

own small part, feel very, very privileged, very privileged to have been born or to be a citizen or to have as fellow citizens people who have come into this country in the United States of America. Just take a look at the last words we have got: "Were it not for the brave, there would be no land of the free."

HISPANIC HEALTH CARE

The SPEAKER pro tempore (Mr. BURGESS). Under the Speaker's announced policy of January 7, 2003, the gentleman from Texas (Mr. RODRIGUEZ) is recognized for 60 minutes.

Mr. RODRIGUEZ. Mr. Speaker, thank you for allowing the opportunity to be here tonight.

This month is health care month and I wanted to take the opportunity to come up here tonight to talk a little bit about health care. And as chairman of the National Hispanic Congressional Caucus, I wanted to specifically emphasize Hispanic health care. I want to thank also my colleagues who are both on the Hispanic Caucus who have been working extremely hard in the area of health care, the gentlewoman from California (Ms. SOLIS) and the gentleman from Texas (Mr. GONZALEZ) and others.

Hispanics are now the fastest-growing population in the United States and comprise 13 percent of the total population. Yet they continue to suffer disproportionately from health disparities and face many barriers in access to quality health care. Over 33 percent of the Hispanics are uninsured. That is one out of every three find themselves without access to insurance, compared to 10 percent of the non-Hispanic whites. Let me just add that the uninsured population continues to grow, continues to become even worse as with the economy as well as with the fact that we have not been supportive of some of those programs.

And I would also add that those people who are uninsured are the ones that are out there. They are working Americans trying to make ends meet but find themselves working in small companies, find themselves working in rural America, find themselves not working for a major corporation or governments, so they find themselves without access to insurance. Yet, they are working. They do not qualify for Medicaid because they are not poor enough because they are making money, but then they do not qualify for Medicare either because they are not senior enough. So here they are in between, working Americans, yet find themselves unable to afford health care. Yet in a country that has the best health care system in the world, it is not affordable; and it is not accessible to working Americans.

When it comes to children, the numbers are equally sad. Hispanic children have the highest uninsured rate in the United States, with the child population one out of every four, 24.1 per-

cent. So we have a situation that not only hits the uninsured but it also hits the most vulnerable, our children. Over 35 percent of all Hispanic children depend on State Children's Health Insurance, or what we have call the SCHIP program, for health care needs.

We know that the uninsured have limited access to care. And we also know that the uninsured suffer disproportionately from diseases that can be prevented, treated and even cured. And that is what is so sad, some of these diseases can be prevented; some of these diseases can be treated and some can be cured. And then I look at the numbers where I see the statistics that show that in 1 year an estimated 2 million Hispanics were diagnosed with diabetes and another 1 million were estimated to have undiagnosed diabetes. And so here now we have the data to be able to diagnose diabetes at a very early age. We have the information. We have the potential of making a difference. We have the capability of being able to provide the data that is needed.

And I want to let you know that in the area of diabetes, I have been well educated in that area. When I served in the Texas House, I was in the public health committee, and I recall very distinctly finding out the data. When we looked at the disease, diabetes, at the number of people that go blind, the number of amputees usually as a result of diabetes, a large percentage of them, and, ironically, enough, in those areas it is an area that can be prevented, especially now that we can diagnose it at an early age, where we can work with those youngsters, work with those families so they do not have to suffer later on where they might lose a limb or go blind.

We also have when we see statistics that show 20 percent of persons living with AIDS are Hispanics, we know we have a serious problem if we do not start to address the state of Hispanic health with targeted prevention programs, treatment programs. With the strains that the health care system is currently experiencing, then we will have even more dramatic problems.

In the area of AIDS, we have made some significant strides. In fact, the data show that the numbers overall have been going down, and that is good and the statistics have shown it. But when it comes to minorities, especially African American and Hispanics, we find within ourselves it is growing disproportionately. And so AIDS has not gone away. It is still there. It is still a killer, and it is still one of the areas that we need to concentrate on. And it is also an area where we identify it as one of those infectious diseases such as tuberculosis that we really need to concentrate on, no matter whether it exists in this country or anywhere else. So eventually we will have to deal with it. So it becomes important that we zero in on AIDS and see what we can do.

One of things I wanted to mention about AIDS is that in our Hispanic

community throughout this country one of the difficulties is that a lot of communities have what we call community-based organizations, and we have a few but our programs were not initially, we do not have as many as other community groups do. And so you find in the Hispanic community a lack of community-based organizations that are not funded. You have some groups, but they do not have sufficient resources. And so when they try to compete for the Federal dollars, for the State dollars, they find themselves a disadvantage because they were not there from the very beginning; they were not there when these other organizations were given these seeds monies to be able to start those programs to be able to make a difference.

I also wanted to take this opportunity also to talk a little bit about the Hispanic Health Improvement Act. Through the caucus, we organized, the Hispanic Congressional Caucus, has organized based on task forces. We have a task force that is headed by the gentlewoman from California (Ms. SOLIS), but we have worked on that task force to come up with our own Hispanic Health Improvement Act; and we have been working on this for some time now. It is a comprehensive bill aimed at improving Hispanic health in the United States. The legislation offers a variety of strategies for expanding health care coverage, for improving access and affordability, which is key, for also reducing health disparities as well as strengthening our Nation's health care workforce.

Let me just add that this particular piece of legislation is a piece of legislation that I have personally been working on for a little bit since I came up here almost 6 years ago; and it has evolved into a piece of legislation that is pretty comprehensive over all and touches on a lot of areas that the Hispanic community has been encountering and the difficulties in the disparities. One of the things that we did about a year ago was we did a conference where we asked every Member, both Republican and Democrat, that had any significant number of Hispanics in their districts, we invited them to a conference, and we had the conference in San Antonio. We had great participation, not only from the legislature, but also from each of the Members' staff. We invited one or two members from each of the staffs. And there we were able to come up with additional recommendations that were extremely helpful in beginning to finalize our piece of legislation and begin to address the responses that we needed in order to make that happen.

This legislation provides for the expansion of the successful State Children's Health Insurance Program, which is known as SCHIP, to cover the uninsured low-income pregnant women and parents. Right now the SCHIP as we well know does not cover women that are pregnant, that are uninsured; and we also know the importance of

covering them is key. It also provides the flexibility to States that want to enroll legal permanent resident children and pregnant women. And once again, these are legal permanent resident children and pregnant women. We do not have that in the present legislation, and it is important. It is important that that also occurs. There must also be flexible incentive for States to increase enrollment in times of economic recession and as the population increases.

It is important, the proposal, that the administration has right now is to basically take the SCHIP program, the Medicaid program and what we call the disproportional share and put it into one lump sum, which is most of the needy programs in this country, and then send it to the States but then it caps it. Our program allows for the flexible incentive that if the numbers increase, you are able to put additional resources. Especially in those areas where the population is growing, it is important that we provide access to that capability. And we know that population fluctuates every 10 years or so because we draw our lines based on that for political representation. So we also know that the numbers of the ones that are in need also grow.

The legislation also addresses the future needs of our health care system and provides increased funding for health resources services, administration health professions, diversity programs; and we must ensure that our health care system can provide both linguistically and culturally appropriate health care. You might say, well, what does that mean? I just want to give one example. I recall a couple of years ago, it has been about 3 years ago when we had a hearing and I remember some testimony that was provided by one of the doctors who said that she had a client, and during that hearing she indicated that the client had been informed that she had been positive for AIDS. But in Spanish it was translated AIDS is positivo. If you just tell someone they are positive without explaining in Spanish as to what it means in terms of what it means to be positive, in Espanol you say "esta positivo," that means everything is okay.

So when you just get it in writing, she assumed that everything was okay. Well, that particular patient had a child and contracted AIDS. And so we have got to be able to communicate. We have got to be able to reach out. And a lot of times our health professionals might not be both linguistically or culturally appropriate in terms of being able to communicate, and sometimes our education assumes a great deal on the part of the patient, and that needs to be considered.

These programs also promote diversity and support training professionals in the fields that are currently experiencing shortages. The bill also targets approaches that will help improve the health care of Hispanic communities in

those areas and to make sure we address some of those needs.

Let me take this opportunity to talk a little bit more about our piece of legislation because when we talk about the importance of shortages in our Nation's health care, the bill begins to look at addressing the needs of what exists. And we know that right now there are thousands and thousands of nurses that are needed. We need nurses. And we need to make sure that we have the resources to make that happen. So this bill calls for beginning to look at providing those resources to make that happen. We have got to begin to educate our health care professionals. We have got to produce our own health care professionals. We need doctors.

Let me give an example, and I think I have shared this before, but I have got to keep saying it because we still do not do anything about it.

□ 2200

We always complain about immigration. We always indicate that there are too many people coming from abroad, and prior to 9/11, we had a little less than 300,000 people come from abroad. This is the professional category, 300,000.

In that category, Mr. Speaker, we have approximately 5,000 doctors. If we look at the data, Mr. Speaker, we graduate 12- to 13,000 each year; yet, we bring in 5,000 doctors each year. We are a brain drain on the rest of the world.

At the same time, we tell people, young people who want to go into medical school, to qualify, we tell two of them, sorry, we do not have any room for them. So at some point we have to produce our own. We have got to produce more doctors, more health care professionals. We need more dentists and pharmacists. We need more nurses, and so we need to begin to provide those opportunities for some of our people in this country to be able to provide that access that is needed.

In addition to that, the bill also calls for improving access and affordability to medically underserved areas. The border area is one of the most underserved areas in the Nation, and it is an area that requires a great deal of help. It is an area that requires a great deal of assistance, and we need the resources to provide access to health care.

I represent San Antonio down to the Mexican border where I have La Salle, Zapata, Starr and Hidalgo, and in those counties there was a recent study that has just been done. In fact, I am going to have a chance to meet the author and discuss it. It is a good friend of mine, and we will discuss the findings; but Dr. Ortiz was telling me that on the survey that he had done of individuals in Hidalgo County, as I recall, and there might be some from Starr County also, that is also on the border, that when they were asked, where did they get access to their health care, 50 percent of them, they were Americans who were asked, where do they get their access to health care, it was in Mexico.

We complained about people coming from Mexico, accessing our services, and yes, they do come over and access our service, but a large percentage of them also go to Mexico to access service, both for prescription drugs, for dental services and for just general health care.

So it is important to note that we still in this country have not been able to meet the needs in those underserved areas. Our rural America is having a great deal of difficulty getting access to good quality care. With the advent of the HMOs and the health care systems, those systems are unwilling to go into rural America because they do not see the profits there. They do not see the way they are going to be able to make a profit, and most of them find themselves in urban areas. So rural areas, the options are very limited to some of the constituencies in our rural communities throughout this country.

There is a real need, and this particular bill provides some resources to begin to look at those underserved areas and begin to provide access to be able to get those resources.

Also, thirdly, the bill increases resources that are needed to combat Hispanic health disparities. I want to take this opportunity to talk about a couple of those disparities.

One of them is the area of diabetes, and I know I mentioned to my colleagues earlier that diabetes is a very important issue that confronts Latinos and others, but I wanted to just mention some of the statistics in the area of diabetes.

In 2000, an estimated 2 million Hispanics had been diagnosed with diabetes, and another 1 million are estimated to have undiagnosed diabetes. Approximately 10 percent of all Hispanics have diabetes; that is one out of 10. That is a pretty significant number when we see one out of 10 Hispanics that suffer from diabetes. For those that are 50 or older, the data goes up to 30 percent that have diabetes. So as they reach the age of 50, it is 30 percent. That is almost three out of 10. So it increases dramatically.

Hispanics, on the average, are almost two times more likely to have diabetes than non-Hispanic whites. So diabetes is definitely an area that we really need to look at, an area that we really need to concentrate on, and I am hoping that we are able to get the resources that we are asking under the Hispanic Health Improvement Act to be able to respond to those needs.

Remember that this is an issue and this is an illness and a disease that causes people to lose their limbs. It causes people to go blind, and their quality of life is hampered. It is an area that in a lot of cases can be prevented, and there are some beautiful programs out there. Dr. Trevino's program in San Antonio that works with kids in the San Antonio ISD school district and others, these are good programs, viable programs.

I have been blessed that in my district, in Starr County was where some

of the first studies that were done in the area of diabetes, where they are able to now identify those youngsters in elementary school that have the signs or the possibility of diabetes; and so we need to make sure that we go forward in that area.

The other area that I have mentioned to my colleagues that is also a disparity that I would like to just kind of address a little more, and that is the area of both HIV and AIDS. Twenty percent of persons living with AIDS are Hispanic, 20 percent, despite the fact that we only represent 13 percent of the population. So we see the disparity, and that 20 percent is significant.

The AIDS incidence rate per 100,000 population, the number of new cases of diseases that occurred during a specific time period among Hispanics in 2000 was 22.5, more than three times the rate for whites. So in the area of AIDS, we are disproportionately hit, and according to projections made by the Harvard School of Public Health, by the year 2050, the number of new AIDS cases among Hispanics will surpass that of whites. When it comes to AIDS and HIV, we have an area that we really need to begin to look at how we are going to concentrate, how we are going to be looking at meeting some of those needs of those individuals.

Once again, there is need for basic grants to start up those community-based organizations that do not exist in our communities. They exist in some of the other communities, but in ours, we still do not have the community-based organizations.

The other areas of disparity are the issues regarding cancer, the issues of asthma, substance abuse and mental health. Let me briefly, in the area of mental health a number of studies suggest that the mental health of Hispanics decreases as Hispanics adapt to the U.S. way of life. That is kind of interesting, that as they become more Americanized, the mental health problems supposedly decrease. Hispanic youth experience, proportionately, more anxiety-related though, and delinquency problem behaviors with both depression and drug use than do non-Hispanic white youth. In fact, many refugees from Central America experience kind of trauma-related traumas in the homelands where they come from with the civil wars, and so a lot of them are suffering from post-traumatic stress disorders.

It is one of the areas that we know especially with our veterans that it is something that needs to be worked on. It is something that needs to be treated, and it is similar to, for example, what happened in New York after 9/11. There is no doubt that we ought to be working with a lot of New Yorkers there and the families because of the issue of post-traumatic stress disorder, and it is something that stays with someone.

If anyone has gone through any experience such as that, it is something that changes their life. It is something

that dramatically causes a person to change, and in some ways, they are even unconsciously doing certain things without realizing why they are doing it and why they think in certain ways because of the impact of that traumatic experience.

So it applies not only to veterans in the war, but it also applies to things that we witness, things that we have experienced. So post-traumatic stress disorders among young Latinos also has increased, along with the issue of depression.

Among Hispanics with mental disorders, fewer than one in 11 contact mental health specialists. So a lot of Hispanics who do suffer from mental health difficulties do not contact for assistance, are not in our mental health programs throughout this country, are not getting the service that they need, while fewer than one in five contact general health care providers, but one in 11 failed to contact.

Among Hispanic immigrants with mental disorders, fewer than one in 20 use the services. So the numbers go even lower as they first come into this country. They tend not to utilize the services.

Let me talk a little bit on mental health. Mental health is one of the areas that for some reason in this country, just like in health care, but more so in mental health, it is an area that we have been reluctant to fund. It is an area that we have been reluctant to provide assistance to, an area where a lot of our youngsters suffer from depression, where a lot of our women suffer from depression, where we have forgotten quickly what happened at Columbine, and so those things are still there. Those problems still exist, and there is a need for us to reach out to our young people. There is a need for us to work with our communities and our schools to see how we can help, and there is really a need for us to reach out.

There is data to show that Latinos, Hispanics, a large number of them, in fact, the number of suicides among Latinos is growing. So it is an area that we need to really kind of look at real close. So I wanted to make sure that I emphasize that our program also talks about the mentally ill as well as substance abuse.

Let me also briefly talk about another disease which is heart disease. Heart disease claims the lives of 30 percent of, more than 107,000, Hispanic Americans who die each year, 107,000, 30 percent are Hispanics. Among Mexican American adults, about 29 percent of men and 27 percent of women have cardiovascular diseases. Among those with high blood pressure, Mexican Americans are much less likely than non-Hispanic whites and non-Hispanic blacks to be aware of it and be treated. So not only do they have high blood pressure, but a large number of them are not even aware of the problem, and they feel okay or think they feel okay and they continue to act in the way

they do, and so they are unable to get it treated.

It becomes real important that we provide the preventive care that is needed, to provide the access to those services that are important.

So I wanted to emphasize those specific programs that we have and indicate the importance of that.

Let me also take this opportunity to also talk briefly about the prescription drug coverage. For access to health care, we know at one time, when both Medicaid and Medicare were established, we could have argued, well, prescriptions were maybe not that important at that time. Although for our indigent, we have provided access to prescription drug coverage, but we have not done that for Medicare, and I know that the President has come up with a proposal on Medicare for prescription drugs, but we also know that that proposal is inadequate, and everyone knows it and everyone recognizes that.

It is a proposal that is just out there that is a facade, that does not really address the needs of our seniors that are suffering from Medicare.

For Hispanics, most of our Hispanic Americans that find themselves in their twilight years, the majority only have Social Security and nothing else and find themselves only with Medicare and no Medicare-Plus or any other, and so it becomes real important that we start to begin to look at a prescription drug plan that helps to address the needs of our seniors and our seniors are in need.

Our seniors are having a great deal of difficulty, and every time I go to a senior citizen center, every time I am at church, people will approach me about the importance of prescription drugs and the importance of making it accessible to our seniors.

The ironical thing about it is, once again, here we have a country that has come up with some beautiful health care programs, some beautiful responses to some of our diseases; yet our people do not have access to them and they are not affordable.

So I would ask what good does it do to have all the information, all the good prescriptions that are out there to address the needs of some of our problems when people do not have access to them, and they are not affordable?

□ 2215

So there is a real need for us to reach out to those seniors and make that accessible.

The importance of the prescription drugs to our seniors is key. We know that that is one of the main ways of addressing the needs of our seniors. We know that that is one of the few ways that they can deal with their problems. So it becomes important that we come up with a program that addresses the need of prescription drug coverage for our seniors, and we know that the President's proposal is not adequate.

The Bush budget basically sacrifices the health of our Nation to provide tax

cuts for the wealthiest 1 percent. The Bush budget fails to adequately address the problems of the 41 million Americans that find themselves uninsured. Nearly 25 percent of all uninsured are children. Even 25 percent of the moderate-income families cannot afford health insurance. And eight out of 10 uninsured Americans are working individuals. We have to keep that in mind. These are people that are trying to make ends meet. These are people trying to work to go after that American dream, yet finding themselves without health insurance, unable to provide the resources when they do find themselves in need of medications.

I wanted to stress one more time that in the area of health care for our seniors we find ourselves in the Congress and in the administration with an unwillingness to respond to a program that addresses their needs. We ought to recognize that the private sector has even indicated that they cannot make a profit from our seniors, Mr. Speaker. We know that they spend a little bit over \$1,000 on prescriptions, and we know that the private sector has a rough time. The only ones they can make a profit on are those healthy seniors that find themselves in a situation where they are not that sick. But as soon as they do get sick, they are not good for our insurance companies because they cannot make a profit.

And that is fine, Mr. Speaker. Insurance companies are there as a for-profit operation. They are there to make a profit. So we should not expect them to provide access to our seniors. But it is the responsibility of the government to provide for its most vulnerable. These individuals have been there for us in the past. These individuals have worked all their lives. Now it is our obligation and our responsibility to provide for access to that health care.

In the same dialogue, when we talk about health care, I wanted to take this opportunity to also talk about our veterans at a time when our veterans are growing in numbers. With a lot of the World War II veterans, the Korean veterans, as well as the Vietnam veterans reaching that age, the demographics show there are a large number of veterans; and that number is increasing. So it is important for us to step up to the plate.

Yes, we have provided some minimal increases throughout the years, but it is not sufficient. So I wanted to take this opportunity, because of the fact that we do have our soldiers in Iraq and Afghanistan and Colombia, but more so in Iraq, to just express that our thoughts and our prayers go out to all our soldiers that are out there, and we wish for their quick and safe return. We know that we are going to be victorious. We know we are going to be able to make that happen. We want that to occur as quickly as possible, and we are going to try to provide them with whatever resources they need. But we must also honor our veterans services. We honor them by en-

suring that they have access to quality benefits and services once they come home, and that is important.

With our troops in the field, and, sadly, with many Americans already experiencing the war's devastating effect, it is shameful that this House passed a budget resolution cutting \$15 billion from veterans disability compensation programs and \$9.7 billion from veterans health care at the same time, Mr. Speaker, that our soldiers began Operation Iraqi Freedom. It is clear that this proposal will have a devastating effect on the VA health care and benefits program, and it would serve as a further insult to millions of veterans already facing reductions in their health care, in their compensation, in their pensions and education benefits.

The administration's budget was already inadequate to meet the health care needs of our veterans, and now the House Republicans have gone further and cut \$844 million above the President's request for veterans health care next year. Not only was the President's budget inadequate, but the House chose to go beyond that and cut even further. The proposal, which was approximately \$1.3 billion above the 2003 appropriations, would not even cover the inflationary impact and anticipated salary increases for the VA health care workers.

Mr. Speaker, the budget relies on unrealistic management efficiencies and increased copayments. Despite the fact that there are arguments that there was money added, it is based on certain management efficiencies that they are going to be able to achieve. So it is not even real dollars. It is based on increasing copayments for our veterans and a new annual enrollment tax on certain veterans using the VA health care system and other inefficiencies, such as eliminating 5,000 VA nursing home vets. Mr. Speaker, that is the bill that we voted out, one that would cut and eliminate 5,000 nursing home beds.

The budget resolution also calls for cutting \$15 billion over 10 years. That is \$463 million just in 2004 alone in the VA mandatory spending under the guise of eliminating fraud, waste and abuse. Well, 90 percent of the spending for the VA health entitlements is paid out of monthly payments to disabled veterans and their survivors. I personally do not consider payments to war disabled veterans, pensions for the poorest disabled veterans, and the GI bill benefits for the soldiers returning from Afghanistan to be fraud, waste or abuse.

I recently joined my colleagues on the House Committee on Veterans' Affairs, led by our Republican colleague, the gentleman from New Jersey (Mr. SMITH), in a bipartisan recommendation to the Committee on the Budget, which would have added \$3 billion. So I want to thank Chairman SMITH for his sincere effort at trying to do that, just to add for next year, for veterans discretionary programs, including med-

ical care and research, construction, and programs that fund the administrative cost of other important benefits such as compensation, pension and education programs.

I urge all my colleagues to do the right thing as we move forward and to look at this veterans budget and be able to do the right thing.

In conclusion, as I talk about the veterans program, we also had a study that was done by the Secretary of Veterans Affairs, Secretary Principi, who I hold in great esteem; and this particular study was called the "Report of the Preparedness Review Working Group to the Secretary of the Department of Veterans Affairs." This report basically talks about some of the problems that we are encountering and the need to look at how we begin to prepare ourselves in case of a major problem.

Since the 9-11 attacks, the Department of Veterans Affairs has been forced to address issues that it never received funding to undertake. The VA continues to serve as a backup provider for the Department of Defense in times of war, and it is also part of the National Disaster Medical System. It is responsible for several roles within the Federal response plan, including providing assistance with procurement, assisting in the management of the national stockpile of anecdotes, which is key and important, and other pharmaceutical and information management technologies that support emergency medical care to veterans as well as active duty military and civilians.

In order to fund such activities, Mr. Speaker, funds are currently being diverted from the VA patient care system. I had an opportunity to provide an amendment to the supplemental last Thursday, the supplemental for \$77 billion. Two billion dollars of that is going for health care for the Iraqis; and I asked that of those \$2 billion for the Iraqis that we look at \$90 million, of which \$70 million was going to be used to help pay for the cost that has already been incurred by the VA since 9-11. That was just \$70 million, but I was not able to do that. The other \$20 million was to begin to start off a piece of legislation that I helped author, that we passed but has not been funded, to establish four health centers throughout the country that will be able to respond for homeland defense in the area of health.

Right now, after the study, the emergency preparedness budget that was sent recommended \$248 million that they need now, and those dollars are not there. And in fact, we are taking \$122 million away from existing services to try to do this. That is taking away from our veterans that need the service now that are reaching that age where they need us the most. In order to fund such activities, funds are currently being diverted. And we have to

stop that. We have to be able to provide the resources for homeland defense, to be able to get the pharmaceutical stockpiles that are needed for a national emergency.

Our health care system, the VA, is one of the best in the country. It covers every region in the United States. And so there is a real need for us to provide them with the resources for the stockpile for pharmaceuticals that they need for antidotes and other things. They need not only the pharmaceuticals but they also need the training. Our personnel need the training. They need the resources to make that happen.

Every time we go code orange or whatever the code might be, there are certain levels where they need a police force to fortify. They need security personnel that go on overtime, not to mention the fact that because we have gone into war we find ourselves in a situation where a lot of our nurses and a lot of our doctors, a lot of our health professionals are not only working for the VA but are in the military. So we are finding a great deal of difficulty in filling those slots, and to the point that they are looking at contracting out some of the services. That is why those resources are needed.

In addition, in order to activate those four critically needed bioterrorist centers that would help us, we needed that \$20 million. The VA's many areas of expertise on such diverse topics as biomedical research, post-traumatic stress disorders, war-related illnesses, as well as environmental hazards, including both treatment of environmental exposures such as Agent Orange, ionizing radiation, as well as Gulf War illnesses, make it poised to make significant contributions to detect and diagnose and treat a lot of our soldiers as well as our constituency if we ever have to. But they need the resources in order to make that happen.

So I would appeal to the Members and to the Republicans to reassess the budget of the VA. Now, I know they will argue, and the average constituent out there will hear, no, we just added \$122 million. They do not mention that

the \$122 million came from existing services. They are coming from the services that are being provided for our veterans. And right now is when our veterans, the numbers and the demographics are growing. This is when we need them the most.

So I wanted to take this opportunity tonight to talk about health care, since this month is Health Care Month, and I wanted to take an opportunity to mention our veterans.

□ 2230

Mr. Speaker, in closing, let me say that our prayers and thoughts are with our soldiers. We pray for their swift and quick return back to their loved ones.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. BECERRA (at the request of Ms. PELOSI) for today on account of personal reasons.

Mr. STUPAK (at the request of Ms. PELOSI) for today and April 8 on account of a funeral in the district.

Mr. LUCAS of Oklahoma (at the request of Mr. DELAY) for today and the balance of the week on account of personal family matters.

SPECIAL ORDERS GRANTED

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

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

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

Mr. MEEK of Florida, for 5 minutes, today.

Mr. CUMMINGS, for 5 minutes, today.

Mr. SKELTON, for 5 minutes, today.

Mr. DEFAZIO, for 5 minutes, today.

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

Mr. RAMSTAD, for 5 minutes, today.

Mr. NORWOOD, for 5 minutes, April 8.

Mr. JONES of North Carolina, for 5 minutes, April 8.

Mr. TANCREDO, for 5 minutes, today.

Mr. BURTON of Indiana, for 5 minutes, April 8, 9, 10, and 11.

(The following Member (at his own request) to revise and extend his remarks and include extraneous material:)

Mr. SMITH of Michigan, for 5 minutes, today.

SENATE BILLS REFERRED

Bills of the Senate of the following titles were taken from the Speaker's table and, under the rule, referred as follows:

S. 273. An act to provide for the expeditious completion of the acquisition of land owned by the State of Wyoming within the boundaries of Grand Teton National Park, and for other purposes; to the Committee on Resources.

S. 302. An act to revise the boundaries of the Golden Gate National Recreation Area in the State of California, to restore and extend the term of the advisory commission for the recreation area, and for other purposes; to the Committee on Resources.

S. 426. An act to direct the Secretary of the Interior to convey certain parcels of land acquired for the Blunt Reservoir and Pierre Canal features of the initial stage of the Oahe Unit, James Division, South Dakota, to the Commission of Schools and Public Lands and the department of Game, Fish, and Parks of the State of South Dakota for the purpose of mitigating lost wildlife habitat, on the condition that the current preferential lease-holders shall have an option to purchase the parcels from the Commission, and for other purposes; to the Committee on Resources.

ADJOURNMENT

Mr. RODRIGUEZ. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 10 o'clock and 31 minutes p.m.), under its previous order, the House adjourned until tomorrow, Tuesday, April 8, 2003, at 10:30 a.m., for morning hour debates.

EXPENDITURE REPORTS CONCERNING OFFICIAL FOREIGN TRAVEL

Reports concerning the foreign currencies and U.S. dollars utilized for speaker-authorized official travel during the first quarter of 2003, pursuant to Public Law 95-384, and for miscellaneous groups in connection with official foreign travel during the calendar year 2002 are as follows:

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, DELEGATION TO POLAND, LUXEMBOURG, MALTA, ITALY, AND PORTUGAL, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN DEC. 1 AND DEC. 12, 2002

Name of Member or employee	Date		Country	Per diem ¹		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency ²	Foreign currency	U.S. dollar equivalent or U.S. currency ²	Foreign currency	U.S. dollar equivalent or U.S. currency ²	Foreign currency	U.S. dollar equivalent or U.S. currency ²
Hon. J. Dennis Hastert	12/2	12/4	Poland		372.00			(3)			
Hon. Richard W. Pombo	12/2	12/4	Poland		372.00			(3)			
Hon. Rob Portman	12/2	12/4	Poland		372.00			(3)			
Hon. Frank D. Lucas	12/2	12/4	Poland		372.00			(3)			
Hon. Richard Burr	12/2	12/4	Poland		372.00			(3)			
Hon. Vito Fosella	12/2	12/4	Poland		372.00			(3)			
Hon. Grace F. Napolitano	12/2	12/4	Poland		372.00			(3)			
Scott Palmer	12/2	12/4	Poland		372.00			(3)			
Sam Lancaster	12/2	12/4	Poland		372.00			(3)			