Putin statements calling for a nuclear free Korean Peninsula. The DPRK, Vice Minister Kim, acknowledged this as a valid point, but indicated that the other nations can rely on the U.S. ''nuclear umbrella,'' while the DPRK has no such option.

A major issue often voiced by DPRK officials remains a requirement on their part to achieve a satisfactory framework for bilateral discussions because of their belief that certain issues ''are too serious'' to be dealt with in an multilateral framework. The delegation believes flexibility exists within a multilateral framework to satisfy the DPRK officials desires for bilateral discussions.

Requested visits by the delegation to the Pyongyang Information (Computer) Center, a school for gifted students, Kim Il Sung's birth place, the North Korean movie studio production facilities, and a Christian church as well as casual evening social events permitted the delegation to interact with a wide variety of North Koreans and to travel to several sections of the city.

Prior to departure, Ministry of Foreign Affairs officials extended an open invitation to the delegation for a return visit and further indicated a willingness to consider visits to the Yong Byon nuclear facility.

*Seoul, ROK*

In Seoul, the delegation was hosted by President Roh for a breakfast meeting, met with Foreign Minister Yoon, Members of the National Assembly, Ambassador Hubbard, General LaPorte, and other officials to discuss the meetings in the DPRK. The ROK officials expressed their appreciation for the efforts of the delegation and reinforced the need for dialogue with the North.

*Observations*

Each of the senior DPRK officials with whom the delegation met cited the importance of the visit, given the current tense relationship between the DPRK and the U.S. They also noted their understanding of the role of Congress and that the delegation was not visiting to negotiate issues for the United States, but to enhance mutual understanding between the two nations.

In each of the meetings, Chairman Weldon cited the past and continued importance of inter-parliamentary exchanges in improving relationships with nations and improving the well-being of the peoples once considered to be enemies of the United States, including the People's Republic of China and the U.S.S.R., and expressed his belief that this could be the case with the DPRK once normalized relations could be established. He also expressed his belief that no one in the Congress wishes ill-will toward the North Korean people and that no one wants another war.

Each of the senior DPRK officials noted the tense international situation and sought to place the blame on the U.S. ''because the U.S. seeks to make us give up our military forces which safeguard our political system.'' Each of the leaders also cited their preference for the ''Clinton approach'' in the bilateral relationship and took strong exception to President Bush's inclusion of the DPRK as part of the ''Axis of Evil.'' They stated their belief that such a characterization demonstrates that the U.S. is unwilling to ''accommodate with our country'' and the U.S. seeks regime change. ''Further, the U.S. is enlisting other nations to prepare a nuclear first strike—seeking to blackmail and intimidate us . . . The U.S. does not want to coexist with us . . . And not only does the Bush Administration not want to coexist, but wishes to get rid of my nation with its nuclear strength . . . We see the U.S. preparing for a military strike . . . The U.S. must change its hostile policy.'' Without necessarily supporting the Bush Administration policies toward the DPRK, all members of the delegation agreed with Representative Engel's point to DPRK officials, that violations of the 1994 Agreed Framework by the DPRK were the reason for the current tensions, not Bush Administration policies.

The DPRK officials stated their belief that the situation can only be resolved by acceptance of the current leadership—coexistence—and dialogue. And in the meantime it intends to continue to develop its ''restraint capability'' (nuclear deterrent). ''We have tried dialogue and have been patient . . . Our willingness to meet in Beijing in April shows our flexibility to allow the U.S. to save face, showing our flexibility and sincerity to resolve the issues at any cost . . . We have not had concrete results. The Bush Administration has not responded to our request for bilateral talks—they are more focused on our first giving up our nuclear program . . . This causes us to believe that the Bush Administration has not changed its policy about disarming my nation . . . We want to conclude a non-aggression treaty between the two countries and avoid a military strike on my country.''

DPRK officials explicitly reconfirmed their nation's possession of nuclear weapons and repeated previous public statements regarding the reprocessing of the 8,000 spent fuel rods from the Yong Byon facility. They also indicated they will use the reprocessed materials for making weapons. They further indicated that the only option open to them, given their inclusion in the ''Axis of Evil'' and U.S. refusal to engage in bilateral discussions, ''is to strengthen and possess restraint (deterrent) capability and we are putting that into action . . . I know some say we possess dirty weapons. We want to deny they are dirty ones . . . I apologize for being so frank, but I believe you have good intentions and I want to be frank. We are not blackmailing or intimidating the U.S. side. We are not in a position to blackmail the U.S.—the only super power. Our purpose in having a restraint (deterrent) is related to the war in Iraq. This is also related to statements by the hawks within the the U.S. Administration. Our lesson learned is that if we don't have nuclear restraint (deterrent), we cannot defend ourselves.''

DPRK officials maintained that their nuclear program is only for deterrence and not being pursued to seek economic aid—that ''we only wish to be left alone. The nuclear issue is directly linked to the security of our nation . . . We need frank exchange on nuclear policies.'' DPRK officials indicated that economic sanctions would be viewed as a proclamation of war.

*Attachment 1*

CODEL WELFON—Members of Congress: Curt Weldon (R–PA); Solomon Ortiz (D–TX); Silvestre Reyes (D–TX); Joe Wilson (R–SC); Jeff Miller (R–FL); Eliot Engel (D–NY).

Professional Staff: Doug Roach; Bob Lautrup.

State Department Interpreter: Tong Kim.

Navy Escorts: Commander Lorin Selby; Lt Commander/Dr. Erik Sawyers; Lt Frank Cristinzio; Lt Tamara Mills.

*Attachment 2*

DPRK—PAEK, Nam Sun, Foreign Minister; KIM Gye Gwan, Vice Minister, Ministry of Foreign Affairs; CHAI Tae Bok, Chairman, Supreme People's Assembly (SPA); CHO, Seung Ju, Director General, Bureau of U.S. Affairs, Ministry of Foreign Affairs; RHEE Sang No, Director of External Affairs, Presidium of SPA; PAK Myong Guk, Director of U.S. Affairs, Ministry of Foreign Affairs.

ROK—ROH, Moo-Hyun, President; YOON, Foreign Minister; YOO, Jay-Kun, Member, National Assembly; KIM Un-yong, Member, National Assembly; LEE, Jae-joung, Member, National Assembly; SONG, Young-gil, Member, National Assembly; LEE By-yang, Member, National Assembly; PARK, Jin, Member, National Assembly; KIM, Suh-woo, Chief of Staff to the Speaker, National Assembly; SOHN, Jang-nai, former Ambassador to Indonesia; Thomas C. Hubbard, U.S. Ambassador to ROK; General Leon LaPorte, Commander, USFK.

## HEALTH DISPARITIES AMONG MINORITIES

The SPEAKER pro tempore. Under the Speaker's announced policy of January 7, 2003, the gentleman from Illinois (Mr. DAVIS) is recognized for the remaining time before midnight as the designee of the minority leader.

Mr. DAVIS of Illinois. Mr. Speaker, I had planned to talk about health care as a result of the Congressional Black Caucus' chairman, the gentleman from Maryland (Mr. CUMMINGS), coming to Chicago on Sunday to participate in a forum dealing with health care issues that is going to be held at the Illinois Institute of Technology.

But listening to much of the discussion this evening as special order speeches have been made talking about tax cuts and tax breaks and which groups got them and which groups did not, I could not help but be reminded of the fact that President Bush has been in office now for about 2 years after being selected by the Supreme Court, and has actually presided over one of the worst downturns in our Nation's history. We have lost 2.7 million jobs, as many as 500,000 in the last 2 months alone. The only answers that I have heard the Republicans give is, tax cuts, tax cuts, and more tax cuts as we have gone from a surplus to a $350 billion deficit, the largest deficit in the history of this country.

As I listen to all of the information about tax cuts and the inability to give certain groups a break, the top 1 percent of the tax cuts that we have made will receive on an average of $24,100 in 2003, this year. Those with incomes of more than $1 million will receive an average of $93,500.

I hear people talk about what will happen for small businesses, and 52 percent of small business owners will only get between zero and $500. Seventy-nine percent of the benefits will go to individuals who have incomes of over $100,000. Twenty-nine percent of the population will go or 29 percent of the breaks will go to individuals who make more than $1 million.

More than two-thirds of the tax cuts will go to the top 10 percent of the population, and over 50 percent of the tax cuts will go to the top 5 percent of the population. The bottom 60 percent of the taxpayers will only get 8.6 percent, averaging less than $100 a year for the next 4 years. The average reduction for the richest 1 percent will be $103,899 for 4 years. Thirty-nine percent will go to this tiny group. The best off 1 percent of the population will get 52 percent of the benefit.

I am not one that always pays a great deal of attention, but oftentimes

I do read them, to what newspapers have to say about these proposals and what we are doing. But as we talk about the need to stimulate the economy, I was reading the New York Times on May 9, and they indicated or they stated, they said, that lower-income families, of course, would be the quickest to spend the money to help provide some of the stimulus the Republicans claim is their first priority. Instead, the GOP remains fixated on high-income concerns. Framing the reconciliation talks is more than an exercise in dueling sugar plums.

So I guess, concerning this whole business of who gets what, a friend of mine told me the other day that there was a quote that said the history of the world, my friend, is relationships between where the money goes, and that after everything else is talked about, look and see where the money goes.

It seems to me that as we have dealt with the tax cut issue, most of the money continues to go to the wealthy. Most of the money continues to go to those who have the most.

At any rate, our health situation is still in bad shape. I am going to spend the rest of my time talking a little bit about that. Our health care system is unacceptable for the world's most powerful and wealthy country. I would say that the state of health care in this country is one of the top critical issues facing the Nation. I do not believe that it can be cured by putting too much of our resources in one population group.

Even as we come to an end of the war against Iraq, there will still be and still are individuals in need of health care. It is true that the state of education, the state of unemployment, and the state of housing are all in dire need of improvement, as well; but they all connect to the need to have a solid, concrete health care system that serves all people.

The state of one's health sets the precedent for everything else in our lives. If we are not in good health, we cannot perform our jobs well or do well in school. If we are not in good health and do not have insurance, we end up with an exorbitant amount of debt that will be virtually impossible for anyone to pay off, if we have been sick.

The numbers are absolutely startling. There are approximately 60 million people without health insurance at some point during the year in this country. Many people believe that it is only the unemployed or individuals with low incomes that cannot afford health insurance.

However, nearly 80 percent of the uninsured are individuals from working families who cannot afford health insurance or cannot access employer-provided health insurance plans. More than one out of every five families making $75,000 a year or more has at least one member without health insurance.

□ 2320

In Chicago, those making between $25,000 and $75,000 or 34 percent have at least one family member without health insurance, as do 41 percent of families making up to $25,000. In Illinois, almost 10 percent of those with at least a bachelor's degree and 20 percent of full time workers are uninsured. America needs to realize that the face of the uninsured has changed. The level of education or salary will not automatically guarantee an individual insurance anymore.

The health crisis is not only due to the number of uninsured in our Nation. There are millions more than the estimated 60 million uninsured at some point that have less comprehensive insurance than what they actually need, and, therefore, are under-insured. They are the families working for small firms or family-owned businesses that are being hit the hardest by the current state of the economy, forcing the employers to cut back and have the employee pay higher premiums. There are senior citizens on Medicare that are being denied care by physicians who can no longer afford to care for them. These are the components of a failing health care system. With State and the Federal Government slashing Medicaid, the safety net we once depended on is instead not a net at all.

Currently in Congress there are numerous resolutions that would help mend our Nation's health care crisis as a whole. The proposed solutions range from a refundable tax credit, to purchasing private insurance, to Congress enacting health care for every American, to amending the United States Constitution. There are also resolutions to help to resolve a single issue plaguing the health system, whether it is the cost of prescription drugs, the reimbursement amounts for a mammogram under Medicare, or a new formula for FMAP.

Although minor changes in health care may be easier for a Member to get passed, it allows many Americans to remain stuck, still unable to afford expensive health insurance. I believe that Congress must act sooner rather than later and reform our health care system as a whole.

One of my American Medical Student Associate fellows, Amanda Muellenberg, once explained the problem of fixing Medicare piece by piece with an old Dutch story. She said there was once a young boy walking down the road and realized that the town's dike had a hole in it. To save the town, the young boy put his thumb in the hole to stop the leaking. Soon another crack and a hole appeared and then another and another. It was not long until the young boy ran out of fingers to clog the holes, and still with all his efforts, he could not stop the dike from leaking. Instead of clogging each new hole in our health care system, we need to rebuild it.

The Kaiser Family Foundation found that uninsured Americans cost Federal, State, and local governments about $35 billion in 2001. Much of that money went to treating individuals who had become seriously ill due to a lack of medical attention. I believe this amount that is spent on helping the uninsured ill could be better used to give screenings and preventative care, leaving less of a financial burden on taxpayers and hospitals for admissions.

President Bush made the commitment to America to leave no child behind in education. Instead, we need to ensure that no American is left behind in preventative care, access to medical treatment, and affordable insurance. The way to accomplish this and the only real way is through enactment of a national health plan, where everyone is in and nobody is out. And as much of a problem that we have across the board with health care and health insurance, when it comes to some population groups, especially when it comes to minorities, nowhere are the divisions of race, ethnicity, and culture more sharply drawn than in the health of the people in the United States.

Despite recent progress in overall national health, there are continuing disparities in the incidents of illness and death among African-Americans, Latino/Hispanic-Americans, Native Americans, Asian-Americans, Alaskan Natives and Pacific Islanders as compared with the U.S. population as a whole. We can point to 6 areas in particular: One, cancer; two, cardiovascular disease; three, infant mortality; four, diabetes; five, HIV/AIDS; and six, child and adult immunizations, aggressively.

Cancer, for example, research shows in general that people of diverse racial, ethnic, and cultural heritage are less likely to get regular medical checkups, receive immunizations, and be routinely tested for cancer when compared with the majority of the U.S. population. Cancer deaths are disproportionately high among Latino/Hispanic-Americans and African-Americans. Vietnamese women are 5 times more likely to have cervical cancer and Chinese-Americans are 5 times more likely to have liver cancer.

Cardiovascular disease. Disparities exist in the prevalence of risk factors for cardiovascular disease, coronary heart disease and stroke. Racial and ethnic groups have higher rates of hypertension, tend to develop hypertension at an earlier age, and are less likely to undergo treatment to control their high blood pressure.

Mexican-American men and women have elevated blood pressure rates. Obesity continues to be higher for African-American and Mexican-American women. Only 50 percent of Native American, 44 percent of Asian-Americans, and 38 percent of Mexican-Americans have had their cholesterol checked within the past 2 years. Coronary heart disease mortality is higher for African-Americans. Stroke is the only leading cause of death for which mortality is higher for Asian-American males.

We look at infant mortality, current studies document that despite advances, African-American and Native American babies still die at a rate that is 2 to 3 times higher than the rate for white Americans. Infant mortality is really a measure that health professionals use to measure quality of life. If infant mortality is high, it usually means that the quality of life is low. If infant mortality is low, it usually means that the quality of life is high.

Statistics revealed that among Native Americans and Alaskan Natives, the incidents of Sudden Infant Death Syndrome, SIDS, is more than 3 to 4 times the rate for white American babies. And while the overall infant mortality rate has declined, the gap between black and white infant mortality rates has widened.

□ 2330

Diabetes, studies indicate that diabetes is the 7th leading cause of death in the United States. Approximately 16 million people in the U.S. have diabetes. African Americans are 1.7 times more likely. Latino Hispanic Americans are 2.0 times more likely. The Alaskan natives and Native Americans are 2.8 times more likely to have diabetes than whites. The Pima tribe of Arizona has the highest known prevalence of diabetes of any population in the world. Native Americans and African Americans have higher rates of diabetes-related complications such as kidney disease and amputation as compared to the total population.

HIV/AIDS, recent data from prevalence surveys and from HIV/AIDS cases surveillance continue to reflect the disproportionate impact of the epidemic on racially, ethnic and linguistically diverse population groups, especially women, youth and children.

The African Americans and Hispanic Latino group accounted for 47 and 20 percent respectively of persons diagnosed with AIDS in 1997. Among African Americans, 56 percent of new HIV infection and AIDS cases are a result of intravenous drug usage. For Hispanic Latino groups, 20 percent of new HIV infections and AIDS cases results from intravenous drug use. Seventy-five percent of HIV/AIDS cases reported among women and children occur among diverse racial and ethnic groups.

Six, child and adult immunizations. Statistics from the President's Initiative on Race reveal that for the most critical childhood vaccines, vaccination levels for preschool children of all racial and ethnic groups are about the same. However, immunization levels for racial and ethnic groups are lower.

School age children and elder adults of diverse racial and ethnic backgrounds continue to lag when compared to the overall vaccination rates for the U.S. general population. While 79 percent of white preschoolers are fully immunized by 2 years of age, only 74 percent of African American and 71 percent of Hispanic Latino children, including preschoolers and school age children, are fully vaccinated against childhood diseases.

Annually, approximately 45,000 adults die of infections related to influenza, pneumonia infections and hepatitis B, despite the availability of preventive vaccine. Among the elderly, there is a disproportionate amount of vaccine preventable diseases in racial, ethnic and underserved populations.

Although the reasons for these disturbing gaps are not well understood, it appears that disproportionate poverty, discrimination in the delivery of health services and the failure of health care organizations and programs to provide culturally competent health care to diverse racial, ethnic and cultural populations are all contributing factors.

For people under 65, blacks and Hispanics have a higher percentage of being uninsured than whites; 12.7 percent of non-Hispanic whites are uninsured; 22.8 percent of blacks are uninsured; and 24 percent of Hispanics are uninsured.

Minorities face greater difficulty in communicating with physicians. Hispanics are more than twice as likely as whites, 33 percent versus 16 percent, to cite one or more communication problems, such as understanding the doctor, not feeling the doctor listens to them or that they had questions for the doctor but did not get asked. Twenty-seven percent of Asian Americans and 23 percent of blacks cite that they also have communication problems.

Minorities, of course, are more likely to be without a regular doctor. Hispanics are twice as likely to not have a regular doctor than whites, 41 percent versus 19 percent. Thirty-one percent of Asian Americans and 28 percent of blacks are without a regular doctor.

Compared with the rates for whites, coronary heart disease mortality was 40 percent more for Asian Americans but 40 percent higher for blacks in 1995. Stroke is the leading cause of death for which mortality is higher for Asian American males than for white males.

Racial and ethnic minorities have higher rates of hypertension, tend to develop hypertension at an earlier age, are less likely to undergo treatment to control their blood pressure. From 1988 to 1994, 35 percent of black males 20 to 74 had hypertension compared to 25 percent of all men.

Among adult women, the age-adjusted prevalence of overweight continues to be higher for black women, 53 percent, and Mexican American women, 52 percent, than for white women. Only 50 percent of American Indians, native Alaskans, 44 percent of Asian Americans and 38 percent of Mexican Americans have had their cholesterol checked in the last 2 years.

According to the 2001 Surgeon General's Report on Mental Health, the prevalence of mental disorders is believed to be higher among African Americans than whites, and African Americans are less likely to be treated for mental problems such as depression or anxiety.

Infant death rates among blacks, American Indians and Alaskan natives and Hispanics in 1995 and 1996 were all above the national average of 7.2 deaths to 1,000 births. The black infant death rate is 14.2 deaths per 1,000 births. This is nearly two-and-a-half times that of white infants, 6 deaths, 1,000 births. Puerto Ricans have a rate of 8.9 deaths, 1,000 births, and overall, American Indians have a rate of 9 deaths to 1,000 live births.

HIV/AIDS is the sixth leading cause of death for African American males and the 10th leading cause of death for African American females. In 2000, 47 percent of all cases reported in the United States were among African Americans. The rate of new AIDS cases among African Americans was almost 10 times higher than among whites.

Cancer is the second leading cause of death in the United States, accounting for more than 544,000 deaths each year. For men and women combined, blacks have a cancer death rate about 35 percent higher than that for whites, 171.6 versus 127 per 100,000. The death rate for cancer for black men is about 50 percent higher than that for white men, 226.8 versus 151.8 per 100,000. The prostate cancer mortality rate for black men is more than twice of that of white men, 55.5 versus 23.8 per 100,000. The death rate for lung cancer is about 27 percent higher for blacks than for whites, 49.9 versus 39.3.

□ 2340

Incident rates for lung cancer in black men is about 50 percent higher than in white men, 110.7 versus 72.6 per 100,000. Native Hawaiian men have also elevated rates of lung cancer compared with white men. Alaskan native men and women suffer disproportionately higher rates of cancer of the colon and rectum than do whites. Vietnamese women in the United States have a cervical cancer rate five times that of white women, 47.3 versus 8.7 per 100,000. Hispanic women also suffer elevated rates of cervical cancer. Black women have the highest death rate from cervical cancer. Stomach cancer mortality is substantially higher among Pacific Islanders, including Native Hawaiians, than other populations.

We mention these numbers because America, our country tis of thee, has a goal to create equal justice, equal opportunity, equal service. The idea that out of many can be one, and one not just in concept but also one in reality. And to make real these ideas, there is obviously a need for special programs and special activities, in addition to changing the way we provide treatment in some instances.

There is a need to increase the numbers of minorities in medical schools, in nursing schools, and to train more professionals. There is the need to put more ambulatory care programs in places where there are none. There is a need to increase accessibility. Of course we know that poverty plays a tremendous role. There is a need for

more education, more assistance for individuals to take control of their own health.

And that is why the Congressional Black Caucus has made health one of its top priority issues. That is why we are pleased that our chairman, the gentleman from Maryland (Mr. CUMMINGS), will in fact be in Chicago on one of his stops as he and other members of the caucus go across the country trying to help raise the issue, trying to help people to understand what they can themselves do, and also continuing to suggest to America that we have to put our resources where our conversations are; that we have to make available quality comprehensive health care to all people in this great country without regard to their ability to pay.

So, Mr. Speaker, as I come to the close of my special order, I want to thank you for your indulgence. I want to thank the American people for watching and listening. And I hope that we can indeed let America be America again, the land that never has been and yet must be. The America that we all continue to dream about. The America that we all continue to hope for. The America that can ultimately crown its good with brotherhood from sea to shining sea. And the America that can have quality comprehensive health care for you and quality comprehensive health care for me.

Ms. LEE. Mr. Speaker, today members of the Congressional Black Caucus rise to expose the truth about minority health disparities in our health care system.

Many of my colleagues will outline the ongoing racial divide when it come to minorities' reliance on emergency and ambulatory services, the issue of access to health care and how minorities are disproportionately uninsured. Others will talk about the leading illnesses and health conditions that kill more Blacks and Latinos than Whites because of social and economic community distrust of the health care system.

However, tonight I want to bring attention to the increasing minority health disparities connected to environmental racism. The simple fact is the environment affects your health, and Blacks, Latinos and other people of color are suffering and dying because of toxins in the environment.

Dr. Martin Luther King, Jr. laid the groundwork when he declared that ''we will not be satisfied until justice rolls down like waters and righteousness like a mighty stream.'' The metaphors of nature are the metaphors of life, and that is fundamentally where environmental justice begins and ends.

Unfortunately, the waters themselves in much of the world are tainted, and the toxic streams flow all too often through neighborhoods at the economic margins of society, particularly minority neighborhoods.

Far too often, the issue of minority health and the environment is ignored. Now, the Administration continues to roll back all of the environmental protections that Democrats have fought for, minorities will pay the highest price of all, trapped in homes near brown fields, power lines and sanitation plants. Democrats must stand against the Administration and the deceptive conservatism that continues to sweep our policy debates and our nation.

Members of the Congressional Black Caucus see the forces of environmental injustice playing themselves out in terms of minority health disparities.

These disparities follow a cradle to grave cycle: beginning with infant mortality, continuing with workplace hazards and increased exposure to pollution, and ending with disparate access to healthcare, diagnoses, and medical treatment.

We see these forces clearly in diseases that strike most deeply into our cities and affect children most severely.

Asthma rates among the urban poor are reaching alarming proportions. Death rates from asthma, and a host of other treatable diseases, are significantly higher among African Americans than any other ethnic group.

In my own district, asthma rates are among the highest in the country, and children in West Oakland are seven times more likely to be hospitalized for asthma than children in the rest of California.

Over twenty-eight percent of low-income African American children suffer from lead poisoning, more than twice the level of exposure among low income white children, and far higher than among children of the middle class or wealthy.

Toxins concentrate along the color lines that have historically divided American society. Children of color are much more likely to suffer from lead poisoning, resulting in devastating effects on mental development. We are also finding that public housing communities have been secretly dealing with mold for years, another place where minorities are disproportionately located. These are minority health injustices that we cannot accept.

Environmental minority health disparities grow not only out of poverty, but racism. We must address the ravages of the past while we forge sounder policies for tomorrow. Our environment may be defined as our surroundings. Inner city neighborhoods that have liquor stores but no grocery stores speak to years of less than benign neglect and to the need for meaningful social and economic investment. That is a form of racism. Superfund sites that are under-funded; factories and plants that emit carcinogens under the protections of grandfather clauses; healthcare that is inadequate and racially biased; all demand our attention and financial resources. They are all forms of environmental racism.

We must demand environment health justice for our communities. The gap between minorities and whites in health care continues to grow, but I stand here today in support of universal health care, more resources for minority health initiatives, and a re-evaluation of the national agenda for health and justice. We must consider the environmental health agenda because it affects our homes, our communities, and the overall health of America.

Mr. CONYERS. Mr. Speaker, in 2002, the Institute of Medicine released a telling report entitled: Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. The report documented many troubling findings which unfortunately, health experts in the underserved communities have been crying out about for decades. It documents the case that the American health care system was set up so that African Americans, Hispanics, and other underserved minorities would receive ''second class back of the bus health care'' in public hospitals and community clinic—many of which are on the verge of economic collapse.

Minority Americans are at least twice as likely as white Americans to be uninsured. More than 30 percent of Latinos and 20 percent of African Americans do not have health insurance—and the gap has been widening over the last decade. Astoundingly, minorities now account for two thirds of the new AIDS cases, and HIV infection is the leading cause of death among younger African Americans. Yet, African Americans are 41 percent–73 percent less likely than whites to receive particular drug therapies.

African American women are far less likely to receive a mammogram than white women and are at far greater risk of being diagnosed with breast cancer. Black men are also 1.5 times more likely to develop prostate cancer than white men, and they are three times more likely to die of the disease. Even more disturbing, African American children are plagued by asthma. They are twice as likely to be diagnosed with the disease and a whopping six times as likely to die from it as white children. Just last month the Harlem Hospital found that an incredible 25 percent of children in central Harlem has asthma—one of the highest rates ever documented in an American neighborhood. Add to all the previously noted findings the fact that African American infant mortality rates are three times higher than the rate for white American babies, and the diagnosis for the future of the African American family seems not only chilling but painfully malignant.

Under George W. Bush and the Republicans, the current health disparities are likely to get worse—the principle reason is that they are gutting health care in general and Medicaid in particular. Medicaid is the bedrock of health coverage for poor Americans in general and minorities in particular—it insures one out of five children in America and two thirds of all nursing home residents.

Because of the budget crisis in the states, the Center on Budget and Policy Priorities has predicted that as many as 1.7 million Americans could lose health coverage entirely under Medicaid cut back proposals in the states. Amazingly, the Bush Administration is opposing efforts to help the States pay their Medicaid responsibilities and help keep poor and minority Americans insured.

This Congress I have been dedicated to bridging the gap in health care disparities amongst Americans. I have introduced a bill that would provide universal health care for all Americans. H.R. 676, ''Medicare For All'' is a national health insurance bill endorsed by 4000 physicians across the country. I also reintroduced H. Con. Res. 99, a resolution that commits to covering all of the uninsured by 2005. Just last month, the Congressional Black Caucus launched campaign to end racial disparities in healthcare by backing my universal healthcare resolution. I am also planning to introduce legislation that will bring Medicaid to anyone earning less than 200 percent of the poverty level. This will allow almost all working poor and unemployed Americans to have health coverage. It will also ensure that major urban hospitals can receive sufficient reimbursements so that they are not forced to shut their doors.

In 2003, in without a doubt the most powerful and wealthy society in the history of the

world, there is absolutely no excuse for the health disparities that are crippling and killing off our African American and minority communities. I urge my colleagues today to support the efforts of the CBC and others who are fighting to improve the health of all Americans.

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

## GENERAL LEAVE

Mr. DAVIS of Illinois. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on the subject of my special order.

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

There was no objection.

## LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mrs. JONES of Ohio (at the request of Ms. PELOSI) for today on account of official business.

Mr. LEWIS of Kentucky (at the request of Mr. DELAY) for today and June 5 on account of a death in the family.

Mr. RYAN of Wisconsin (at the request of Mr. DELAY) for today on account of personal reasons.

## SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. TURNER of Texas) to revise and extend their remarks and include extraneous material:)

Ms. CORRINE BROWN of Florida, for 5 minutes, today.

Mr. PALLONE, for 5 minutes, today.

Mr. DEFAZIO, for 5 minutes, today.

Mr. WAXMAN, for 5 minutes, today.

Mr. LEWIS of Georgia, for 5 minutes, today.

Ms. WOOLSEY, for 5 minutes, today.

Ms. LEE, for 5 minutes, today.

Mr. EMANUEL, for 5 minutes, today.

Mr. GEORGE MILLER of California, for 5 minutes, today.

Ms. SCHAKOWSKY, for 5 minutes, today.

Ms. JACKSON-LEE of Texas, for 5 minutes, today.

Mrs. JONES of Ohio, for 5 minutes, today.

Mr. OWENS, for 5 minutes, today.

Ms. WATSON, for 5 minutes, today.

Mrs. MALONEY, for 5 minutes, today.

Mr. STRICKLAND, for 5 minutes, today.

Mr. BROWN of Ohio, for 5 minutes, today.

Mr. MCDERMOTT, for 5 minutes, today.

(The following Members (at the request of Mr. GUTKNECHT) to revise and extend their remarks and include extraneous material:)

Mr. BURTON of Indiana, for 5 minutes, June 11.

Mr. PENCE, for 5 minutes, today.

Mr. TANCREDO, for 5 minutes, today.

Mrs. BLACKBURN, for 5 minutes, today.

Mr. HENSARLING, for 5 minutes, today.

Mr. FRANKS of Arizona, for 5 minutes, today.

Mr. WOLF, for 5 minutes, June 5.

Mr. COLLINS, for 5 minutes, today.

Mr. BURGESS, for 5 minutes, today.

Mr. DREIER, for 5 minutes, today.

Mr. WELDON of Pennsylvania, for 5 minutes, today.

## EXTENSION OF REMARKS

By unanimous consent, permission to revise and extend remarks was granted to:

Mr. WAXMAN, and to include therein extraneous material, notwithstanding the fact that it exceeds two pages of the RECORD and is estimated by the Public Printer to cost $780.

## SENATE BILL REFERRED

A bill of the Senate of the following title was taken from the Speaker's table and, under the rule, referred as follows:

S. 313. An act to amend the Federal Food, Drug, and Cosmetic Act to establish a program of fees relating to animal drugs; to the Committee on Energy and Commerce.

## ADJOURNMENT

Mr. DAVIS of Illinois. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 11 o'clock and 45 minutes p.m.), the House adjourned until Thursday, June 5, 2003, at 10 a.m.

## EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

2511. A letter from the Congressional Review Coordinator, Department of Agriculture, transmitting the Department's final rule — Importation of Beef from Uruguay [Docket No. 02-109-3] received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

2512. A letter from the Director, Regulations Policy and Management Staff, Department of Agriculture, transmitting the Department's final rule — Change in Disease Status of Canada Because of BSE [Docket No. 03-058-1] received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

2513. A letter from the Under Secretary, Department of Defense, transmitting the Department's quarterly report entitled, ''Acceptance of contributions for defense programs, projects and activities; Defense Cooperation Account,'' pursuant to 10 U.S.C. 2608; to the Committee on Armed Services.

2514. A letter from the Director, Regulations Policy and Management Staff, Department of Health and Human Service, transmitting the Department's final rule — Ingrown Toenail Relief Drug Products for Over-the-Counter Human Use [Docket No. 02N-0359] (RIN: 0910-AA01] received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2515. A letter from the Director, Regulations Policy and Management Staff, Department of Health and Human Services, transmitting the Department's final rule — Antidiarrheal Drug Products for Over-the-Counter Human Use; Final Monograph [Docket No. 78N-036D] (RIN: 0910-AA01) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2516. A letter from the Director, Office of Management and Budget, transmitting the Office's FY 2002 report on Federal Government Information Security Reform; to the Committee on Government Reform.

2517. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Exclusive Economic Zone Off Alaska; Yellowfin Sole by Vessels Using Trawl Gear in Bycatch Limitation Zone 1 of the Bering Sea and Aleutian Islands Management Area [Docket No. 021212307-3037-02; I.D. 052103B] received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Resources.

2518. A letter from the Deputy Assistant Administrator for Regulatory Programs, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Magnuson-Stevens Fishery Conservation and Management Act Provisions; Fisheries of the Northeastern United States; Monkfish Fishery; Framework Adjustment 2 [Docket No. 030225045-3096-02; I.D. 020603A] (RIN: 0648-AQ29) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Resources.

2519. A letter from the Assistant Administrator for Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Caribbean, Gulf of Mexico, and South Atlantic; Coastal Migratory Pelagic Resources of the Gulf of Mexico and South Atlantic; Reef Fish Fishery of the Gulf of Mexico; Revision of Charter Vessel and Headboat Permit Moratorium Eligibility Criterion [Docket No. 030303053-3118-02; I.D. 022403] (RIN: 0648-AQ70) received May 30, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Resources.

2520. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Drawbridge Operation Regulations: Mystic River, CT [CGD01-03-047] received May 29, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2521. A letter from the Attorney, Research and Special Programs Administration, Department of Transportation, transmitting the Department's final rule — Hazardous Materials: Requirements for Maintenance, Requalification, Repair and Use of DOT Specification Cylinders; Correction of Compliance Dates [Docket No. RSPA-01-10373 (HM-220D)] (RIN: 2137-AD58) received May 29, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2522. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Special Local Regulations for Marine Events; Atlantic Ocean, Point Pleasant Beach to Bay Head, New Jersey [CGD05-03-049] (RIN: 1625-AA08) received May 29, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2523. A letter from the Chief, Regulations and Administrative Law, USCG, Department