

Darfur region of Sudan. Mr. McGovern has long pushed for increased U.S. involvement in saving thousands of refugees.

Mr. McGovern, who was greeted enthusiastically yesterday, backs legislation that would require the U.S. government to officially recognize the Armenian genocide. Some say the reluctance is tied to deference to Turkey's importance to America's interests abroad. Modern Turkey strongly rejects the characterization of what happened as genocide.

Loud applause erupted after the congressman said he would direct naysayers to a public library where they could learn about the deaths of Armenians. "Facts are stubborn things," he said.

The main speaker was filmmaker Apo Torosyan, a native of Istanbul, Turkey, who now lives in Peabody. His documentary, "Voices," finished this year, is based on interviews with three survivors of the genocide. After he began making documentaries, Mr. Torosyan was not allowed to return to Turkey.

A 15-minute version of "Voices" was shown yesterday.

Mr. Torosyan spoke passionately about the Jan. 19 slaying in Turkey of Hrant Dink, a Turkish citizen of Armenian descent who was the editor of a Turkish-Armenian newspaper. His enemies included nationalist Turks who resented his use of the genocide label. He was killed outside his office in Istanbul.

The commemoration was organized by members of the Armenian Church of Our Saviour, Holy Trinity Armenian Apostolic Church and the Armenian Church of the Martyrs.

HEALTH CARE ISSUES AFFECTING MINORITY COMMUNITIES IN AMERICA

The SPEAKER pro tempore. Under the Speaker's announced policy of January 18, 2007, the gentlewoman from California (Ms. SOLIS) is recognized for 60 minutes as the designee of the majority leader.

GENERAL LEAVE

Ms. SOLIS. Mr. Speaker, I ask unanimous consent that all Members 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 gentlewoman from California?

There was no objection.

Ms. SOLIS. Mr. Speaker, I thank the Speaker for the opportunity to serve as moderator for this special designated time for recognition under Special Orders for celebration of health care, and, in particular, the uninsured.

Tonight I have several colleagues who will be joining me to speak on different topics with respect to health care issues affecting minority communities. Just to give you a brief summary of some of the topics we will touch on, obviously reauthorization of SCHIP, language access, obesity, diabetes, cancer, tobacco, HIV and AIDS, health professions, community health workers, environmental health and Medicaid citizenship.

Mr. Speaker, tonight I rise to recognize National Minority Health Month. This week is Covering the Uninsured

Week. Tonight you are going to hear from some of my colleagues representing the Congressional Black Caucus, the Congressional Hispanic Caucus and the Congressional Asian Pacific Islander Caucus and their efforts to improve health care in our communities.

Did you know that life expectancy and overall health have improved in recent years for large numbers of Americans due to an increase in and focus on preventive medicine and new advances in medical technology? However, not all Americans are faring that well, particularly communities of color, which continue to suffer from significant disparities in overall rate of disease incidence, prevalence, morbidity, mortality and survival rates in the population, as compared to the health status of the general population.

The National Minority Health Month was launched in an effort to eliminate health disparities and to improve health status of minority populations across the country. This month was created in response to Healthy People 2010, a set of comprehensive health objectives established by the U.S. Department of Health and Human Services. Disparities continue to persist, and we must eliminate health disparities by identifying significant opportunities to improve health care.

There are disparities in the burden of illness and death experienced by African Americans, Hispanic Americans, Asian Americans, Pacific Islanders, and American Indian and Alaskan Natives as compared to the U.S. population as a whole.

I am pleased to once again be working with my colleagues in the Congressional Black Caucus, the Hispanic Caucus, and the Congressional Asian Pacific Islander Caucus to develop a comprehensive tri-caucus health disparities bill. Our bill will address the importance of language access, health professions, training, data collection and health coverage for immigrants. Our colleagues in the Senate are also working on a disparities bill, and I hope that they too will pass legislation that will truly save the lives of millions of minorities. We must do more to better the health of our population, which includes all communities of color.

With that, I want to just briefly touch on this issue of the uninsured. Today marks the start of the fifth year of Covering the Uninsured Week. Although the United States has one of the best health care systems in the world, not everyone has the means to access our health care system. The number of uninsured people affects us all and is a national problem that needs a national solution.

We all know that lack of health insurance results in reduced access to care. Access can be defined as the ability to get to health services, receive service at the right time, and obtain the appropriate services necessary to promote the best health outcomes possible.

Reduced access could mean that someone is less likely to have regular sources of care, less likely to receive preventive services and more likely to use emergency departments as primary sources of care. The long-term consequences of reduced access to care include lower quality of life, higher mortality rates and the decline of the population's overall health.

Despite the growth of our economy, the number of uninsured persons continues to increase. In 2005, more than 44 million people were uninsured, and of that number, 14 million were Latinos.

The cost of private health insurance continues to rise astronomically, and we hear that every single day when we go back home to our districts. Health insurance premiums continue to rise by double-digit rates each year, and over 80 percent of the uninsured come from working families, people who are working and getting a paycheck. While two-thirds of uninsured children are eligible for public programs such as Medicaid and the SCHIP program, most are still uninsured.

These adults also are low-income populations who are not eligible for public programs but have incomes below 200 percent of the Federal poverty level. This group is composed predominantly of parents and childless adults who work but may have difficulty in obtaining and affording coverage. Due to the low Medicaid eligibility level for parents, many uninsured parents have children who qualify for public coverage but do not qualify, themselves, as parents. What an irony.

Members of racial and ethnic minority groups make up a large number, a disproportionate share, of the uninsured population. The uninsured rate for Latinos was 33 percent in 2005, 20 percent for African Americans and 18 percent for Asians and 30 percent for Native Americans. They lack health care coverage.

In addition to impacting health and the finances of the uninsured themselves, the lack of health care coverage has had repercussions for all of us in America. Many hospitals, as you know, are currently struggling under the strain of providing uncompensated emergency care to uninsured individuals.

In my own district in California, community health centers bear the brunt of responsibility for treating the uninsured. These community health centers are often the first place that the uninsured turn to when seeking health care services. These community health centers are a vital part of our health care safety net.

Poor health leads to poor financial status, and a never-ending cycle of low socioeconomic status often leads to poor health. The core values for a strong and secure America should include the right to universal access to affordable, high-quality health care for all.

In a country that prides itself on equality, it is evident that our health

care system is broken when people suffer from a lack of access to health insurance and to quality care. We must make health care services affordable and provide quality through linguistically and culturally competent services for all Americans. That must be our national priority.

I want to refer myself to the State Children's Health Insurance program, known by many as SCHIP, which covers currently 6 million children, building on Medicaid's coverage of 28 million children. However, statistically speaking, 9 million children remain uninsured.

Over the past decade, SCHIP and Medicaid together have reduced the uninsured rate among low-income children by one-third. We know that uninsured children are more likely to receive cost-effective preventive services and are healthier, which leads to greater success in school and life. Although programs such as SCHIP and Medicaid have decreased the number of uninsured children, the lack of funding and outreach efforts have left millions of those children ineligible without any coverage. Reducing disparities in children's access to health care is extremely important and should be one of our biggest priorities here in Congress.

For example, uninsured African American and Latino children are less likely to have a personal doctor and are more likely to forego needed medical care than any other group of uninsured children. More than half of insured African American children, 51 percent, and insured Latino children, 50 percent, are covered by Medicaid and SCHIP. Nearly 95 percent of eligible but uninsured children live in families with incomes below 200 percent of the Federal poverty level, which is \$33,200 for a family of three, and over 40 percent of this population is Latino.

Enrollment in SCHIP has proven to reduce disparities in access to health care services as well as reducing the coverage gap for minority children. More than 80 percent of African American children and 70 percent of uninsured Latino children appear to be eligible for this public coverage, but currently are not enrolled.

Additional funding for SCHIP, as you know, is necessary for the coverage of all uninsured. SCHIP plays a critical role for children of color. After SCHIP was created back in 1997, the percent of uninsured children steadily declined from a high of 15.4 percent in 1998 to a low of 10 percent in 2004, and for racial and ethnic minorities the decline was remarkable. In 1998, roughly 30 percent of Latino children, 20 percent of African American, and 18 percent of Asian Pacific Islander children were uninsured. In 2004, those numbers had dropped to about 21 percent, 12 percent and 8 percent respectively.

In addition to reducing the coverage gap for minority children, SCHIP enrollment has helped to reduce disparities in access to health care services. For example, a study of children en-

rolled in New York's SCHIP program for one year found an almost complete elimination of these disparities and the number of children with unmet health care needs decreased. A study from California's SCHIP population confirmed those results as well. Across racial and ethnic groups, SCHIP enrollment was associated with a significant reduction in disparities and access to needed care.

We need adequate SCHIP reauthorization. Currently there is insufficient Federal funding for SCHIP to cover the children currently enrolled. We need additional money to cover them and to expand coverage to uninsured children who are eligible.

In order to expand health coverage for minority children, we also need to address the underlying barriers to enrollment in Medicaid and SCHIP that minorities are more likely to face; as an example, the distrust of government and a health care system where language may not be spoken adequately to the different groups that are affected. And misinformation about eligibility rules is often complicating the process for many who don't understand the paperwork.

Enrollment strategies targeted to minority communities, including the use of community health workers, known as promotoras, could help guide families through the enrollment process and have been proven to increase enrollment and reduce disparities. We must improve outreach efforts and simplify enrollment in order to reach the millions of unenrolled children from communities of color who are eligible for Medicaid and the SCHIP program. This year, with the reauthorization of SCHIP, this is an opportunity for us to address racial and ethnic disparities in children's access to health care. I hope that we can work together with our colleagues across the aisle to begin the debate and see that we reauthorize these programs that are so vitally needed.

I am very pleased this evening to have one of my colleagues, the gentlewoman from Guam, who has chaired the Congressional Asian Pacific Islander Caucus Task Force on Health who has joined me this evening. She has been a pioneer on health care access and will give us, I am sure, very informative data regarding the problems that are faced currently in the Asian Pacific Islander community. I welcome her this evening.

I gladly yield to the gentlewoman.

Ms. BORDALLO. Mr. Speaker, I want to thank my colleague and good friend, HILDA SOLIS, for bringing this forum together.

Tonight I come to the floor to take part in a very important dialogue about National Health Month that has been organized, as I said earlier, by my colleague from California, Congresswoman HILDA SOLIS. Congresswoman SOLIS' leadership in the area of minority health disparities, particularly with regard to environmental health

factors, is strong and it has raised awareness of these issues on Capitol Hill.

I thank her for yielding me the time, and I commend her for her efforts, along with those of the members of the Congressional Hispanic Caucus, the Congressional Black Caucus, and my colleagues in the Congressional Asian Pacific American Caucus, in ensuring that minority health disparities are on the national agenda.

□ 2130

I am here tonight as the Chair of the Congressional Asian Pacific American Caucus Health Task Force to recognize April as National Minority Health Month. Designated in 2001, National Minority Health Month is sponsored by the National Minority Quality Forum, an organization dedicated to addressing and eliminating the disparity in care, treatment, and access faced by racial and ethnic minority populations.

The National Minority Quality Forum has been a leader in addressing these disparities and since 2004 has hosted a national summit each year to address these issues. Because the fourth annual summit began today in Washington, D.C., this is an opportune time to bring further awareness of the increasing need to address health disparities. It is very important that within this dialogue surrounding minority health disparities, that the needs of Asian American and Pacific Islanders are included. Asian Americans and Pacific Islanders face a number of hurdles towards receiving adequate health care stemming from linguistic and cultural challenges, and a lack of data collection.

Based on the following statistics, the health care disparities in the Asian American and Pacific Islander community become readily apparent, according to the President's Advisory Commission on Asian American and Pacific Islanders.

Ms. SOLIS covered in detail the lack of insurance coverage. I am here to give statistics on the diseases prevalent among minorities.

Asian American and Pacific Islander women have the lowest rate of cancer screening compared to other ethnic groups. Asian Americans and Pacific Islanders make up over half of the cases of chronic hepatitis B. Asian Americans and Pacific Islanders make up 20 percent of all cases of tuberculosis; and Vietnamese Americans are 13 times more likely to die of liver cancer than Caucasians.

There are many diseases and illnesses that disproportionately affect communities of color, ranging from HIV/AIDS to diabetes. Hepatitis B, which disproportionately affects the Asian American and Pacific Islander community, is often overlooked.

Today as we recognize National Minority Health Month, I would like to take this opportunity to raise awareness about this deadly disease. Hepatitis B is an infection caused by the

hepatitis B virus. Usually, people infected with the disease do not show early symptoms. But if left undetected, it may lead to cirrhosis of the liver, liver failure, and liver cancer. The statistics regarding hepatitis B are alarming. According to the Asian and Pacific Islander American Health Forum, one in 10 Asian Americans and Pacific Islanders are chronically infected with hepatitis B.

And of all those infected with hepatitis B in the United States, 50 percent are Asian Americans and Pacific Islanders, and liver cancer is the leading cause of death for Laotian American men in California.

The promising thing with hepatitis B is there is a three-shot vaccination series that can prevent hepatitis B and its dire consequences. Unfortunately, only one in 10 Asian American and Pacific Islander children have received the vaccination series. So with the proper education, outreach, and funding, I hope that we can address the killer disease within the Asian-American and Pacific Islander community, increase the vaccination rate, address the need for early detection and monitoring, and improve the quality of life for the people and families that live with hepatitis B.

Additionally, I hope we take this opportunity during National Minority Health Month to strengthen data collection and dissemination that will lead to improved access to health care for all racial and ethnic minority communities across the United States.

Again, as the Chair of the Health Care Task Force for the Congressional Asian Pacific American Caucus, I want to thank my colleague, Ms. SOLIS, for organizing tonight's Special Order speech on the occasion of National Minority Health Month and for the purposes of generating greater attention and raising awareness to the disparities in access to quality health care that our minority communities face and that deserve to be eliminated.

Ms. SOLIS. I thank the gentlewoman from Guam, and I would like to at this time thank her for her hard work and deliberations in the past few years as a strong member of the tri-caucus working on health care issues. I know she is going to continue to lead and be a voice for those underrepresented communities.

I would like to now recognize a very special individual who is Chair of our Subcommittee on Health on Energy and Commerce, but also plays a very important role in representing the Native Americans in our great country and that is the gentleman from New Jersey (Mr. PALLONE).

Mr. PALLONE. Thank you. I want to thank my colleague from California and also my colleague from Guam. I know that for a number of years now they have both been involved in the health care disparities issue, and have actually put together legislation that we have tried to get passed for several years. It was a little difficult with the

Republican majority. And hopefully now with the Democratic majority, we can address those health disparities and concerns.

I would like to talk about the Native American aspect of this. And I also want to mention that addressing the concerns of minority health care is important in my district because we do have many Asian Americans. We have the largest number of Indian Americans of any congressional district, and by that I mean Asian Indian Americans, and also a large Latino and African American population in my district.

I just know when I go and visit some of the hospitals or community health centers, many times the issue is brought to my attention, whether it is data collection which has already been mentioned tonight, or it is the need for more minority health care professionals, be they doctors, nurses or whatever, or even that more research attention needs to be paid to diseases or afflictions that basically impact the minority communities in disproportionate ways.

It is very important that we address this and we need legislation, and we will move forward with the health care disparities legislation that my colleagues have really championed over the last few years.

I want to talk about Native Americans. I actually don't have any federally enrolled Native American tribes in my district or even in New Jersey. We have quite a few, we just don't have any recognized tribes at a Federal level. We have five that are State recognized. Unless you are federally recognized and enrolled with the Department of the Interior, you are not for the most part eligible for the health service.

American Indians are a little unique in that unlike most Americans, they have a right pursuant to their treaties and the Constitution to health care. When they gave their lands up to the Federal Government by treaty, they were given the right to health care. That, of course, doesn't necessarily mean they can all access it because a lot of them don't necessarily live on the reservation, and that is one of the reasons why we have urban health centers around the country, including several in California, because many Native Americans now do live in L.A. and in some of the larger cities, and don't necessarily live on their homelands on the reservations.

So we need to address their concerns in not only providing hospitals and clinics in their homelands, on the reservations, but also in the urban areas where many now reside.

Unfortunately, in the last few years, and I know I sound so partisan and I don't mean to be, but the amount of money that was made available in the last 12 years under the Republican Congress was really not sufficient. There is a need for a lot more dollars. This year we did budget significantly more for

the Indian Health Service, but we also need to reauthorize the Indian Health Service because it hasn't been reauthorized since 2000.

I have sponsored legislation called the Indian Health Care Improvement Act which will be marked up in the Resources Committee this year and will come to the Energy and Commerce Committee and the Health Subcommittee, and we will try to get it passed in this Congress.

When you talk about Native Americans and the disparities, the disparities are just incredible. When we had a hearing on the Indian Health Care Improvement Act in the Resources Committee a few weeks ago, I asked a question about how many American Indian or Native American doctors there were in the United States. I could not believe the number. There are less than 500, somewhere between 400 and 500 Native American physicians for a Native American population that is probably over 2 million. I don't know what that works out to percentage-wise, but there is clearly a need for scholarship and grant and loan programs that would specifically target the Native American community so we can have not 400 doctors but at least 4,000 or maybe 40,000 when you talk about a community that has over 2 million people.

And the same is true, and I don't have the statistics for nurses or other health care professionals, but there are really very few Native American health care providers, and we need to boost those numbers up and allow for opportunities to get more health care professionals.

With regard to actual treatment, if they are not on the reservation and able to access the Indian health care hospital or clinic, it is very difficult. There is a huge unemployment rate. Even if you are on a reservation, sometimes distances are great because many Native Americans live in rural areas where health care is simply not available.

We also have the phenomenon of diseases or afflictions that target that community. The incidence of diabetes, juvenile or type 2 diabetes, is for many tribes over 50 percent. I have been to some where the numbers are over 60 percent. We need a lot more research into the reasons why, in the example of diabetes, but I could talk about other diseases or health care problems, why the incidence is so high and what could be done.

For example, there has been some effort to look at nutrition as an answer, the feeling that many Native Americans, for example, used to live on a subsistence diet. If they were a desert people, they would eat foods that they gathered in a desert. Or they may have lived on a ranch or in a situation where they were getting a lot more natural foods, and now as those opportunities have eased to exist and they are eating processed foods, there is a lot of evidence to suggest that is a major reason

for diabetes. This is the type of thing we need. We need research into those kinds of afflictions as to what is causing a better than 60 percent diabetes situation for a number of tribes.

Even transportation needs are there because of many of the problems that are in rural areas.

So I just wanted to say when you talk about the Native American population in this country, the disparities problem is so great that it has actually gotten to the point of crisis, in my opinion; and that is why we need legislation to deal with these disparity issues, and we need to reauthorize the Indian Health Service through the Indian Health Care Improvement Act.

And to the extent that we are looking at this from the Asian population, the Latino population, or whatever population, this type of initiative is very important. I just want to commend my colleagues again for being here tonight and speaking out because I do think we need to speak out. In many cases we are talking about people who don't have people to speak out for them other than a few of us. Thank you again.

Ms. SOLIS. I thank the gentleman from New Jersey for his kind words and knowledge and always helping Members to better organize their messages, particularly when it comes to health care and the need to improve access for all people in our great country.

As the gentleman says, the fact is that we are undergoing a change where our populations are exploding, our minority populations have increased, and we don't see more services provided, one of which is the Native American population. I have a significant Native American population in L.A. County and there is one center available for them. It is just horrifying to think that people have to travel so many counties just to get there. Lord help them if they have an episode of some sort, that they get there in time to receive the necessary care. To know that this is not a priority with the administration is very alarming. We need to prioritize this issue.

□ 2145

I again want to recognize my colleague from Guam to talk about some other very pressing health care issues that affect not just Asian Pacific Islanders but these other minority populations. So I would yield to her.

Ms. BORDALLO. Mr. Speaker, I thank the gentlewoman from California (Ms. SOLIS) for organizing this forum, and I would also like to thank my colleague from New Jersey (Mr. PALLONE) who joined us on the floor tonight to discuss this very important issue.

I am to cover cancer, and today is a very sad day for the House of Representatives. We have lost a dear colleague to cancer, and this is the second cancer-related passing this year in the House of Representatives.

Cancer is the second most common cause of death in the United States and

accounts for one out of every four deaths. Unfortunately, health disparities in cancer continue to persist. Minority groups face unique problems and concerns about cancer, including higher rates of developing some cancers and barriers to early detection.

In 2001, the National Cancer Institute formed the Center to Reduce Cancer Health Disparities. In 2005, the center launched a new program to reduce cancer deaths among minority and underserved populations through \$95 million in grants that funded community-based projects in geographically and culturally diverse areas of our country.

Dr. Harold Freeman, a leader in reducing cancer health disparities, and former surgeon at Harlem Hospital, said that cancer disparities are attributable to three interacting factors: first, low socioeconomic status; second, culture; and third, social injustice.

Low socioeconomic status and lack of health insurance lead to disparities. Lack of coverage prevents many Americans from receiving optimal health care. Frequently, people are not getting screened and treated because they feel they cannot afford to pay for a test if they are uninsured. The same populations also express concern that if they are diagnosed with cancer they will not be able to get the care they need.

Culture also plays a role. Some Native American tribes do not use the word "cancer." When asked why they cannot discuss this disease, they say that in their culture, if they say the word "cancer," it will bring disease to all of their families.

It is necessary to understand the cultural beliefs of different populations when talking about diseases. According to Dr. Freeman, much of the disparity in cancer outcomes is a result of the cancer type, the time of diagnosis, and the continuity of cancer care, not the disease itself.

Screening and early detection are extremely important to avoiding cancer-related deaths. Many deaths from breast, colon and cervical cancer could be prevented by increased usage of established screening tests.

Although white and African American women aged 40 and older had the same prevalence of mammography use, other racial and ethnic groups of women were less likely to have had a mammogram. The lowest prevalence of mammography use occurred among women who lacked health insurance and by immigrant women who lived in the United States for less than 10 years.

The incidence of some cancers is much higher in communities of color. For example, African American men are at least 50 percent more likely to develop prostate cancer than men of any other racial or ethnic group in the United States.

Latino males have the third highest incidence rate for prostate cancer after African Americans and whites. Death rates for Latino males reveal that they

have the third highest death rates from prostate and colon and rectal cancer after African Americans and whites.

Asian Pacific Islander males have the third highest rate for lung and bronchus cancer and colon and rectal cancer.

Cervical cancer occurs most often in Latinas; the incidence rate is more than twice the rate for non-Latina white women. Among Latinas in the United States, cervical cancer ranks as the fourth most common type of cancer.

Although African American women are less likely to develop breast cancer than other women, those who do are about twice as likely to die from it.

Consequently, programs such as the National Breast and Cervical Cancer Early Detection Program are essential for low-income, uninsured and underserved women.

Although breast cancer is the leading cause of cancer death for Latina women, cancer screening rates are lower for Latinas.

Providing culturally appropriate health education and health services is so essential to preventing and treating cancer.

Again, I want to thank Congresswoman SOLIS for providing and organizing this forum.

Ms. SOLIS. Mr. Speaker, I thank the gentlewoman for joining us this evening and representing the caucus so well, the Asian Pacific Islander Caucus, and demonstrating a willingness to work across the aisle and in a coalition so that we can better improve access to health care for all underrepresented groups.

I want to talk very briefly before I recognize one of our other colleagues who has joined us here from the Congressional Black Caucus, SHEILA JACKSON-LEE.

I want to talk about diabetes because diabetes, in my opinion, is one of the major chronic illnesses. It does not just affect ethnic minority or underrepresented groups, but many, many people in our country.

One of the goals that I mentioned earlier of the Healthy People 2010 program, a campaign underway, by the way, by the Department of Health and Human Services, is to reduce the disease and economic burden of diabetes and to improve the quality of life for all people who have or are at risk of getting diabetes.

Diabetes, as you know, is a chronic disease affecting both children, Type I, and adults, Type II. The number of people with diabetes has increased steadily in the past decade, and the increase has occurred within certain racial and ethnic groups.

Today, approximately 20.8 million Americans have diabetes, and of these people, an estimated 6.2 million individuals have not even been diagnosed. According to the Centers for Disease Control and Prevention, another 54 million people have pre-diabetes.

Complications of diabetes include heart disease, stroke, blindness, kidney

failure, dental disease, pregnancy complications and amputations. These are very serious illnesses, and diabetes is now the sixth leading cause of death in the United States and costs the Nation over \$132 billion per year in direct and indirect costs.

Diabetes, as you know, is the leading cause of nontraumatic amputations, and about 150 amputations per day are due to diabetes.

Two million Latinos have been diagnosed with diabetes, and Latinos are 1.5 times more likely to have diabetes than whites, on the average, and many children with Type II diabetes are Latino or African American.

Reducing the incidence of diabetes and thus reducing racial and ethnic disparities involves diet and lifestyle changes. However, strategies to manage the disease and prevent the disease also need to be culturally sensitive and targeted to specific populations.

The number of overweight minority children has increased in recent years, and more of them are being diagnosed with adult-type diabetes. It is estimated that now at least 40,000 children now have Type II diabetes, which is the type of diabetes associated with adult obesity.

Regular diets of low-cost, high-calorie fast food and sodas, in addition to inadequate daily physical activity, have contributed to the prevalence of diabetes. Health education, as you know, is extremely important, and we need to teach people how to prevent diabetes because it is preventable. For people who already have diabetes, we need to teach them how to manage that disease.

In order to prevent or delay complications and early death from diabetes, patients need to understand the disease, take charge of blood glucose management, comfortably talk to their provider about diabetes care, and have access to equipment, supplies and prescriptions. Cultural competence and access to health care play a very large role in preventing deaths due to diabetes.

Sixty percent of my district, as you know, is Latino, and I have seen firsthand the community clinics that have helped my constituents who are diagnosed with this deadly but preventable disease. A large proportion of the people who visit these clinics in my district are uninsured. When I see the packed waiting rooms, I understand how hard it is to manage this chronic illness. Even with appointments, people can have waiting times of several hours, resulting in loss of work.

A 2005 Commonwealth Fund study of public hospitals also found that African American and Latino patients were less likely than their white counterparts to have well-controlled diabetes, and uninsured patients received even less care. Public hospitals serve a high number of patients at high risk for not receiving access to needed health care. In the study, about two out of five patients with diabetes were uninsured,

and two-thirds were members of racial and ethnic minority groups, and up to two-thirds of patients primarily spoke a language other than English.

Insurance status and race influences health care use and outcomes for diabetes patients. Uninsured patients have the worst diabetes control, and 33 percent do not have their condition under control now, which is almost double the rate for Medicare patients.

The routine costs for managing diabetes, to test and control glucose levels, can reach hundreds of dollars per month. Uninsured patients have difficulties paying for equipment to effectively manage their treatment. Consequently, the higher prevalence of diabetes and the inability to manage diabetes leads to more diabetes-related deaths in communities of color.

This is just one example of how social determinants impact our health care status, and I wanted to draw your attention to that.

This evening we have been joined by two members of the Congressional Black Caucus, and I would first like to recognize the gentlewoman from Texas (Ms. JACKSON-LEE). Thank you for joining us this evening.

Ms. JACKSON-LEE of Texas. Mr. Speaker, let me thank the gentlewoman from California for convening us this evening and providing such leadership to the issue of health disparities. And also I believe it is enormously important to emphasize the collaborative work between the Asian Pacific Caucus, of which I am a member, the Hispanic Caucus, of which I am an adopted daughter, and the Congressional Black Caucus.

I am also very pleased to be on the floor with our chair of the Congressional Black Caucus health brain trust, which I have been a Member on, I believe, for as long as I can remember, to join us for what is really an indictment of American society. It is an indictment of this government, frankly, and the correction that is due is long overdue. That is the whole question of health disparities.

We have heard an eloquent presentation by HILDA SOLIS on the question of diabetes. We heard from the distinguished gentlewoman from Guam who spoke about the Pacific illnesses that impact the Asian Pacific community, and I rise to speak holistically about the health crisis in America that does not address the longstanding question of disparities in health care.

I am reminded of an African American gentleman in a Florida hospital just a few years ago who was to go into surgery and hopefully had all the T's crossed and I's dotted. Lo and behold, the wrong leg was amputated. He obviously suffered from, as we call in our community, sugar diabetes, and rather than be cured, unfortunately, his situation was made worse by amputating the wrong leg.

There is extensive documentation that indicates that the question of health access or access to health care

falls heavily on minorities, and particularly African Americans. In fact, there is data to suggest that African Americans, when given access to the Nation's hospitals and other health facilities, that the care is less than it is for other populations. That, in itself, does not speak to the greatness of this Nation and the fact that this Nation is considered a world power.

□ 2200

If you want to speak to inequities of language, you will find in Hispanic communities, in particular, that before we started moving on community health clinics and really making a push to have culturally sensitive treatment, you will find in many instances that there was a lack of ability to communicate with Hispanic populations because of the language barrier. These, my friends, were citizens, people who were permanent legal residents, who could not get the proper health care.

Today, I rise to acknowledge the importance of National Minority Health Month, but really to give us a challenge that we maybe have come this far by faith, as many of us have been known to say, but we have a mighty long way.

Let me just share some of the indictments of poor health care in America. African American adolescents accounted for 65 percent of new AIDS cases reported among teens in 2002, although they only account for 15 percent of American teenagers.

We also recognize that the leading cause of death of young African American males between the ages of 15 and 24, that cause is not disease or accidental death, but homicide.

We recognize, as has been already noted, that obesity is an increasing dilemma for America. It certainly is a dilemma for minority populations and African Americans.

Let me express appreciation for joining Congressman DONALD PAYNE a few weeks ago for a very exciting conference on obesity, so much so that it was contagious. Those of us, as Members of Congress who were able to attend, with the University of New Jersey medical and dental school, are going to repeat that conference around the country. I know that we in Houston look forward to hosting a conference on obesity.

A few weeks ago, the Congressional Children's Caucus hosted, with the Congressional Black Caucus Foundation, a briefing on obesity, where we focused on what happens to obese children and obese infants as well.

Just a couple of days ago, I believe Friday, I was very gratified to participate with the Congressional Black Caucus Foundation and the CBC Health Brain Trust on the status of African American men, questions of mental health, the question of homicide, HIV/AIDS, domestic violence, abuse, and the preservation of the good health of African American men.

Every time I rise to speak about this question, I pay tribute to my father,

my late father, a man who worked hard for his family, who believed that no job was beneath him to support his family, a man who was a brilliant artist. But because of segregation, the work that he had, he was, if you will, replaced when men came back who happened to be white, from World War II.

But even with all of those trials and tribulations, he kept his hand involved in art, and in the later part of his life, he got another chance to work 10 years for one of the comic book companies in New York. Who would have thought that he would have been a victim of prostate cancer. When I say a victim, not diagnosed, so much so that ultimately it metastasized to his lung and his brain. My most visual memory of him was him laying in a fetal position in a hospital bed, way before the time, and he died of that dastardly disease.

But I think one of the challenges was that in the male line of our family, that cancer is prevalent, but not being diagnosed, or having access to health care that would inform us, we saw uncles pass without really knowing what they were dying of.

So today, now, 2007, a tribute to my father, Ezra Jackson, and relatives across America who have died undiagnosed, whose families were not aware of, maybe, the DNA or their characteristics for these diseases, because of the poor access to health care. We stand today, one, wanting a universal access to health care system; two, passing the Congressional Black Caucus and the bill that went to the Senate, dealing with disparities in health care, that, as I understand, Dr. CHRISTENSEN, we never got passed. We need to get it passed in this Congress.

Then I would just simply say that each of us must hold forums in our districts on the question of disparities in health care. As I do the obesity one, we look forward to putting together an advisory committee on black males that talks about health care as well.

Let me close by simply saying that I could recount for you any number of statistics on health care. I think my colleagues have accurately pronounced these challenges. But let me give a roll call to show you where we have these devastating, if you will, disparities, so that you won't think that we are limited, hypertension, high cholesterol, type 2 diabetes, coronary heart disease, stroke, gall bladder disease, osteoarthritis, asthma, bronchitis, sleep apnea and other respiratory problems, cancer, which is breast, colon and endometrial.

We expect that we will do a better job of trying, if you will, of trying to improve the health conditions in America. We must do so. It is a civil rights issue. I want to thank you so much for highlighting and provoking us to be part of the change of creating opportunities for better health for all Americans, and particularly those experiencing these health disparities.

Mr. Speaker, I rise to honor and recognize the importance of National Minority Health

Month. National Minority Health Month is a very important time to bring awareness to the many health concerns facing minority communities. My colleagues in the Congressional Black Caucus and I understand the very difficult challenges facing us in the form of huge health disparities among our community and other minority communities. We will continue to seek solutions to those challenges. It is imperative for us to improve the prospects for living long and healthy lives and fostering an ethic of wellness in African-American and other minority communities. I wish to pay special tribute to my colleague, Congresswoman DONNA CHRISTENSEN, the Chair of the CBC Health Braintrust, for organizing an important conference last week on the health and wellness of African-American males. I thank all of my CBC colleagues who been toiling in the vineyards for years developing effective public policies and securing the resources needed to eradicate racial and gender disparities in health and wellness.

Let me focus these brief remarks on what I believe are three of the greatest impediments to the health and wellness of the African-American community and other minority communities. The first challenge is combating the scourge of HIV/AIDS. Second, we must reverse the dangerous trend of increasing obesity in juveniles and young adults. Finally, we must confront the leading cause of death of young African-American males between the ages of 15–24; that cause is not disease or accidental death, but homicide.

HIV/AIDS

In 1981, HIV/AIDS was thought by most Americans to be a new, exotic, and mysterious disease which seemed to inflict primarily gay white males in New York City and San Francisco. But since then we have learned that in the America of 2006, AIDS is overwhelmingly a black and brown disease. And that means that we have to assume the major responsibility for finding the solutions to rid our communities of this scourge. Consider the magnitude of the challenge confronting us:

HIV/AIDS is now the leading cause of death among African-Americans ages 25 to 44—ahead of heart disease, accidents, cancer, and homicide.

The rate of AIDS diagnoses for African-Americans in 2003 was almost 10 times the rate for whites.

Between 2000 and 2003, the rate of HIV/AIDS among African-American males was seven times the rate for white males and three times the rate for Hispanic males.

African-American adolescents accounted for 65 percent of new AIDS cases reported among teens in 2002, although they only account for 15 percent of American teenagers.

Billions and billions of private and federal dollars have been poured into drug research and development to treat and “manage” infections, but the complex life cycle and high mutation rates of HIV strains have only marginally reduced the threat of HIV/AIDS to global public health.

Although the drugs we currently have are effective in managing infections and reducing mortality by slowing the progression to AIDS in an individual, they do little to reduce disease prevalence and prevent new infections. It simply will not suffice to rely upon drugs to manage infection. We can make and market drugs until we have 42 million individually tailored treatments, but so long as a quarter of

those infected remain detached from the importance of testing, we have no chance of ending or even “managing” the pandemic.

Currently, the only cure we have for HIV/AIDS is prevention. While we must continue efforts to develop advanced treatment options, it is crucial that those efforts are accompanied by dramatic increases in public health education and prevention measures.

Learning whether one is infected with HIV before the virus has already damaged the immune system represents perhaps the greatest opportunity for preventing and treating HIV infection. According to the Centers for Disease Control (CDC), between 2000 and 2003, 56 percent of late testers—defined as those who were diagnosed with full-blown AIDS within one year after learning they were HIV-positive—were African-Americans, primarily African-American males.

African-Americans males with HIV have tended to delay being tested because of psychological or social reasons, which means they frequently are diagnosed with full-blown AIDS soon after learning they are infected with HIV. This is the main reason African American males with AIDS do not live as long as persons with HIV/AIDS from other racial/ethnic groups.

Researchers have identified two unequal tracks of HIV treatment and care in the United States. In the first, or “ideal track,” a person discovers she or he is HIV-infected, seeks medical care, has regular follow-ups, and follows a regimen without complications. Persons in this track can now in most cases lead a normal life.

But some individuals follow a second, more-dangerous track. These individuals come to the hospital with full-blown AIDS as their initial diagnosis. They may have limited access to care because of finances or because other social or medical problems interfere. The vast majority of deaths from HIV/AIDS are among this second group. And the persons making up this group are disproportionately African-American males.

I have strongly supported legislation sponsored by CBC members and others to give increased attention and resources to combating HIV/AIDS, including the Ryan White CARE Act. I support legislation to reauthorize funding for community health centers (H.R. 5573, Health Centers Renewal Act of 2006), including the Montrose and Fourth Ward clinics in my home city of Houston, and to provide more nurses for the poor urban communities in which many of these centers are located (H.R. 1285, Nursing Relief Act for Disadvantaged Areas). I have also authored legislation aimed to better educate our children (H.R. 2553, Responsible Education About Life Act in 2006) and eliminate health disparities (H.R. 3561, Healthcare Equality and Accountability Act and the Good Medicine Cultural Competency Act in 2003, H.R. 90).

Twenty-five years from now, I hope that we will not be discussing data on prevalence and mortality of HIV/AIDS among African-American males, but rather how our sustained efforts at elimination have come into fruition. But for us to have that discussion, we must take a number of actions now. We must continue research on treatments and antiretroviral therapies, as well as pursue a cure. We absolutely have to ensure that everyone who needs treatment receives it. And we simply must increase awareness of testing, access to testing, and the accuracy of testing. Because we

will never be able to stop this pandemic if we lack the ability to track it.

African-Americans males are eleven times as likely to be infected with HIV/AIDS, so we must make eleven times the effort to educate them until HIV/AIDS becomes a memory. If we do not, then the African-American male will indeed become an endangered species.

When it comes to the scourge of HIV/AIDS, the African-American community is at war. It is a war we absolutely have to win because at stake is our very survival. With HIV/AIDS we need not wonder whether the enemy will follow us. The enemy is here now. But so is the army that can vanquish the foe. It is us. It is up to us. For if not us, who? If not now, when? If we summon the faith of our ancestors, the courage of our great grandparents, and the determination of our parents, we will march on until victory is won.

OBESITY

Although the obesity rates among all African-Americans are alarming, as Chair of the Congressional Children's Caucus, I am especially concerned about the childhood obesity epidemic among African-American youth. More than 40 percent of African-American teenagers are overweight, and nearly 25 percent are obese.

Earlier this year, my office in concert with the office of Congressman TOWNS and the Congressional Black Caucus Foundation, held a widely-attended issue forum entitled, "Childhood Obesity: Factors Contributing to Its Disproportionate Prevalence in Low Income Communities." At this forum, a panel of professionals from the fields of medicine, academia, nutrition, and the food industry discussed the disturbing increasing rates of childhood obesity in minority and low-income communities, and the factors that are contributing to the prevalence in these communities.

What we know is that African-American youth are consuming less nutritious foods such as fruits and vegetables and are not getting enough physical exercise. This combination has led to an epidemic of obesity, which directly contributes to numerous deadly or life-threatening diseases or conditions, including the following: hypertension; dyslipidemia (high cholesterol or high triglyceride levels); Type 2 diabetes; coronary heart disease; stroke; gallbladder disease; osteoarthritis; asthma, bronchitis, sleep apnea, and other respiratory problems; and cancer (breast, colon, and endometrial).

When ethnicity and income are considered, the picture is even more troubling. African-American youngsters from low-income families have a higher risk for obesity than those from higher-income families. Since the mid-1970s, the prevalence of overweight and obesity has increased sharply for both adults and children. According to the Centers for Disease Control and Prevention (CDC), among African-American male adults aged 20–74 years the prevalence of obesity increased from 15.0 percent in 1980 survey to 32.9 percent in the 2004.

There were also increases in overweight among children and teens. For children aged 2–5 years, the prevalence of overweight increased from 5.0 percent to 13.9 percent; for those aged 6–11 years, prevalence increased from 6.5 percent to 18.8 percent; and for those aged 12–19 years, prevalence increased from 5.0 percent to 17.4 percent.

As the debate over how to address the rising childhood obesity epidemic continues, it is

especially important to explore how attitudes, environmental factors, and public policies influence contribute to obesity among African-American males. Some of these contributing factors are environmental, others are cultural, still others are economic, and others still may be lack of education or information. But one thing is clear: we must find ways to remove them.

GUN VIOLENCE AND HOMICIDE

The third and final health challenge confronting the African-American community, and African-American males in particular, involves the issue of gun violence and homicide. This must be a priority health issue for our community. Over 600,000 Americans are victimized in handgun crimes each year, and the African-American community is among the hardest hit.

One week ago, on Monday, April 16, 2007, at Virginia Tech University, one of the nation's great land grant colleges, we witnessed senseless acts of violence on a scale unprecedented in our history. Neither the mind nor the heart can contemplate a cause that could lead a human being to inflict such injury and destruction on fellow human beings. The loss of life and innocence at Virginia Tech is a tragedy over which all Americans mourn and the thoughts and prayers of people of goodwill everywhere go out to the victims and their families. In the face of such overwhelming grief, I hope they can take comfort in the certain knowledge that unearned suffering is redemptive.

Thirty-three persons died in the massacre at Virginia Tech. But there is a much less noticed, though no less devastating, massacre and loss of life going on in African-American communities across the country. Since 1978, on average, 33 young black males between the ages of 15 and 24 are murdered every 6 days. Three-quarters of these victims are killed by firearms.

In 1997, firearm homicide was the number one cause of death for African-American men ages 15–34, as well as the leading cause of death for all African-Americans 15–24 years old. The firearm death rate for African-Americans was 2.6 times that of whites. According to the Centers for Disease Control, the firearms suicide rate amongst African-American youths aged 10–19 more than doubled over a 15 year period. Although African-Americans have had a historically lower rate of suicide than whites, the rate for African-Americans 15–19 has reached that of white youths aged 15–19.

A young African-American male is 10 times more likely to be murdered than a young white male. The homicide rate among African-American men aged 15 to 24 rose by 66 percent from 1984 to 1987, according to the Centers for Disease Control. Ninety-five percent of this increase was due to firearm-related murders. For African-American males, aged 15 to 19, firearm homicides have increased 158 percent from 1985 to 1993. In 1998, 94 percent of the African-American murder victims were slain by African-American offenders.

In 1997, African-American males accounted for 45 percent of all homicide victims, while they only account for 6 percent of the entire population. It is scandalous that a 15-year-old urban African-American male faces a probability of being murdered before reaching his 45th birthday that ranges from almost 8.5 percent in the District of Columbia to less than 2 percent in Brooklyn. By comparison, the prob-

ability of being murdered by age 45 is a mere three-tenths of 1 percent for all white males.

Firearms have become the predominant method of suicide for African-Americans aged 10–19 years, accounting for over 66 percent of suicides. In Florida, for example, African-American males have an almost eight times greater chance of dying in a firearm-related homicide than white males. In addition, the firearm-related homicide death rate for African-American females is greater than white males and over four times greater than white females.

As the tragedy this week at Virginia Tech University revealed, school shootings are sobering and tragic events that cause much concern for the safety of children. Homicides involving children and youth that are school related make up one percent of the total number of child and youth homicides in the United States. Most school associated violent deaths occur during transition times such as the start or end of the school day, during the lunch period, or the start of a semester.

Nearly 50 percent of all homicide perpetrators give some type of prior warning signal such as a threat or suicide note. Among the students who commit a school-associated homicide, 20 percent were known to have been victims of bullying and 12 percent were known to have expressed suicidal thoughts or engage in suicidal behavior.

My legislative agenda during the 110th Congress includes introducing legislation to assist local governments and school administrators in devising preventive measures to reduce school-associated violent deaths. In devising such preventive measures, at a minimum, we must focus on:

Encouraging efforts to reduce crowding, increase supervision, and institute plans/policies to handle disputes during transition times that may reduce the likelihood of potential conflicts and injuries.

Taking threats seriously and letting students know who and where to go when they learn of a threat to anyone at the school and encouraging parents, educators, and mentors to take an active role in helping troubled children and teens.

Taking risk talk of suicide seriously and identifying risk factors for suicidal behavior when trying to prevent violence toward self and others.

Developing prevention programs designed to help teachers and other school staff recognize and respond to incidences of bullying between students.

Ensuring that each school has a security plan and that it is being enforced and that school staff are trained and prepared to implement and execute the plan.

My legislative agenda during the 110th Congress also includes introducing sensible legislation to assist law enforcement departments, social service agencies, and school officials detect and deter gun violence.

Again, thank you all for your commitment to working to find workable solutions to the health and wellness challenges facing our communities. I look forward to working with you in the months ahead to achieve our mutual goals.

Have a successful and inspiring conference.

Ms. SOLIS. I thank the gentlewoman from Texas for joining us this evening.

Before I conclude with our discussion on the uninsured and celebrating, actually, a call to action, a call to action

for all people of color and all Americans, that we have a balanced health care system that serves all of us, one last item I would like to bring up, before I recognize the gentlewoman from the Virgin Islands for the last 5 minutes is to talk a little bit about one of the biggest killers in our community, and it is about tobacco. Each year tobacco use kills more than 400,000 Americans and costs our country more than \$96 billion in health care costs.

According to the Centers for Disease Control and Prevention, tobacco use by pregnant women alone costs at least \$400 million per year due to complications such as low birth weight, premature birth and sudden infant death syndrome. Every day, 1,000 kids become regular smokers, one-third of whom will die prematurely as a result. Smoking is responsible for 87 percent of lung cancer deaths in the U.S.

Tobacco-related cancers are disproportionately higher among low-income and ethnic-minority communities. Because these groups have been repeatedly targeted by the tobacco industry, they unfairly carry a greater weight of the health and economic burden tobacco has in our country. For communities of color, tobacco addiction brings a disproportionate amount of death and disease to communities with low rates of health insurance coverage. Lung cancer is the leading cause of cancer among Latino men and second leading cause of death among Latinas.

Approximately 25,000 Latinos will die from smoking-related illnesses this year, surpassing all other causes of cancer. Each year, approximately 45,000 African Americans die from smoking-caused illness.

Native American adults have the highest tobacco use rates for all major ethnic groups. The prevalence of smoking is 37.5 percent among Native American, 26.7 among African American, and 24 percent among white men. This year it is expected that the rate of lung and cancer deaths for white males will be 73.8 per 100,000, while for African Americans it will be 98.4 per 100,000. Tobacco use is an important risk factor for coronary heart disease, the leading cause of death among Latinos.

Unfortunately, tobacco companies have increased their marketing to our minority communities, and I have seen advertisements in magazines popular with Latino youth. R.J. Reynolds is running ads for Kool cigarettes with images that appeal to Latinos.

I recently learned that the Kool Mixx campaign focused its marketing images around music and hip-hop, which appeals to African American and Latino youth. The Kool Mixx campaign included 14 music concerts around the country and a DJ competition, as well as a special theme park with cartons displayed on them.

In addition, the tobacco company placed advertisements in publications popular with Latino youth, like this one here, including "Latina" and "Cos-

mopolitan en Espanol." The ads include slogans like: "It's about pursuing your ambitions and staying connected to your roots." To reach everybody in our community, they not only use attractive Latino models, but they also make sure ads are in English and Spanish.

The cigarette companies have focused on African American populations as well. One company created a line of cigarette flavors like Caribbean Chill and Mocha Taboo and used images of African Americans to promote their cigarettes. This targeted marketing is having an impact on the rates that we are seeing, higher number of people smoking. In 2005, 22 percent of Latino high school students smoked, a 19 percent increase over 2003, when the smoking rate was down to 18 percent.

Smoking continues to be a huge public health risk for us, and we must not tolerate it in our communities. We have to stand up to these big corporations and say, enough advertising, let's speak the truth, let's talk about prevention, let's talk about awareness, let's talk about alternative lifestyles so we can have healthier communities.

I am pleased that we were able to entertain this discussion on the uninsured, the celebration of Uninsured Week and to talk about the disparities that exist in our communities and communities of color.

I am pleased to give the remainder of my time to the distinguished woman from the Virgin Islands, who is chairperson of the task force for the Black Caucus, the Congressional Black Caucus.

□ 2210

Mrs. CHRISTENSEN. Mr. Speaker, I came to the floor to speak on another issue, but let me say a few words about health disparities before I do.

Health disparities is one of the remaining issues and causes of our civil rights struggle. And because our country does not recognize health care as a right, African Americans, Latino Americans, Native Americans, Alaskan natives, and other people of color, poor and rural people, do not receive the same kind of health care, prevention, or health maintenance. And because of that, you will find that in this country more than half of the uninsured are people of color.

We have two times more diabetes than the white population, and all people of color suffer from more complications.

African Americans have higher rates of death from heart disease and several cancers, prostate, colon, lung, and breast. We are over 50 percent of all new HIV cases and over 50 percent of new AIDS cases. African American and Latino women are 70 to 80 percent of all AIDS cases among women. Hypertension we find is becoming a worldwide epidemic, and African American women are the most impacted by hypertension; however, more African American men die from hypertension.

Our infant mortality is twice as much as our white counterparts, and the New York Times yesterday reported that it is growing in the southeast region of our country. So we really have an obligation in this Congress to address the health care disparities and the health disparities and the lack of coverage in this country to ensure that health care is provided equally to every American.

And so, Mr. Speaker, I want to pay tribute to a woman who was a champion of health for minorities and other people of color. The extremely sad news of Congresswoman MILLENDER-MCDONALD's death came as a shock to all of us, and it is with a deep sense of loss that I join my colleagues who were here earlier in mourning her passing. Not only have I lost a colleague, but also a mentor, a sister, and a friend.

I am honored to work alongside Congresswoman MILLENDER-MCDONALD as members of the Congressional Black Caucus together, and the Small Business Community. JUANITA was a true champion for minority and women-owned small businesses, and played a pivotal role in proposing and passing legislation to expand financing and contracting opportunities for our Nation's small businesses. Her dedication to helping women-owned businesses was evident in her dedication to increasing funding to expand women's business centers throughout our Nation.

Her commitment to improving the lives of minorities is reflected in her lifelong work in affiliations with organizations such as the NAACP, Alpha Kappa Alpha, and a number of other organizations devoted to the advancement of minorities. She will also be remembered for her outstanding stewardship in the areas of transportation, education, health, and FEMA legislation.

We are grateful for the leadership and the innovation that she brought to the Committee on House Administration, which led to her historic achievement as the first African American woman to chair a committee in Congress.

I know that the House staff and all of the Members appreciate her role in establishing the House Fitness Center and creating an outlet for mental and physical activity. She has truly left a legacy for all of us through her distinguished service on this important committee.

JUANITA will also be remembered for her passion for education, which was evident in her many eloquent speeches on the floor. She was truly a gifted and skilled orator. JUANITA had the distinct ability to captivate and engage her audiences. Although she possessed strong and determined qualities, she personified grace, compassion, and beauty both inside and out.

On a more personal note, it was through JUANITA, a minister's daughter, that I began attending Thursday morning prayer breakfast when I first

came to Congress. Her godliness was seen in all that she did.

JUANITA championed the cause of AIDS long before it was fashionable to do so. Every year she held a race in her district. And while I could never get away to attend, she always had all of our support, and we never missed a t-shirt or any of the other paraphernalia that she gave out each year.

JUANITA always spoke of her district with great affection and dedication. She frequently remarked that she had the most diverse district in the country, that she was able to bring them together. And to be reelected over and over is a testament to her leadership and her abiding belief that we are all children of God, equal in His sight and made in His image. Her mission was one of justice, fairness, and opportunity for all.

One cannot speak of JUANITA MILLENDER-MCDONALD without remarking on her exquisite taste and her unequalled sense of style. She was always dressed to the nines and was always the epitome of elegance and grace.

Mr. Speaker, although her passing leaves a void in the halls of Congress, her spirit and legacy will forever be with us. Words are not enough to express our profound sorrow. On behalf of my family, staff, and the people of the U.S. Virgin Islands, my deepest sympathy goes out to her husband, James McDonald, their children, grandchildren, extended family, and dedicated staff. May God bless and comfort them at this time in grief as we know He is welcoming our sister home.

Ms. WATERS. Mr. Speaker, I would like to thank Congresswoman HILDA SOLIS, the Chair of the Congressional Hispanic Caucus Task Force on Health and the Environment, for organizing this evening's Special Order in honor of National Minority Health Month.

Martin Luther King, Jr., said, "Of all the forms of inequality, injustice in health care is the most shocking and inhumane." Unfortunately, injustice in health care is widespread and growing in American society today.

THE UNINSURED

Over 46 million Americans don't have health insurance.

That is a 15 percent increase in the number of uninsured since the President took office.

Twelve percent of white Americans, 19 percent of Asian Americans, 20 percent of African Americans, 27 percent of Native Americans and 35 percent of Hispanic Americans have no health insurance.

Nationwide, 9 percent of children under the age of 18 and 19 percent of adults ages 18 to 64 are uninsured.

LOS ANGELES COUNTY

In Los Angeles County, 8 percent of children under the age of 18 and 22 percent of adults ages 18 to 64 are uninsured.

In the Southern Service Planning Area of Los Angeles County [SPA6], where my district is located, lack of access to health insurance is especially high: 11 percent of children under the age of 18 and 32 percent of adults ages 18 to 64 are uninsured.

In the same area, an alarming 44 percent of adults reported difficulty accessing medical

care, and 21 percent of children have difficulty accessing medical care.

Furthermore, in the Southern Area of Los Angeles County, 35 percent of adults and 19 percent of children did not obtain dental care in the past year, because they could not afford it.

We cannot continue to ignore these alarming statistics.

INFANT MORTALITY

Infant mortality rates are considered to be one of the most important indicators of the health and well-being of a population. In 2003, the last year for which nationwide data is available, the infant death rate was 6.9 deaths for every one thousand live births.

Infant death rates among African Americans are considerably higher. Among whites, there were 5.7 infant deaths per thousand live births in 2003; while among blacks, there were 14.0 infant deaths per thousand live births.

In Los Angeles County, there are 5.0 infant deaths per thousand live births. Among African Americans, there are 11.7 infant deaths per thousand live births.

According to an article in Sunday's New York Times, infant deaths in the South are growing.

In Mississippi, the infant death rate had fallen to 9.7 in 2004 but then jumped sharply to 11.4 in 2005. In concrete human terms, a total of 481 babies died in Mississippi in 2005. That's 65 more babies than died the previous year.

Among African Americans in Mississippi, infant deaths rose from 14.2 per thousand in 2004 to an astonishing 17 per thousand in 2005.

Infant death rates also increased in 2005 in Alabama, North Carolina, and Tennessee.

Clearly, injustice in health care is taking its toll.

If we truly believe that all men and women are created equal, we cannot allow these disparities to continue.

HIV/AIDS

Racial and ethnic minorities have disproportionately high rates of HIV and AIDS in the United States.

According to the Centers for Disease Control and Prevention, racial and ethnic minorities represent 71 percent of new AIDS cases and 64 percent of Americans living with AIDS.

African Americans account for half of new AIDS cases, although only 12 percent of the population is black.

Hispanics account for 19 percent of new AIDS cases, although only 14 percent of the population is Hispanic.

Asian Americans and Pacific Islanders account for 1 percent of new AIDS cases, and American Indians and Alaska Natives account for up to 1 percent.

Racial minorities now represent a majority of new AIDS cases, a majority of Americans living with AIDS, and a majority of deaths among persons with AIDS.

It was because of the severe impact of HIV and AIDS on minorities that I developed the Minority AIDS Initiative back in 1998. The Minority AIDS Initiative provides grants to community-based organizations and other health care providers for HIV/AIDS treatment and prevention programs serving African American, Hispanic, Asian American and Native American communities.

Unfortunately, the Republicans in Congress cut the funding for the Minority AIDS Initiative

from its maximum level of \$411 million in fiscal year 2003 to under \$400 million today. Meanwhile, the need for the initiative has continued to grow as the disease has continued to spread.

This year, I am calling for an appropriation of \$610 million for the Minority AIDS Initiative in fiscal year 2008. So far, a total of 62 Members of Congress have agreed to sign a letter in support of this level of funding. I am hoping to convince additional Members to support the expansion of the initiative before this week is over.

DIABETES

Diabetes is the sixth leading cause of death in the United States, and it has a particularly severe impact on minorities.

The Centers for Disease Control and Prevention estimates that 9.5 percent of Hispanic Americans, 12.8 percent of American Indians and Alaska Natives, and 13.3 percent of African Americans over the age of 20 have diabetes. Many Asian Americans are also at high risk.

Diabetes can lead to serious and sometimes deadly complications, including high blood pressure, heart disease, stroke, blindness, kidney disease, and nerve damage.

Too often, some of these complications result in lower-limb amputations.

Minorities with diabetes often lack access to proper health care and are more likely to suffer from complications.

Because of these disparities, I introduced H.R. 1031, the Minority Diabetes Initiative Act.

This bill would establish an initiative to provide grants to physicians, community-based organizations, and other health care providers for diabetes prevention, care, and treatment programs in minority communities.

The Minority Diabetes Initiative is based on the successful model of the Minority AIDS Initiative.

This bill would help to reduce diabetes disparities and improve the ability of minorities with diabetes to live healthy and productive lives.

The bill has 40 cosponsors, representing both political parties.

CANCER

Health disparities also affect minorities who suffer from cancer.

Blacks have a cancer death rate that is about 35 percent higher than whites.

The mortality rates for blacks with breast, colon, prostate and lung cancer are much higher than those for any other racial group.

Black and Hispanic women are less likely to receive breast cancer screening with mammograms than white women.

Black and Hispanic men are more likely to be diagnosed with more advanced forms of prostate cancer than white men.

The incidence of prostate cancer is approximately 60 percent higher among African-American men than white men, and the death rate from prostate cancer is 2.4 times higher in African-American men than white men. This is the largest racial disparity for any type of cancer.

Earlier this year, I introduced H.R. 1030, the Cancer Testing, Education, Screening and Treatment (Cancer TEST) Act. This bill would provide grants for cancer screening, counseling, treatment and prevention programs for minorities and underserved populations.

The Cancer TEST Act would authorize grants for the development, expansion and operation of programs that provide public education on cancer prevention, cancer

screenings, patient counseling services and treatment for cancer.

Grants would be made available to community health centers and non-profit organizations that serve minority and underserved populations.

The Cancer TEST Act would emphasize early detection and provide comprehensive treatment services for cancer in its earliest stages, when treatment is most likely to save lives.

The bill has 29 cosponsors.

NINETY-SECOND COMMEMORATION OF THE ARMENIAN GENOCIDE

The SPEAKER pro tempore (Mr. ELLISON). Under a previous order of the House, the gentleman from New Jersey (Mr. PALLONE) is recognized for 5 minutes.

Mr. PALLONE. Mr. Speaker, I want to thank my colleagues on the Republican side for agreeing to let me reclaim the time. I will try to limit my time to less than 5 minutes.

Mr. Speaker, I rise this evening to commemorate the 92nd anniversary of the Armenian genocide. As the first genocide of the 20th century, it is morally imperative that we remember this atrocity and collectively demand reaffirmation of this crime against humanity.

On April 24, 1915, 92 years ago tomorrow, that day marked the beginning of the systematic and deliberate campaign of genocide perpetrated by the Ottoman Empire. Over the following 8 years, 1½ million Armenians were tortured and murdered, and more than one-half million were forced from their homeland into exile. These facts are indisputable, but to this day the U.S. Congress has never properly recognized the Armenian genocide.

The historical record, Mr. Speaker, on the Armenian genocide is unambiguous and well-documented with overwhelming evidence. The U.S. Ambassador to the Ottoman Empire at the time, Henry Morgenthau, protested the slaughter of the Armenians to the Ottoman leaders. In a cable to the U.S. State Department on July 16, 1915, Ambassador Morgenthau stated that, "A campaign of race extermination is in progress."

Mr. Speaker, if America is going to live up to the standards we set for ourselves, and continue to lead the world in affirming human rights everywhere, we need to finally stand up and recognize the tragic events that began in 1915 for what they were: the systematic elimination of a people.

Despite pleas by Members of Congress and the Armenian-American community and recognition by much of the international community, President Bush continues to avoid any clear references to the Armenian genocide, while consistently opposing legislation marking this crime against humanity. Instead, he has chosen to succumb to shameless threats by the Government of Turkey. I strongly believe that Turkey's policy of denying the Armenian

genocide gives warrant to those who perpetrate genocide everywhere, because denial is the last stage of genocide. If the cycle is to end, there must be accountability. And just as we would not permit denying the Holocaust, we cannot accept Turkey's falsification of the facts of 1915.

Mr. Speaker, I must say that in the last few months the Turkish Government has made every effort to try to prevent the Armenian genocide resolution from coming to the floor of the House of Representatives. But I just want to show why denial is such a bad thing in a sense. Last week, I came to the floor and I pointed out that when the U.N. wanted to do a project or an exhibit at the United Nations headquarters talking about the genocide in Rwanda, because the Turkish Government protested the inclusion of the Armenian genocide, the Rwandan genocide never took place. There again, if you deny one genocide, you end up denying or impacting the other.

And the fact of the matter is that when some of my colleagues say to me, "Well, why do you need to bring up something that occurred 92 years ago," I say, "Because by denying this, the Turkish Government continues to perpetrate genocide or oppression of its minorities."

Just a few weeks ago, there was something in the New York Times about how the Turkish Government continues to persecute the Kurdish minority. Many Kurds have been killed, driven from their homelands in the same way Armenians were. The Kurds happen to be a Muslim people, not a Christian people. That doesn't matter. The Turkish Government consistently oppresses minorities. They refuse also to open their borders with Armenia. They have actually had a blockade of Armenia in placed for several years, which contributes to the economic instability of Armenia.

So this is something that must be done. It must be accomplished, that we recognize this genocide if it continues in various ways in Turkey today.

The second thing I would point out is that the Turkish Government has been basically hiring lobbyists for millions of dollars to go around and tell Members of Congress that if they pass the genocide resolution, there will be dire consequences: Turkey will not allow supplies to go to U.S. troops in Iraq.

□ 2220

They have actually taken to having Members of Congress called and told that their own soldiers in Iraq might be threatened if they pass the genocide resolution.

Well, again, this is the type of bullying that we, as a free government, should not allow because bullying is essentially the same thing that takes place when genocide takes place. Why should we give in to the threats of a country that tries to bully our country over such an important issue as the genocide?

Now, let me just mention, Mr. Speaker, to wrap up, that tomorrow evening at 6:30 the Armenian Caucus, which I cochair, will host an Armenian genocide commemoration event with the Armenian embassy, and I hope that many of the Members will attend this.

THE COUNTDOWN CREW

The SPEAKER pro tempore. Under the Speaker's announced policy of January 18, 2007, the gentleman from Pennsylvania (Mr. SHUSTER) is recognized for 60 minutes as the designee of the minority leader.

Mr. SHUSTER. Mr. Speaker, I am coming to the floor this evening, as I have been for the past couple of months, to make sure that the American people realize what is going to happen in the next couple of years if we, in Congress don't act, if the Democratic majority doesn't act.

In 1,349 days, if we don't act, we are going to see the largest tax increase in American history. And this is coming about because the tax cuts, the tax reductions that we put in place as a Republican majority in 2001, 2003, extended some of those in 2005, they are going to expire. And the majority party doesn't have to act. All they have to do is run the clock out, and those tax increases will go into effect on the American people. The American family, small businesses, all around this country are going to feel the pain.

As I said, my friends and I have been, colleagues and I have been coming to the floor for the past few months talking about this, making sure that the American people are aware that this is going to occur.

And I have heard some folks on the other side of the aisle say that they are not going to vote for a tax increase, thus it is not really a tax increase. Only in Washington do we employ that type of rationale, that type of logic.

If we don't act, there is going to be a tax increase. And for the American people, who have just paid their taxes this year, and when they go to pay their taxes in 2008 and 2009 and 2010, they are going to see that their taxes have increased. Although there wasn't necessarily a vote on the House floor to specifically increase those taxes, those tax cuts expiring are, in effect, and, in fact, going to increase their taxes.

What kind of tax increase are we talking about? First of all, raising, from the 10 percent tax bracket to 15 percent. And more than 5 million individuals and families previously who owed no taxes will become subject to those individual income taxes in 2011, if we don't act on the House floor. If the Democratic majority doesn't act, the Democratic majority will be responsible for raising taxes on people in the lower-income levels in this country.

It will eliminate the marriage penalty relief that we put in place in the early 2000s. By 2011, 23 million taxpayers would see their taxes increase an average of \$466 just because they are married.