

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

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

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

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

HEALTHCARE EQUALITY AND
ACCOUNTABILITY ACT OF 2005

HON. DONNA M. CHRISTENSEN

OF THE VIRGIN ISLANDS

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 28, 2005

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr. Speaker, last Congress, my colleagues and I in the TriCaucus introduced a bill that

would reduce racial and ethnic disparities in health and in health care. This Congress, we decided to re-introduce that bill in a concerted effort to continue our commitment and work to ensure that racial and ethnic health disparities are eliminated from our health care system.

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

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

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

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

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

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

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

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

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

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

THE FINAL MISSION OF THE LATE
OSSIE DAVIS

HON. CHARLES B. RANGEL

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 28, 2005

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

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

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