

million to develop a set of telephone numbers, \$100 million to build seven planned communities with 3,258 houses, \$10 million to finance 100 prison building experts, \$50,000 for garbage trucks. How about \$850 million for health construction and medical equipment, \$20 million for Afghanistan consultants, whatever they are, and \$900 million to import petroleum products such as kerosene and diesel to a country with the world's second largest oil reserves?

Some of these requests do not make sense. Instead of again dipping into the pockets of working Americans and risking veteran benefits for our troops when they return home, I support proposals to suspend the tax cuts for the top 1 percent of income earners to pay for the President's \$87 billion request for Iraq; and I urge Congress to consider my bill, H.R. 3051, to include support for our troops in this supplemental package on Iraq.

Again, my bill provides for a \$1,500 bonus to military personnel who served under the Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard or Reserves in a combat zone under Operation Iraqi Freedom or Operation Enduring Freedom.

In the coming year, in this coming year, an estimated 150,000 young men and women will not see their families. A record number of Reservists and Guardsmen and women will put their private sector opportunities and employment on hold, and thousands of children every night will say a prayer for their parent's safe return. These extraordinary times deserve extraordinary measures. I urge Members to support my bill, H.R. 3051, to provide our troops in Iraq and Afghanistan a \$1,500 bonus, a bonus they certainly deserve, and make this part of the supplemental appropriation bill.

HEALTH DISPARITIES

The SPEAKER pro tempore. Pursuant to the order of the House of January 7, 2003, the gentleman from New Jersey (Mr. PALLONE) is recognized during morning hour debates for 5 minutes.

Mr. PALLONE. Mr. Speaker, this afternoon I would like to discuss the issue of health disparities.

Unfortunately, Mr. Speaker, we have a system of delivering health care in the United States that has resulted in severe disparities along racial and ethnic lines in health care access, quality of care, and also health outcomes. All Americans deserve equal treatment in health care, and in an effort to appropriately address this issue, Democrats will soon offer legislation to eliminate these racial and ethnic health disparities.

Mr. Speaker, there are several principles that I would like to highlight that will be reflected in the Democrat's bill. I emphasize that Democrats are committed to ensuring that minority communities aren't burdened by higher prevalence or incidence of disease and illness than the general population.

Some of these principles involve expanding the health care safety net. There is a lack of health insurance for many minorities and also access to adequate health services. This results in significant declines in health status within racial and ethnic minority communities.

Also, we need, and this is the second principle, to diversify the health care workforce. Efforts must be made to recruit and train health care professionals from underrepresented groups.

Third, we have to ensure that health care access is made in compliance with civil rights laws. There are many people with limited English proficiency in the country that have a difficult time accessing federally conducted and supported programs. Persons with limited English proficiency should not be inhibited from accessing vital health care services, paid for often by their families and their own personal Federal income taxes.

Fourthly, we have to promote the collection and dissemination of data that is helpful to give indication of disparities amongst minorities. In order to fully understand the scope of health care disparities, it is necessary to have data on an individuals' health care access and utilization that includes race, ethnicity, primary language, immigration status and socioeconomic status.

Fifth, Mr. Speaker, we have to combat diseases that disproportionately affect racial and ethnic minorities. Existing research has illustrated that diseases such as diabetes, obesity, heart disease, asthma and HIV/AIDS disproportionately impact racial and ethnic minorities.

Federal initiatives should focus on preventing and treating these diseases, educating all communities about their impact, and identifying the behavioral, emotional and environmental factors that contribute to these diseases.

Next we have to enhance medical research that benefits these communities. It is important that Federal medical research be conducted by and on behalf of racial and ethnic minorities.

Lastly, I want to emphasize, Mr. Speaker, prevention and behavioral health. Estimates suggest that as much as 50 percent of health care costs are caused by behavior-related illnesses, including heart disease, high blood pressure, obesity and substance abuse. Cultural and social factors can contribute to the behavioral patterns underlying these illnesses, and intervention is necessary to prevent such illnesses and save billions of dollars in health care costs.

Now, Mr. Speaker, I wanted to talk about in the context of the overall issue of disparities and the principles that the Democrats seek to initiate in this legislation that we are soon to introduce, I wanted to pay particular attention to the problems of Native Americans because I am the vice chair of the Native American Caucus.

And Democrats feel that, in particular, when we address health care

disparities, we cannot leave out Native Americans. Native Americans have been subject to extreme discrimination in health care access and, as a result, they are a population with overall low health status.

Some of these issues will be addressed in not only the legislation I mention, but also in a hearing tomorrow in the House Committee on Resources where we will be holding a hearing on the Indian Health Care Improvement Act which is vital, I think, to the health care and well-being of American Indians as well as Alaskan natives.

The focus of the hearing tomorrow will be on Title I of the Indian Health Care Improvement Act which deals with Indian health, human resource, and development in an effort to address the need for an adequate supply of health care professionals in the Indian health system and creating more opportunities for Native Americans to pursue health careers.

I want to emphasize, Mr. Speaker, that Congress has never funded Indian health care at a level that would result in health services that are comparable to services received by other Americans. So the big problem in the disparity issue, with regard to Native Americans, is making sure there is adequate funding for the Federal Indian Health Service Program.

The Native American population is approximately 40 percent rural and predominantly lives in geographically dispersed areas with low population density. And this demographic aspect makes access to health care more difficult. There are Indian Health Service facilities available throughout the country, however, there are still some States that completely lack any Indian Health Service facilities.

Overall, Mr. Speaker, I believe access to primary health care and prevention services is good amongst Native Americans. However, beyond primary care, the situation quickly gets worse. For example, speciality services are sparse. What services are available are typically overcrowded and patients are often prioritized.

So we must address these issues, and I hope they can be addressed both in the Democratic health disparities legislation and in the hearing we have tomorrow on the Indian Health Care Improvement Act.

RECESS

The SPEAKER pro tempore (Mr. CHOCOLA). There being no further requests for morning hour debates, pursuant to clause 12(a), rule 1, the House will stand in recess until 2 p.m. today.

Accordingly (at 1 o'clock and 18 minutes p.m.) the House stood in recess until 2 p.m.