottles.

3 (B) Asian, Pacific Islander, and Latino  
4 men, the men for whom English is more likely  
5 to be a second language, most frequently re-  
6 ported dissatisfaction with the quality of care  
7 received from health care providers.

8 (10) PRISON HEALTH.—The rates for incarcer-  
9 ated men of color are generally much higher than  
10 for White men. Men of color also enter the prison  
11 population suffering from a wider range of primary  
12 and chronic diseases. Men of color, who are ex-of-  
13 fenders, also return to low-income communities with  
14 the fewest health resources. The unmet health needs  
15 of these men threaten scarce public resources by  
16 placing additional burdens on the health infrastruc-  
17 ture of a wide range of urban and rural commu-  
18 nities.

19 (A) In 2005, the percentage of African  
20 American and Hispanic men who were incarcer-  
21 ated was significantly higher than the incarcer-  
22 ation rate for White men.

23 (i) Many of these inmates suffer with  
24 HIV/AIDS, hepatitis, and tuberculosis and

1 various chronic diseases such as diabetes,  
2 hypertension, and asthma.

3 (ii) Even more male inmates suffer  
4 from undiagnosed or untreated mental ill-  
5 ness.

6 (B) These disproportionate rates of chronic  
7 disease and conditions have a tremendous affect  
8 on many low-income communities, both urban  
9 and rural.

10 **SEC. 3. ESTABLISHMENT OF OFFICE OF MEN'S HEALTH.**

11 Title XVII of the Public Health Service Act (42  
12 U.S.C. 300 et seq.) is amended by adding at the end the  
13 following section:

14 **“SEC. 1711. ESTABLISHMENT OF THE OFFICE OF MEN'S**  
15 **HEALTH.**

16 “(a) ESTABLISHMENT.—The Secretary of Health  
17 and Human Services shall establish within the Depart-  
18 ment of Health and Human Services an office to be known  
19 as the Office of Men's Health, which shall be headed by  
20 a director appointed by the Secretary.

21 “(b) PERSONNEL.—The Secretary, acting through  
22 the Director of the Office of Men's Health, shall recruit  
23 and hire qualified personnel for the Office, including mem-  
24 bers of racial and ethnic minority populations with rel-  
25 evant expertise in men's health issues.

1           “(c) COORDINATION WITH FEDERAL HEALTH AGEN-  
2           CIES.—The Secretary, acting through the Director of the  
3           Office of Men’s Health, shall collaborate with all relevant  
4           agencies and offices of the Federal Government, including  
5           the Institute of Medicine, the National Center for Health  
6           Statistics, and the National Center on Minority Health  
7           and Health Disparities at the National Institutes of  
8           Health, the Office of Minority Health, the Substance  
9           Abuse and Mental Health Services Administration, the In-  
10          dian Health Service, the Agency for Healthcare Research  
11          and Quality, and others to identify and report on men’s  
12          health data, including health disparities for chronic dis-  
13          eases and health conditions related to men of color.

14          “(d) DEFINITION.—In this section, the term ‘racial  
15          and ethnic minority populations’ means American Indian  
16          or Alaska Native, Asian, Black or African American, His-  
17          panic or Latino, and Native Hawaiian or other Pacific Is-  
18          lander populations.”.

19          **SEC. 4. GRANTS.**

20          (a) AUTHORIZATION.—The Secretary of Health and  
21          Human Services shall make grants to institutions of high-  
22          er education for the purpose of—

- 23                  (1) conducting conferences on men’s health;  
24                  (2) conducting public education campaigns to  
25          reduce health disparities relating to men’s health;

1           (3) evaluating the effectiveness of government  
2           and public sector resources that focus on men's  
3           health; and

4           (4) reporting on the gaps and problems that  
5           men of color have in utilizing health resources in a  
6           city or county.

7           (b) PRIORITY.—In evaluating grant proposals under  
8           this section, the Secretary of Health and Human Services  
9           shall give priority to proposals from Historically Black  
10          Colleges or Universities (HBCU) and proposals from his-  
11          torically Hispanic, Native American, or other ethnic col-  
12          leges and universities.

13          (c) AUTHORIZATION OF APPROPRIATIONS.—To carry  
14          out this section, there is authorized to be appropriated  
15          \$50,000,000 for fiscal year 2008 and each subsequent fis-  
16          cal year.

17       **SEC. 5. REPORTING.**

18          (a) IOM STUDY ON MEN'S HEALTH.—

19               (1) IN GENERAL.—The Secretary of Health and  
20               Human Services shall enter into an agreement with  
21               the Institute of Medicine of the National Academy  
22               of Sciences—

23                       (A) to conduct a comprehensive study on  
24                       men's health; and

1 (B) to submit to the Congress a report on  
2 the results of such study, to be entitled “Report  
3 to the Nation on Men’s Health”.

4 (2) CONTENTS.—The study conducted under  
5 this subsection shall be a fair and impartial review  
6 of the state of men’s health in the United States (in-  
7 cluding the District of Columbia, the Commonwealth  
8 of Puerto Rico, the United States Virgin Islands,  
9 Guam, American Samoa, the Commonwealth of the  
10 Northern Mariana Islands, the Republic of the Mar-  
11 shall Islands, the Federated States of Micronesia,  
12 the Republic of Palau, and any other territory or  
13 possession of the United States) and shall—

14 (A) include information on racial and eth-  
15 nic minority men and a focus on African Amer-  
16 ican, Hispanic, Native American, and Asian  
17 and Pacific Island men and their health dispari-  
18 ties;

19 (B) describe the activities and accomplish-  
20 ments of the Office of Men’s Health;

21 (C) include statistics and information that  
22 indicate men’s health in standard and cus-  
23 tomary health categories with commonly used  
24 health indices;

1 (D) provide, in addition to commonly used  
2 health indices, the status of social determinants  
3 of men’s health;

4 (E) include all relevant qualitative mate-  
5 rials that indicate the state of men’s health, in-  
6 cluding statistical studies, qualitative evalua-  
7 tions, findings, and program evaluations of cur-  
8 rent programs and initiatives of the Depart-  
9 ment of Health and Human Services;

10 (F) draw from both primary and secondary  
11 research resources from local, State, and Fed-  
12 eral agencies; and

13 (G) include updated information relative to  
14 the Institute of Medicine’s study entitled “Un-  
15 equal Treatment: Confronting Racial and Eth-  
16 nic Disparities in Healthcare”.

17 (3) PANEL OF INDEPENDENT EXPERTS.—

18 (A) ESTABLISHMENT.—The agreement  
19 under paragraph (1) shall provide for the estab-  
20 lishment of a panel of independent experts (in  
21 this paragraph referred to as the “panel”) to  
22 assist in the conduct of the study under this  
23 subsection by reviewing and providing guidance  
24 on appropriate outcomes and assessments for

1 men's health and health disparities of men of  
2 color.

3 (B) COMPOSITION.—The agreement under  
4 paragraph (1) shall provide for appropriate rep-  
5 resentation on the panel from the racial and  
6 ethnic groups covered by the study under this  
7 subsection.

8 (b) ANNUAL REPORTING.—Subsequent to the sub-  
9 mission of the report required by subsection (a)(1)(B), the  
10 Secretary of Health and Human Services, acting through  
11 the National Institutes of Health and the Director of the  
12 Office of Men's Health, shall submit an annual report to  
13 the Congress that—

14 (1) includes the same extent of information on  
15 men's health as is included in the Secretary's annual  
16 reporting to the Congress on women's health; and

17 (2) uses analytical tools similar to those used in  
18 such reporting on women's health.

19 (c) NATIONAL HEALTHCARE DISPARITIES RE-  
20 PORT.—In each report submitted under section 903(a)(6)  
21 of the Public Health Service Act (42 U.S.C. 299a-  
22 1(a)(6)), the Director of the Agency for Healthcare Re-  
23 search and Quality shall include analysis of available data  
24 on racial, ethnic, and geographic disparities in men's  
25 health, including rates for uninsured populations, heart

- 1 disease, cancer, chronic lower respiratory disease, uninten-
- 2 tional injuries, mental health and suicide, oral and dental
- 3 health, chronic liver disease, and HIV/AIDS.

○