

seatbelt, car seat. Those children, the oldest two right now are old enough to have their own family and their own children.

When I am in Kenosha, Wisconsin, visiting the Tower family, Emma, age 4, and Lilly, age 2, will not allow the ignition in the car to be turned on until they are buckled into their seats and safely strapped in. That is the first thing they do when they get in the car.

When I am in Sacramento with son Ted Oberstar and granddaughter Katherine, age 4, and granddaughter Claire, age 2, the same story. Grandpa, we cannot move until we are buckled up. And buckled up comfortably, too, by the way. They want to be just right in that seat. Then they want to make sure that I am buckled in because, once in a while, I am so busy dealing with them and other things and talking that I do not strap myself in before the key is turned on; and they say, make sure that grandpa is buckled in.

Education works, and it is passed on from one generation to the next. That is the message. The program that we have instituted has proven itself. It has prevented death. It has prevented injuries. It helps educate the public on all aspects of proper installation of child restraints.

Children today of the age when we began teaching them child restraint seats is an important safety issue now are insisting on buying vehicles that are properly equipped with the right kind of seat restraint facilities in the car to accept any kind of child restraint seat or infant carriage device.

My oldest daughter will not nurse her now 10-week-old child while the car is moving. Believe me, that is not very pleasant when you have a poor little baby who is very hungry, who wants to nurse. But not until the car is stopped and we are not moving will that child come out of its child restraint seat.

So the point is that the message has worked. Education is effective. But not everybody has got the message. That is why we need this legislation, why we need this \$7.5 million funding. It is a modest amount. It is peanuts compared to the \$218 billion in TEA-21 over the 6 years.

It is available to train safety professionals, police officers, fire and emergency medical personnel, high school educators, grade school, elementary school educators in safety and in all aspects of child restraint use.

Every State that gets a grant submits a report to the Department of Transportation describing the activities they have carried out with the funds made available under the grant, and the Secretary of Transportation will report to Congress within the coming year on the success of this program with a complete description of all the programs carried out, materials developed, and the success stories from the States.

I urge the passage of this legislation by this body, promptly by the other body, signature into law by the President, and implementation with the adequate funding that we need to carry it out.

Mr. SIMPSON. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I want to thank the gentleman from Minnesota (Mr. OBERSTAR) in his dedication on this subject in making sure this gets done. It is a very important subject.

Mr. OBERSTAR. Mr. Speaker, will the gentleman yield for just a moment.

Mr. SIMPSON. I yield to the gentleman from Minnesota.

Mr. OBERSTAR. Mr. Speaker, I apologize for not thanking the gentleman from Idaho (Mr. SIMPSON) for pinch-hitting on the floor and substituting and helping us move this bill. We are grateful for the gentleman's care and concern, and I thank him for his kind words.

Mr. SIMPSON. Mr. Speaker, I am very honored to do so. I want to thank the gentleman for his support on this subject and his interest in it and his dedication to it.

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

Mr. LARSEN of Washington. Mr. Speaker, I yield back the balance my time.

The SPEAKER pro tempore (Mr. KENNEDY of Minnesota). The question is on the motion offered by the gentleman from Idaho (Mr. SIMPSON) that the House suspend the rules and pass the bill, H.R. 691.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill was passed.

A motion to reconsider was laid on the table.

APPOINTMENT AS MEMBERS TO THE COMMISSION ON INTERNATIONAL RELIGIOUS FREEDOM

The SPEAKER pro tempore. Without objection, pursuant to section 201(b) of the International Religious Freedom Act of 1998 (22 U.S.C. 6431), amended by Public Law 106-55, and upon the recommendation of the minority leader, the Chair announces the Speaker's appointment of the following members on the part of the House to the Commission on International Religious Freedom to fill the existing vacancies thereon, for terms to expire May 14, 2003:

Ms. Leila Sadat, St. Louis, Missouri and

Ms. Felice Gaer, Paramus, New Jersey.

There was no objection.

SPECIAL ORDERS

The SPEAKER pro tempore. Under the Speaker's announced policy of Jan-

uary 3, 2001, and under a previous order of the House, the following Members will be recognized for 5 minutes each.

STRENGTHENING UNITED STATES FOREIGN ASSISTANCE

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Virginia (Mr. MORAN) is recognized for 5 minutes.

Mr. MORAN of Virginia. Mr. Speaker, I would like to say a few words about a national priority that too often gets overlooked: humanitarian and development assistance in our foreign operations appropriations bill. That bill will probably be coming to the floor within the next few legislative days.

Foreign assistance is an important and effective policy device when words and diplomacy are not enough or when military action is not appropriate. Strengthening U.S. foreign assistance will improve the lives of millions of people around the world and is consistent with America's long history of extending a helping hand to those less fortunate.

We, and in fact much of the rest of the world, too easily forget the fact that, over the last half century, U.S. humanitarian and development assistance has successfully elevated the standards of living for millions of people.

More than 50 nations have graduated from U.S. assistance programs since World War II, including such nations as France, Spain, Portugal, South Korea, Taiwan, Italy, and Germany. More than 30 of these former aid recipients have gone on to become donor nations themselves.

Over the years, foreign assistance programs have helped create some of our closest allies and best trading partners and greatest contributors to the world's economy. For example, the United States now exports to South Korea in just 1 year the total amount we gave that country in foreign assistance during all of the decades of the 1950s and 1960s.

But despite substantial global accomplishments, as we enter the new millennium greater disparities exist between the wealthy and the poor than ever before. Of the world's 6 billion people, half live on less than \$2 a day, and one-fifth live on only \$1 a day. That is more than a billion people, four times the population of the United States living on less than a dollar a day. Two billion people are not connected to any energy system. One and a half billion lack clean water. More than a billion lack basic education, health care or modern birth control methods.

Poverty, disease, malnutrition, rapid population growth, and lack of education paralyze billions of people and extinguish hope for a better future. The world's population grows by about

75 million people a year, and most of them will live in the world's poorest countries.

If current trends continue, the result will be more abject poverty, environmental damage, epidemics, and political instability; and we are not such an isolated island of prosperity that we are not immune from the ramifications of this desperation.

From our own shores to the far reaches of the world, there is ample evidence that we have not been able to use our trade policies as effectively as we would like to address the negative impact of globalization which contributes to these great disparities between the privileged and impoverished.

□ 1845

Our failure to respond adequately to these problems is a moral dilemma that should be a pivotal part of our overall foreign assistance and international trade framework. Consider, for example, the plight of the seriously ill in the developing world. It is a testament to the failure of industrialized nations that 80 times more pharmaceutical products are sold in the much less populace west than on the entire continent of Africa.

Each year, 300,000 people in Africa develop sleeping sickness, and many of them die from this disease. It is a disease that we could conquer if we had the political will and the research wallet to do it, but we do not. We will apply more of our resources to cure bald American males than African children with sleeping sickness.

The most shocking global misallocation of health resources, of course, is the HIV/AIDS pandemic. AIDS is a global crisis which threatens the security of every government in every Nation including the United States. This is not merely a health issue, this is an economic, social, political, and moral issue. AIDS has destroyed societies, destabilized governments and has the potential to topple democracies. According to UNAIDS, nearly 22 million people have lost their lives, and over 36 million people today are living with HIV and AIDS. Fewer than 2 percent of them have access to life-prolonging therapies or basic treatment. The number of new infections of HIV is estimated at 15,000 every day, and it is growing. I am told that nearly a quarter of some of Africa's armies are HIV positive.

In a year when President Bush has requested an \$8 billion increase in spending over the current \$320 billion defense budget, U.N. Secretary General Kofi Annan has called for a global AIDS trust fund to raise \$7 billion to \$10 billion a year to combat the pandemic. That is almost the same figure as the defense spending increase that we would be adding to a \$320 billion budget. This has to be a joint effort among governments, private corpora-

tions, foundations, and nongovernmental organizations.

We are ranked last among the 22 OECD countries in terms of what we spend on foreign assistance, and we have got to spend more. It is in our interest as well as in the interest of the rest of the world. If we are going to maintain our position as the world's superpower, the most prosperous Nation in the history of western civilization, then we have got to share our resources. If we do not, we are going to pay a price in the long run.

These are national priorities, and I hope that they get better addressed in our foreign assistance budget and in our national priorities generally.

THE NATURE OF THE BEAST

The SPEAKER pro tempore (Mr. KENNEDY of Minnesota). Under a previous order of the House, the gentleman from Illinois (Mr. DAVIS) is recognized for 5 minutes.

Mr. DAVIS of Illinois. Mr. Speaker, I rise today to add my voice to those who have been talking about support for a patient's bill of rights. But, of course, Mr. Speaker, not just any patients' bill of rights. I support the robust patients' bill of rights sponsored by my esteemed colleagues, Mr. MCCAIN, Mr. KENNEDY, and Mr. EDWARDS in the Senate, and the companion legislation, sponsored by the gentleman from Iowa (Mr. GANSKE) and the gentleman from Michigan (Mr. DINGELL) in the House. I support the patients' bill of rights that puts patients before profits and values human life over the bottom line.

The idea of a patients' bill of rights is nothing new to this Congress. We have all listened to the rhetoric and we have all been involved in the debate. As a Member of Congress since 1996, I must say that it is interesting to see where this debate has gone. I find it worth commenting that the question we are now faced with is not so much whether or not we should pass a patients' bill of rights but which version we should pass. In other words, we are all in agreement that patients need to be afforded an increased level of protection from the predatory tendencies of managed care organizations.

Rather than immediately delve into the particulars of why we should prefer one version over another, I believe it is instructive to take a step back for a moment and look at the concept of a patients' bill of rights in the first place. The very idea that we need a patients' bill of rights, an idea I remind my colleagues that we all are in support of, implies the presence of an injurious element within our health care system. The simple fact that we are debating this idea means that each one of us, on some level, acknowledges the basic reality that the interests of managed care organizations tend to be adversarial to the interests of patients.

I believe that the debate over which patients' bill of rights to accept can be resolved simply by looking more closely at the nature of the beast. Too often I believe we talk about solutions without fully understanding the problem. I believe that with a careful examination of the means and motives by which managed care corporations make money, off the pain and suffering of patients, the answer to the question of which patients' bill of rights is the real patients' bill of rights becomes self-evident.

Now, what is it about managed care that is so inherently evil? Well, let me just quote one thing that Milton Friedman, a well-known advocate of free market economics, said. "Few trends could so thoroughly undermine the very foundation of our free society as the acceptance by corporate officials of a social responsibility other than to make as much money for their stockholders as possible." In other words, if we go by the dictates that managed care organizations live by, not only is it undesirable to take a patient's well-being into account, it is simply unethical to do so. Any motive other than profit is extraneous and inappropriate.

Now, obviously, this narrow-minded approach has put us in the situation that we are currently in. And I would suggest, Mr. Speaker, that we simply take stock of where we are as a country with a health care delivery system, put patients before profits, make sure that patients and their physicians have the opportunity to collaborate, to make decisions and determinations about the kind of treatment they should receive, and not some bureaucrat or clerk sitting in an office. That is the only real way to do it.

So I would urge all of my colleagues and all of America to really support the Ganske-Dingell bill so that patients can have real rights, and that is the right to be involved, the right to live, the right to get good medicine when they are in need of it.

HONORING THE NATION'S PREMIER LATINA LABOR LEADER, DOLORES HUERTA

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from California (Ms. SOLIS) is recognized for 5 minutes.

Ms. SOLIS. Mr. Speaker, I rise today to honor one of our Nation's premier Latino labor leaders, Dolores Huerta.

Growing up in a predominantly Latino neighborhood in Southern California, I often looked to my community leaders for lessons in how to live and how to treat other people. One of the most influential role models continues to be Dolores Huerta, pre-eminent civil rights leader who has fought for the rights of underserved laborers for more than 40 years.

Born in Dawson, New Mexico, on April 10, 1930, Dolores Huerta was