Epoct threats to the health of people all over the world continue to challenge governments, domestic infrastructures and societies on a rapidly growing scale. Their crisis is our crises. The stability of the region is at risk and with that, our interests in the stability of governments in Africa.

Despite these daunting facts, there is something we can do. Unprecedented opportunities exist today to improve health around the world and the U.S. must maintain its leadership role on these issues. It is in our interest to do so. Our borders are not impervious to these global health threats. To address these global health threats, I am introducing the Global Health Act of 2001.

During the 106th Congress, over 75 members of Congress and 152 organizations joined me in support of the Global Health Act of 2000 and we are reintroducing this legislation this year to reaffirm our commitment to improve the health of men, women and children around the world.

Today, I am joined by 52 of my colleagues in introducing bipartisan legislation to increase the U.S. commitment to global health by $1 billion dollars over FY 2001 appropriated levels. With these additional funds, our commitment to global health will be authorized at $2.55 billion.

Mr. Speaker, I would like to thank the fifty-two cosponsors of the Global Health Act of 2001. These cosponsors represent a broad cross section of the House; Democrats and Republicans, faithful to their promise, maintaining the bipartisan leadership on this issue.

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I ask that a copy of the Global Health Act be printed in the RECORD following my remarks.

We are joined in this effort by over 70 international organizations and two coalitions committed to global health, such as the Global Health Council, Save the Children, the Christian Children’s Fund, and the American Foundation for AIDS Research, and the list is growing every day.

I have included that list of the global health organizations, faith-based organizations and development NGOs that support this legislation and ask that it be entered into the RECORD.

What does the Global Health Act do?

The Global Health Act of 2001 provides an additional $1 billion to the global health programs of the Federal Government. This includes $225 million for the Clinton Global Initiative, $100 million increase for maternal health, a $200 million increase for family planning, a $225 million increase for child survival, and a $200 million increase for infectious diseases.

While other legislation will seek to target specific diseases, the Global Health Act understands the interconnectedness of health and seeks an increase for all of the global health programs that play an important role in improving the health of men, women and children around the world.

It also calls for increased coordination between the different government agencies administering health programs.

The HIV/AIDS pandemic is the greatest public health disaster to face mankind since the bubonic plague. Already, 58 million people have been infected or died as a result of HIV/AIDS and more than 95 percent of new infections occur in developing countries. Sub-Saharan Africa has been the hardest hit and in South Africa it is estimated that 10 percent of its 45 million people are infected with the virus.

But, the pandemic is not limited to Africa: Asia will soon have more new HIV infections than any other region and Russia is the new “hot spot” for the disease. The disease is ravaging families and communities and young people have been particularly devastated. Every minute, five young people contract HIV/AIDS--more in the world and in Southern Africa it is projected that more than half of today’s teenagers will become infected and die of AIDS.

UNAIDS has estimated that it would take $3 billion to address HIV/AIDS in Africa alone (excluding access to drugs) and while the international community is providing less than $1 billion a year for HIV/AIDS programs in the developing world.

The world looks to the United States to be a leader and now is the time for the United States to significantly expand its support for global HIV/AIDS programs. The creation of new drugs and vaccines cannot stand alone and we must also invest in the development of public health infrastructure.

This infrastructure will be important as we continue to expand investment in treatment and care programs. In addition, 42 million children will be orphaned by HIV/AIDS by 2010 and we must be prepared to provide good health care to these children across the health spectrum.

All children of the world need our support. As we approach the 10-year anniversary of the World Summit for Children, we must make a strong commitment in their future by investing in the world’s children. Ten million children die before their 5th birthday each year in developing countries from preventable diseases, such as pneumonia, diarrhea and measles.

Yet, funding for the core child survival programs remained fairly stable in the FY 2001 budget. Without additional funding, the successful child survival programs will not continue to provide needed services for young girls and boys in developing countries. Through its research and development programs, the United States has developed interventions that work. Clean water and sanitation prevent infections, and oral rehydration therapy (a simple salt sugar mixture taken by mouth, which costs only pennies) has been proven to be among the most effective public health interventions ever developed.

Immunization programs have also proven to be successful and almost 75 percent of children are immunized today in developing countries.

Annually, immunizations avert two million childhood deaths from measles, neonatal tetanus, and whooping cough. The success of these programs is striking and the U.S. should reaffirm its commitment to children as we meet with other world leaders at the UN Special Session for Children in September, 2001.

Another equally compelling problem that has not yet been given the recognition it deserves is the death of 600,000 women each year during pregnancy and childbirth—one woman every minute.

Over 80 percent of these deaths are due to complications that are routinely prevented in the developed world, such as obstructed labor, infections and unsafe births. 99 percent of these 600,000 deaths could be averted.

Of all the health statistics monitored by the World Health Organization, the figures on maternal mortality reveal the largest discrepancy between developed and developing countries.

Women in developing countries are 18 times more likely to die during childbirth than
women in developed countries. This disparity does not need to continue. The WHO has identified a path forward for health interventions that for a cost of $1–$3 per mother, could save the lives of countless mothers and their children.

This small investment in mothers will have an enormous impact on the families of tomorrow.

Other interventions, such as family planning, also play a large role in protecting the integrity of a family.

One third of the world’s population is between the ages of 10 and 24. As these young people begin to raise families, the demand for safe voluntary family planning services will increase dramatically.

Many women will choose to have children and over 200 million will become pregnant in the coming year.

But, following the birth of a healthy child, many couples prefer to delay or cease childbearing. About a quarter of a billion couples around the world find themselves in this situation and they do not have access to voluntary contraceptive methods. As a result, many pregnancies are unwanted.

The World Bank has found family planning to be one of the best ways to improve maternal and child health and it is time for the U.S. to significantly expand funding and support for the international family planning programs at the U.S. Agency for International Development and increase the U.S. allocation to the United Nations Population Fund.

The final important piece of the Global Health Act is the increased funding for programs that address infectious diseases.

My own district was surprised and concerned when West Nile Encephalitis entered our community during the Summer of 1999. This incident reminded us that infectious diseases know no geographic boundaries, and are crossing U.S. borders with greater frequency.

Tuberculosis has re-emerged on the world stage in deadlier and more drug resistant forms.

With the appearance of multi-drug resistant tuberculosis, and its spread to Europe and the U.S., we face the possibility that this could again become a leading killer. But, through effective collaborative projects, the United States has been able to leverage its support for infectious disease programs and rates of malaria and polio are decreasing.

In just the past ten years, the number of polio cases worldwide has fallen by almost 50 percent and the death toll from malaria has been reduced by 97 percent. These partnerships have proven to be very fruitful and are crossing national borders with greater frequency.

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EXTENSIONS OF REMARKS

ORGANIZATIONS ENDORsing THE GLOBAL HEALTH ACT OF 2001

1. Adventist Development and Relief Agency.
2. Advocates for Youth.
5. Alan Guttmacher Institute.
6. Alliance Lanka.
7. American Association for the Advancement of Science.
8. American Association of University Women.
10. American International Health Alliance Organization.
11. American Society of Tropical Medicine and Hygiene.
16. Association of Reproductive Health Professionals.
17. Association of Schools of Public Health.
18. Baertracks.
19. The Centre for Development and Population Activities—CEDPA.
20. Catholics for a Free Choice.
22. Center for Women Policy Studies.
25. CONRAD Program.
27. Elizabeth Glaser Pediatric AIDS Foundation Organization.
28. Family Care International.
29. Female Health Company.
30. FOCUS.
32. Global AIDS Alliance.
34. Infectious Diseases Society of America.
35. InterAction.
38. Institute for Global Health.
40. Joint Action Against AIDS Nigeria.
41. Management Sciences for Health.
42. National Abortion and Reproductive Rights Action League.
43. National Association of People with AIDS.
44. National Audubon Society.
45. National Family Planning and Reproductive Health Association.
47. Programs for Appropriate Technology in Health.
50. PLAN International.
52. Population Institute.
54. Project Hope.
55. Rights Action Center of Action for Jus
desm.
56. San Francisco AIDS Foundation.
57. Save the Children.
58. United Methodist Church, General Board of Church and Society.
59. U.S. Coalition for Child Survival (see members list below).
60. U.S. Committee for UNICEF.
61. U.S. Fund For UNICEF.

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64. Unitarian Universalist Service Committee.
65. University of North Carolina at Chapel Hill.
66. White Ribbon Alliance for Safe Motherhood (see members list below).
67. Women’s EDGE.
68. World Neighbors.

MEMBERS OF THE U.S. COALITION FOR CHILD SURVIVAL


Academy for Surveys and Studies, Advance Africa, Adventist Development and Relief Agency (ADRA), Aisyiyah, Indonesia, AIWC, American Association of World Health, American College of Nurse Midwives (ACNM), American Women’s Association, Indonesia, APIK, Archik Samata Mandra, Association of Women’s Health, Obstetric, & Neonatal Nurses, Association for Maternal and Child Health Concern in Nigeria, AusAID WHF Project/OPCV.

Biodun Mac/eye Clinic, North Tongu, The Global Registered Midwives Assoc., BKKN (National Family Planning Coordinating Board), BSKW (Coordinating Body of Women’s Organizations, West Java), Cambodian Midwives Association, Canadian Women’s Association, Indonesia, CARE, CARE—India, CASP, Catholics for Contraception, Center for Development Control, Center for Development and Population Activities (CEDPA), Center for Human Survival, Nigeria, Center for Reproductive Law and Policy (CRLP), CHEPTA, Child Survival Collaborations and Resources (CORE) Group, Children’s Association of Nigeria, CMAI, Children’s Children’s Fund, Community Based Health Care Women’s Group, Kimillili, Kenya, CRS, DFID, EEC, EngenderHealth, Equilibres et Populations, France, Family Care International, National Federation, Women’s Association of Muslim, FK—PKMI (Collaborative Forum—for the Promotion of Community Health, Indonesia), Ford Foundation, Indonesia.

Jakarta International School, JIPPEGO, Indonesia, Johns Hopkins University—PCUS, Johns Hopkins University—School of Public Health, JHU/CPCP, Kalyanamitra, La Lesche League International, Linkages Project, Academy for Educational Development, Local Government Service Commission, Nigeria, Loma Linda School of Public Health, Mamtta Health Institute for Mother and Child—India, Market Women’s Association, Nigeria, Matrika, MELIS Production, Indonesia, Mitra Perempuan (Wone in Sisterhood), MNH Program Indonesia, MotherCare/John Snow International (JSI), Indonesia, National Union of Teachers, Nigeria, NGO Networks for Health, NGO Networks for Health, Armenia, Nurses Association, Nigeria, Organization For Student Health Care Services, Monrovia, Liberia, Pacific Institute for Women’s Health, PATH, Indonesia, Pathfinder International, UNESCO.
LEGISLATION CLARIFYING THE INCOME FORECAST METHOD

HON. MARK FOLEY
OF FLORIDA
IN THE HOUSE OF REPRESENTATIVES
Wednesday, March 28, 2001

Mr. FOLEY. Mr. Speaker, Congressman BECERRA and I introduced legislation today to clarify the income forecast method.

As Chairman of the House Entertainment Industry Task Force, I have understood that changes made in the Small Business Job Protection Act of 1996 that modified depreciation under the income forecast method have had unintended consequences for the movie industry. Our legislation corrects those consequences.

The “income forecast” method is a method for calculating depreciation under section 167 for certain property, including films. Under the income forecast method, the depreciation deduction for a taxable year for a property is determined by multiplying the cost of the property by a fraction, the numerator of which is the income generated by the property during the year and the denominator of which is the total forecasted or estimated income to be derived by the property during its useful life.

The total forecasted income to be derived from a property is based on conditions known to exist at the end of a period for which depreciation is claimed and these could be revised upward or downward at the end of a subsequent taxable year based on additional information that becomes known after the last estimate.

In the case of films, income to be taken into account means income from the film less the expense of distributing the film, including estimated income from foreign distribution or other exploitation of the film including future television exhibition.

The Small Business Job Protection Act addressed the income forecast method in order to make the formula a more appropriate method for matching the capitalized costs of certain property with the income produced by such property. While the new law modified the method by including all estimated income generated by the property, however, it made no changes to the treatment of participations.

Projected participations—such as percentages of the gross receipts due an actor—have been included and accounted for in the income produced by a film ever since studios have been forced to forecast the total revenues of a film under the income forecast method. But the Internal Revenue Service (IRS) has indicated that it will disallow participations as part of a film. Participations were not an issue addressed by modification to the income forecast method.

Studies have negotiated their complex transactions on the clear and well-established principle that the cost of a film includes participations.

The legislation that we have introduced today will ensure that participations are a part of the total cost of a film. First, the legislation would guarantee that income-contingent costs are includible in basis, thereby accepting the conclusion of Transamerica Corp. v. U.S. The legislation provides that the depreciation allowance, as so determined, will apply notwithstanding section 404 or section 419. There would be “no inference” clause with regard to films placed in service after the effective date to the 1996 amendments to section 167 (that is, films placed in service after September 13, 1995).

Second, the look-back regime is tightened in two ways: (i) a third recomputation year is added; and (ii) the 10 percent de-minimis rule is applied on an annual basis not on a cumulative basis in the recomputation year. Thus, if the taxpayer initially estimates that the film’s ultimate income will be $1,000X and the estimated ultimate income in year two is increased or decreased by more than 10 percent, then the look-back computation is required for that year. The 10 percent threshold then applies to the new estimated ultimate income.

This legislation was the result of consultations with the staff of the Committee on Ways and Means and the Joint Committee on Taxation. An analysis was done of the legislation for films in the following three situations: (1) where the film takes off late; (2) where the film falls short of expectations; and (3) where the film exceeds expectations. For each scenario, calculations were done using escalating income-contingent costs, and provided calculations on both an annual basis and a cumulative basis of accounting for adjustments to forecasted revenues. The conclusion confirmed that the legislative changes would not create distortion under the income forecast method.

We look forward to working with the Committee on Ways and Means to find the appropriate legislative vehicle to address this technical correction that will reiterate Congressional intent on changes made to the income forecast method in the Small Business Job Protection Act.

THE IMPORTANCE OF COMMUNITY HEALTH CENTERS

HON. MICHAEL BILIRAKIS
OF FLORIDA
IN THE HOUSE OF REPRESENTATIVES
Wednesday, March 28, 2001

Mr. BILIRAKIS. Mr. Speaker, today, I would like to discuss the importance of community health centers.

Since 1965, America’s health centers have delivered comprehensive health and social support services to people who otherwise would be uninsured individuals, and families. They have negotiated their complex transactions on the clear and well-established principle that the cost of a film includes participations.

Community health centers are not-for-profit health care providers and are required by law to make their—thrive accessible to everyone, regardless of their ability to pay.

There are more than 1,000 community health centers located in every state, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands. Collectively, these centers serve as a health care safety net for more than 11 million patients, over 4 million of whom are uninsured.

Health centers foster growth and development in their communities. Over $4 billion in annual economic activity is generated by health centers in many of America’s most economically depressed communities, and they employ over 50,000 people and train thousands of health professionals and volunteers.

Community health centers offer a wide range of preventative and primary medical and dental care, as well as health education, community outreach, transportation, and support programs. Health centers focus on wellness and early prevention—the keys to cost savings in health care. Through innovative programs in outreach, education and prevention, health centers reach out and energize communities to meet urgent health needs and promote greater personal responsibility for good health.

For less than one dollar per day for each person served (less than $350 annually), health centers provide quality primary and preventative care to uninsured, unprepared and early prevention—those who lack assistance without a significant increase in their appropriations.

President Bush recognized the importance of health centers with his recent proposal to double the number of patients health centers serve over the next five years. I strongly support this proposal, and an increase in funding this year is the first step needed to reach this goal.

Today, America’s health centers are the family doctor and health care provider for over 10 million people. Expanding the role of community health centers is a proven, viable, and cost effective way to bring quality health care to uninsured patients and medically underserved communities.