on the books. It means removing regulatory barriers to economic opportunity—something we are in the throes of trying to do right now on the Senate floor—including the discriminatory Davis-Bacon Act. It means school choice for low-income, inner-city people and means meaningful welfare reform that will transform lives from ones of dependence to ones of independence. And it means making our streets safer and renewing the war on drugs. After all, our first civil right is freedom from the fear of crime.

This is the real civil rights agenda of our time. Not preferences, not set-asides, not quotas, but the dreams that are built on real opportunity.

Madam President, I would hope when I introduce my bill it will become at least a focus of dialog because I know different people have different views. But none of us believes that discrimination is appropriate. It is wrong. It has always been wrong. It should be punished. And I think that is what this debate is all about.

DANGEROUS TRENDS IN DOWNSIZING MILITARY HEALTH SERVICES

Mr. INOUYE. Madam President, I would like to bring to your attention a matter of serious concern to me regarding the future of our currently superb military forces—and the inextricable link between a quality volunteer force and an equally robust, quality, military health care system.

I have followed closely the downsizing of our military forces over the past several years. The Active Force will have come down from 2.1 million service members in 1990 to 1.45 million by 1997, a 32-percent reduction from cold war levels. The Navy will see its fleet reduced from 546 battle force ships to 346 in the same time period with only 12 aircraft carriers in commission by the end of the century. The Army will go from 18 to 10 active divisions and the Air Force from 24 to 13 active fighter wing equivalents. The Marine Corps will likewise be reduced from a force of 200,000 men and women in uniform to a force of 174,000.

We have repeatedly promised that there will be no more Task Force Smiths—a tragic result of that period of time just prior to the Korean conflict in the early 1950's when we truly had a hollow force. Yet, I see us slowly but surely moving toward this state of readiness—or should I say, unreadiness. Although it causes me great sadness to even contemplate the repeat of such a tragedy, I must tell you that in the not-too-distant future, I envision us once again being called upon to answer to our brave service members and the American people, ''Why did we let another Task Force Smith occur?''

I have been here long enough to know what is meant by a hollow military. In the 1970's, 25 percent of new recruits were category IV—the lowest recruitable mental group—and, as a result, 30 percent of our ships—brandnew ships with brandnew equipment—were not fit for combat due to a lack of sailors to man them. For although our military possesses superior technology and superior weapons systems, it is the people who really determine the readiness of our forces. And these people, the men and women in uniform, are recruited from and reflect a cross-section of the American population. Although the services met their recruiting goals last year—and keep in mind that these goals are much lower than they were a few years ago—the military has had to dramatically increase their recruiting budget as well as the number of their recruiters to do so. Even so, it now takes 1.6 times the number of recruiter contacts to achieve one recruit. The reality of our national culture today is that the propensity for young people to join our military is at a 10-year low, down 39 percent among 16- to 21-year old males just since 1991, according to the Army.

While it concerns me to watch the reduction of our forces, I understand and support the need to balance the size of our military services with the threats facing us today and in the near future. However, we must not lose sight of the reality that major armed conflicts are still a very real possibility and could come at any time in the form of aggression by regional powers such as Iraq and North Korea. In his recent testimony before the Senate Defense Appropriations Subcommittee, Vice Admiral Macke, the commander in chief of the United States Pacific Command, called North Korea the nation with the highest threat potential today. Dr. Henry Kissinger, in his testimony before the Senate Armed Services Committee in February, warned that ''more and more states are coming into being that feel no responsibility to any global international system or international stability.'' He also cited the North Korean situation, the proliferation of nuclear and other weapons of mass destruction, and the growth of Islamic fundamentalists as serious threats to our national security that could involve us once again in armed conflict.

More recently and more frequently, however, we have seen a preponderance of internal regional and national conflicts that require our armed services to respond with operations short of war. These operations not only strain our defense capabilities but drain current year defense budgets. When taken into consideration with other security threats, I become gravely concerned about the speed and direction of our force reductions.

Of particular concern to me is the downsizing of the services' medical structure—both peacetime and wartime personnel and units. While I do not wish to tie the hands of the Department or the service chiefs as they restructure their forces, I am increasingly concerned over the severity of reductions to the services' medical departments. In my opinion, the military health service system is being taken down too far, too fast.

The military leaders and decisionmakers have a tendency to see military health care as less important than the men and women who fly airplanes or who drive tanks. However, I caution you that our military is essentially a team, and if one member of the team is weak, the entire team is weak. Although the medical departments might seem less crucial to the preparation for or the outcome of war, I assure you that to the men and women in combat, they are absolutely essential members of the team. To be effective fighting forces, the servicemembers must be able to concentrate on combat and keep their minds completely clear—free from worry about their own well-being and, even more importantly, free from worry about the health and well-being of their spouses and children at home. Without the knowledge and security that their families are well cared for, our military personnel will lose much of their effectiveness that they have so ably demonstrated during the past decade.

First, I will address combat medicine—caring for the soldiers, sailors, marines, and airmen who risk injury and death around the world. When I was injured in World War II, it took 9 hours for me to get to medical care—9 hours. But in 1945 that was not too bad—Americans probably did not expect any faster battlefield evacuation and care. Today, when a soldier or marine is wounded in combat, he or she can be at the hospital within 15 minutes. In fact, we learned in Korea and Vietnam that if we could get wounded soldiers to hospitals within 15 to 30 minutes—and we did that pretty regularly—we could save most of those who survived their initial wounding.

Because of our experiences in these wars, Americans now have come to expect emergency medical services [EMS] systems, 911 phone lines, paramedics with highly technical skills, and advanced EMS and air flight ambulances with sophisticated emergency medical equipment. Most of these capabilities also exist in our military combat health support systems and soon they will have more advanced combat medical technologies such as telemedicine, filmless x rays, and other new medical innovations that will further improve battlefield survival rates. Americans have come to expect this level of care and our service members and their families deserve it.

Trauma experts talk of the golden hour—the first hour after initial injury—when the greatest percentage of patient lives can be saved. Let me give you one example. In March 1994, there was a horrible training accident involving soldiers of the 82d Airborne Division on the green ramp—the area where the paratroopers wait to take off—at Pope Air Force Base, adjacent to Fort Bragg, NC. Many soldiers were saved by the expert buddy aid training that

all soldiers receive as part of their combat training. However, many more were saved by the quick response of medical and non-medical personnel who quickly evacuated their comrades to Womack Army Hospital there at Fort Bragg. Several of the most seriously burned soldiers were evacuated to the outstanding Institute of Surgical Research, frequently referred to as the Burn Unit, at Brooke Army Medical Center in San Antonio. And, of course, our world-renowned Air Force evacuation system composed of DC–9 Nightingale aircraft equipped with sophisticated medical equipment and staffed by top-notch flight nurses handled the evacuation of these critically injured soldiers.

All of this takes a lot of medical personnel—trained and experienced in emergency care, in trauma care, and in combat medicine—and a lot of medical resources such as ambulances—helicopters, wheeled and tracked ground ambulances, and, yes, even fixed wing ambulances—as we plan for even longer evacuation lines in future conflicts. It means a lot of medical facilities—especially hospitals—located throughout the evacuation pipeline—combat theater and elsewhere. This requires a robust, quality, flexible, military medical force.

During Operation Desert Shield/Storm, the military medical operations plan called for emptying almost all of the military hospitals in the continental United States as well as some of those in Europe of medical personnel to deploy with the field hospitals to the Middle East. And that was before downsizing was implemented in the medical departments. Today, the medical departments have lost more than 30 percent of their personnel, but are still expected to provide the same level of support to defense plans that call for conducting two nearly simultaneous major regional contingencies [MRC's], possibly in conjunction with one or more operations-other-than-war [OOTW] scenarios. I would like someone to tell me how this is to be accomplished with 30 percent fewer assets. I would also like to know who will provide care for the military family members in such a situation.

As a result of having such a superbly trained and equipped military medical capability, an interesting, but potentially dangerous, precedent has become evident in recent years. Whenever large numbers of people are in need of health care services, whether in this country or elsewhere in the world, the United States military medical departments are requested. You might not be aware of this, but the first U.S. military units to be placed under the command of a foreign nation were medical units. Why? Because we have the most sophisticated, comprehensive, state of the art combat medical capability in the world and other nations sending their sons and daughters off to danger want their soldiers to have the best too.

More than just providing combat health services to our deployed service members, a robust health care system is critical to maintaining our quality volunteer force. When the draft ended in 1973, many people both here in Washington and throughout the United States doubted the success of an All Volunteer Force. After all, given the history of the draft and the need to force our citizens to serve their country, how could anyone reasonably expect that there would be enough young men and women who would volunteer to serve—and at a quality that would be acceptable. A great many people were very surprised when the All Volunteer Force not only met previous recruiting standards, but actually exceeded them.

I believe we were able to do this in large part because one of the benefits promised to the potential recruits was world-class quality health care, not only for themselves but also for their family members throughout their career and even after retirement. No one said, ''unless we have to downsize.'' I doubt that very many recruiters explained or even understood themselves the fine distinction between ''entitled to'' and ''eligible for'' that separates the statutory provision for health care services for family members of active duty personnel from the retirees and their military dependents. Or that anyone explained about space available care. What the soldiers and sailors and marines and airmen heard, what they were promised, was lifetime health care for themselves and their dependent family members.

And how have the services been able to meet their recruiting goals? By continuing to promise lifetime health care for themselves and their eligible family members. Why? Because the military knows that without this benefit, the recruitment of, and particularly the retention of, quality, career service members would be nearly impossible.

Now our retirees and service members see us breaking our promises to them. Space available care in our peacetime medical facilities in some cases has already disappeared or is rapidly disappearing for our retirees and, in many places, even active duty family members are forced out on the Civilian Health and Medical Program of the Uniformed Services [CHAMPUS] because of drastically downsized or closing medical treatment facilities. If we continue to cut retirement benefits, we will have a difficult time recruiting soldiers, sailors, marines and airmen for our next war. As Maj. Gen. Jim Pennington, U.S. Army, retired, said, ''If we do not stop this constant effort to renege on the promises to those who have served and kept their part of the bargain, we will destroy the Volunteer Force and consequently our national defense.''

How important is military health care to the service member? I can tell you, it is very important. I have traveled to a great number of military bases and posts and invariably the first or second question I am asked is about health care—usually not for service members themselves so much as for their family members. Much as we would like to believe that there are millions of patriotic Americans willing to serve their country without any additional incentives, the reality is that our service members want pretty much the same thing most Americans want—including families and the ability to take care of their family members. In World War II, only 4 percent of the soldiers had dependents. In 1973, when the draft ended, 40 percent of our military force had dependents. Today, more than 60 percent of our military personnel have family members. When our troops are deployed away from home—and we are asking them to do that more frequently now—their foremost concern is their families. This is just as true, and perhaps even more so, during times of armed conflict. I cannot overemphasize the importance of the military health care system in providing peace of mind and security for our service members and their families, especially when faced with the possibility of deployments and combat as these men and women are every day.

Madam President, my concerns with the drawdown of our medical forces are in three areas: The civilian workyear reductions directed at the Department of Defense—DOD, medical readiness, and the continual erosion of retiree health care benefits.

CIVILIAN WORKYEAR REDUCTIONS

The DOD is committed to streamlining its civilian workforce in accordance with the National Performance Review [NPR] and the administration's guidance to increase its efficiency and effectiveness. The DOD seeks to do this without sacrificing quality or compromising military readiness. Between 1993 and 1999, the DOD projects a 32-percent reduction in civilian positions. In accordance with the fiscal year 1996 President's budget, the DOD has targeted headquarters, procurement, finance, and personnel staffs. Downsizing the infrastructure in this way should not affect the military services' ability to carry out their mission nor to respond quickly and effectively.

The Military Health Service System's [MHSS] share of these 272,900 civilian reductions is more than 11,000 spaces. However, these positions are predominantly in the business of delivering health care—nurses, lab technicians, and other medical technicians. Less than one-third of the MHSS civilian work force are in the targeted job series. Although the medical ward clerk or medical transcriptionist might appear to be optional, they are as critical to the health care team effort as are the health care providers.

The Congress has been concerned about the adverse impact of downsizing both the military and civilian work force for a number of years. To insure that this downsizing and civilian conversion does not cost the American

taxpayers more in contract and other costs, a number of Federal laws have been enacted in recent years.

The Federal Workforce Restructuring Act of 1994, Public Law 103–225, prohibits agencies from converting the work of employees included in the 272,900 civilian reductions to contract performance unless a cost comparison demonstrates that such a conversion would be to the financial advantage of the Government.

Section 8020 of the Defense Appropriations Act for fiscal year 1995, Public Law 103–335, provides specific guidance prohibiting the conversion to contract of any DOD activity ''until a most efficient and cost-effective organization analysis is completed on such activity or function and certification of the analysis is made to the Committees on Appropriations of the House of Representatives and the Senate.''

Section 711 of the National Defense Authorization Act for fiscal year 1991, Public Law 101–510, prohibits reductions of medical personnel until the Secretary of Defense certifies to the Congress that the number of personnel being reduced is excess to current and projected needs of the services and that CHAMPUS costs will not increase.

And, finally, section 716 of the National Defense Authorization Act for fiscal year 1991 requires congressional notification before any military medical services are terminated or facilities are closed. These restrictions have all been placed on the DOD to ensure that reductions to the MHSS have been thoroughly analyzed for their impact not only on costs, but also on military readiness and preparedness.

In my own State, Tripler Army Medical Center staff can expect to pay 30 percent more for child and maternal health care contract personnel to replace existing civilians. And that is for just one medical unit in one hospital. I understand that the U.S. Army Medical Command's [MEDCOM] experience in contracting for health care services indicates that direct hire civilian employees—the same civilians that the DOD has been mandated to cut—are almost always the most cost-effective alternatives when hiring on the margin one for one.

For instance, a civilian nurse costs $40,000 per year compared to $60,000 for a contract nurse. At Fort Drum, NY, where contracting care is required because there is no inpatient medical facility on post, the per beneficiary costs are 56 percent higher than costs at similar military installations. In fact, the MEDCOM's experience with commercial activities [CA] studies has shown that it is almost always considerably less expensive for the military system to provide health services than it is to contract for them.

The inevitability of these mandated civilian cuts affecting nursing personnel is particularly worrisome, especially in the Army where civilian nurses comprise approximately 50 percent of the work force and where military nurses are being consistently cut more than any other health care profession. As the medical departments downsize, careful consideration must be given to the health professionals such as nurses who are actually providing care. The integration of health promotion, health maintenance, and wellness should be at the forefront of providing quality health care. However, the steep cuts in the endstrength of Army nurses jeopardize the ability of the Army Medical Department [AMEDD] to deliver on its promises to increase access, maintain quality and improve cost-effectiveness of the health care services provided in both peacetime and wartime facilities and settings. With the drastic losses of both military and civilian nurses, the AMEDD has few options other than massive contracting arrangements.

If these contract costs were applied across the full spectrum of the MHSS-directed civilian reductions, what would be that cost? I hope that the appropriate DOD personnel are prepared to answer that question, if indeed, we are to draw down medical civilian personnel. It just does not make good business sense to contract out services that can be provided just as well, and far less expensively, in military facilities. Yet, we continue to subject our medical departments to a civilian work force reduction that is intended largely for administrative positions.

In addition to the experience of the MEDCOM, I understand that the RAND Corp., in a study commissioned by the DOD to comply with section 733 of the National Defense Authorization Act for 1992, Public Law 102–190, concluded that medical treatment facilities' in-house care is more cost effective than their civilian counterparts by 24 percent overall and even more in some areas such as primary care. The Civilian Health and Medical Program of the Uniformed Services [CHAMPUS] has not been the preferred cost-effective alternative to either the medical departments who bear the major costs of the program or to the beneficiaries who share the cost. The simple fact is that medical inflation in the private sector has skyrocketed over the past several years.

These civilian reductions are all the more disturbing given not only the studies indicating that the MHSS is the most cost-effective alternative, but also given the great strides that the MHSS has made in reorganizing and reengineering toward a business-like culture. For example, the activation of the U.S. Army Medical Command [USAMEDCOM] in 1994 marked a major milestone in re-engineering the Army Medical Department [AMEDD]. In phase I of that re-engineering, the Army Surgeon General's staff in the Washington area has already been reduced by more than 75 percent. We are all very proud that DeWitt Army Community Hospital at nearby Fort Belvoir in northern Virginia was a recent recipient of Vice President GORE's National Performance Review Hammer Award. The DeWitt Army Hospital's Primary Care Reinvention Plan will dramatically improve the way health care is provided to the more than 140,000 beneficiaries in DeWitt's catchment area. The plan includes the establishment of six new satellite clinics, expanded clinic hours to accommodate working parents, a 24-hour nurse advice system, expanded child and adolescent psychiatric services, and the creation of a special Well-Woman clinic. These initiatives increase primary care access and decrease expensive tertiary care costs. In fact, the MHSS abounds with examples such as these cutting-edge innovations in all of the services.

Another long recognized example of the military's enormous contribution to America is the military medical research and development community which is composed of more than 50-percent civilians. These contributions have benefited military readiness, military preventive and curative care, and have impacted tremendously on the kind of civilian health care that has come to be expected by all our citizens. For example, the Army's Medical Research and Material Command [USAMRMC] has unique expertise and facilities for all phases of vaccine development. This includes a hepatitis A vaccine that was recently developed, tested, and demonstrated safe and effective by Army scientists working with SmithKline Beecham Pharmaceuticals. To health care providers, hepatitis A has proven to be a pervasive, but difficult, disease to treat with recovery taking anywhere from several weeks to several months. Hepatitis A is a serious health risk for more than 24 million U.S. citizens that will visit endemic areas this year. In the United States, there are an estimated 143,000 cases occurring each year at a cost of $200 million. This vaccine was the first licensed by the Food and Drug Administration for use in the United States.

The MHSS has long been acknowledged as a leader in research and an expert on many diseases throughout the world. Military units deploying to Somalia, the Persian Gulf, Macedonia, and Haiti received comprehensive advice books prepared by USAMRMC on avoiding local health hazards ranging from disease-carrying insects and poisonous snakes to contaminated food and water, heatstroke, and frostbite. This military unique research and expertise has made, and continues to make, massive contributions to our civilian medical capabilities. In fact, as noted in a recent edition of the television program, ''Dateline'', the U.S. military has the only capability in our Nation to deal with an invasion of potentially lethal infectious agents, such as the filoviruses, to the United States.

In the area of peacetime medical research, the Medical Research and Materiel Command has led a very successful effort in breast cancer research, HIV-AIDS research, defense women's

health research, and malaria research, to name a few. In fact, the Army's successful management of $236.5 million for breast cancer research in 1993 and 1994 has won high praise from both scientific and advocacy groups. Additionally, they have been able to apply 91 percent of the funds directly to research, thus restricting the administrative overhead to a mere 9 percent. Their success has prompted the Congress to ask the DOD to manage another $150 million for breast cancer research in fiscal year 1995.

Other MHSS treatment facilities have similar initiatives underway. Many of these initiatives serve as force multipliers by reducing attrition and enhancing soldier confidence. The U.S. Army Center for Health Promotion and Preventive Medicine [CHHPM] led the effort to develop an outside-the-boot parachute ankle brace that has significantly reduced jump-related ankle sprains common in airborne soldiers. All of these research and preventive medicine initiatives are done for the purpose of improving soldier readiness, providing quality health care for beneficiaries, and improving cost efficiencies.

These successful efforts are possible because of the blending of civilian and active duty medical personnel as a team. The active duty personnel infuse new energy and fresh ideas gleaned from their many varied experiences and provide the mobilization force; the civilians provide institutional memory, continuity, stability, and invaluable expertise gained from years of specialized concentration in highly technical fields. To lose either perspective would severely handicap the ability of the MHSS to continue to produce their outstanding results.

My final, but by no means least important concern, is of the impact on the morale of the dedicated MHSS civilian employees. Preliminary feedback from Tripler Army Medical Center and other health care facilities indicates that the civilian work force continues to see medical military personnel departing as part of the military drawdown. Yet, the workload has not diminished. The beneficiaries—active duty, retired, and family members—continue to come for the health care they were promised and expect.

At the same time, the civilian employees see their own jobs at risk for contracting, probably at greater expense. Our dedicated medical civilians at Tripler and all the MHSS facilities deserve so much better for their dedicated service to their customers—the men and women in our Armed Forces, both present and past.

READINESS

I am also deeply concerned about the medical readiness of our military units and the impact that downsizing will have upon them. The persistent reductions to the military medical structure from downsizing, civilian reductions, base closures, and bottom-liners—those faceless men and women who make decisions without having any idea of how it affects people—have resulted in the instability of the medical system. The MHSS is looking at reductions in medical personnel of more than 30 percent at a time when the beneficiary population is decreasing by about 10 percent.

Medical readiness is a service-unique responsibility with each service focusing on its mission essential requirements. I applaud joint service cooperation as a means of more efficiently utilizing scarce resources. The medical departments of the services have demonstrated that they can work together in many areas—TRICARE—the DOD's managed care program, telemedicine, research, training and more. However, I am concerned with the increasing pressure to centralize medical readiness and eliminate the individual services' autonomy and flexibility. Each service has a unique culture and specialized roles and missions that cannot be accommodated in an entirely purple suited DOD system. Each must preserve a large degree of autonomy.

There is no compelling reason to centrally manage the medical resources of each service under a DOD civilian umbrella. The structure that was created to implement the MHSS's managed care program, TRICARE, is not suited to manage the services' medical readiness assets nor their respective mobilization missions. I, and all of the Congress, will continue to hold each of the service chiefs responsible for military medical preparedness in accordance with their title 10 authority.

The military trains for its readiness mission by caring for all categories of beneficiaries in peacetime. This type of training can not be obtained exclusively in a field environment. However, the needs of both the peacetime health care system and the field health care system must be met, in many cases, by the same personnel who must be able to transition quickly and effectively from one system to the other as the mission requires.

I am also concerned about the premises upon which several ongoing studies are based for decisions on how downsizing will be accomplished. The Nation and even many of our senior policymakers seem to believe that the recent Persian Gulf war and the Somalia peacekeeping operations are evidence that any future military conflicts will be bloodless affairs—that is, wars where there will be no, or at least very few, casualties. Well, I have been in combat and I can assure you that there is no such thing as a bloodless war. We were very lucky in Desert Storm—just plain lucky. There is no reason to assume that we will be that lucky again or that any adversary will again miscalculate so badly. We must not become complacent and delude ourselves that we no longer need medical personnel, hospitals, ambulances, and other medical assets for combat health care or the resources to enhance and to practice combat medicine. That naive belief is irrational and irresponsible in an age of high-technology weapons of mass destruction and global instability.

In the Pacific rim, we need look no further than North Korea to see evidence of a potential conflict that would create thousands of casualties in the first hours of operation. Major military medical centers—like Tripler in Hawaii; the Naval Medical Center, San Diego; Madigan in the State of Washington, and Willford Hall in Texas—must be maintained if we are to be prepared for these conflicts. Any recommendation to downsize these facilities displays ignorance of the lifesaving role these facilities would play.

A recent RAND Corp. study titled, ''Casualties, Public Opinion, and U.S. Military Intervention: Implications for U.S. Regional Deterrence Strategies,'' concluded that once deterrence and diplomacy fail and war begins, public opinion demands that the conflict be escalated to bring finality to the operation. Such was the public opinion in the Persian Gulf war. Many Americans would have preferred that United States forces had continued on to Baghdad to overthrow Saddam Hussein, and many still feel that the operation was not completed when it stopped where it did.

Assuming that such a view is correct, the resulting military decisions to escalate the measures deemed necessary to win a decisive victory could well lead to more, not fewer, casualties. Our military medical facilities must be structured for such an occurrence. Therefore, other recent study recommendations to downsize or close many of our peacetime medical facilities and to greatly reduce military and civilian medical endstrengths imperil military preparedness.

Every day, the dedicated men and women of the military medical departments train in peace for their war mission. To believe that this capability can be contracted out, accomplished in civilian medical institutions, and be made ready for war given a certain amount of time is a certain recipe for disaster.

I have heard the argument that we can park our tanks in motor pools when training dollars are short, but we cannot park our eligible health care beneficiaries outside our hospitals. We have seen what happens to readiness when we do so. Not only do the beneficiaries not get the care they deserve, but medical readiness suffers as well. The Nation can no more sacrifice our medical readiness than we can our combat preparedness.

I believe the basis for a sound medical readiness posture lies in the medical centers. The medical centers function in much the same way as does a Navy battle group. A modern Navy battle group usually consists of an aircraft carrier, surface warships, support ships, and submarines. The medical centers are somewhat like an aircraft carrier. They are very large and do not

directly engage in combat. They serve as command and control and training centers for the task force and stand ready to launch their expert systems forward as needed.

Just as the expert systems of the aircraft carriers are its jets and pilots, a medical center's experts are its military personnel, who work in the medical center during peacetime but staff the field hospitals during wartime or operations short of war, and its telemedicine capabilities. The surface warships and submarines are like smaller hospitals, field hospitals, clinics, and field medical units that directly support the combat mission.

These escort ships need the carrier for command and control of its units as well as training for augmentation personnel. Much in the same way, smaller base and installation hospitals and field medical units rely upon medical centers for the establishment of medical policy and procedures—command and control, a pool of qualified and trained clinicians, and projection of its medical expertise forward via telemedicine.

The importance of medical centers cannot be overstated. Much of the success of the MHSS is due to its medical centers. They serve as a medical boot camp for health care personnel such as physicians, nurses, and corpsmen; research and development for new medical procedures, programs, and materials; reference centers for world-class medical knowledge and expertise; and the state-of-the-art inpatient care capabilities of modern medicine.

One essential type of medical boot camp is Graduate Medical Education [GME]. As with other components of the MHSS, GME has also come under attack. Although it is true that certain segments of military medical GME can be restructured and consolidated, the underlying premise of a medical center-based GME program cannot be refuted.

The MHSS benefits tremendously from in-house GME. These benefits include providing specialty and subspecialty care and increases in physician productivity due to the teaching environment. Other benefits include lower patient care expenses, the attraction of more qualified physicians to the academic environment of teaching hospitals, and a higher retention rate of physicians, especially for those trained in military facilities, that leads to lower acquisition and training costs.

Opponents of the MHSS would argue that the need for in-house GME would be removed if older, nonactive duty beneficiaries were not treated in MTF's. Again, studies have consistently shown that military in-house care is less expensive than the civilian sector. If we could get Medicare reimbursement legislation passed, the MHSS could continue to provide low-cost care to retirees and ultimately lower the cost of total Federal expenditures.

Eliminating GME in the military would force military hospitals to rely on the civilian sector for recruiting physicians—the same system that is currently overproducing specialists and underproducing primary care physicians. Current research literature indicates that only 26 percent of those completing residency training go on to primary care practice. The current mix of specialists is inappropriate for accessible and cost-effective care. We should not force the MHSS back to the high-cost U.S. national average.

Our medical centers have also been the projection platforms for telemedicine initiatives. Using commercial off-the-shelf equipment—a digital system camera and a video teleconferencing system, telemedicine enables medical personnel at remote locations to consult with physicians at a medical center and to quickly obtain expert advice on critical or unusual cases. Telemedicine puts the diagnostic firepower of Walter Reed Army Medical Center, the National Naval Medical Center in Bethesda, Maryland, or Tripler Army Medical Center into the hands of the deployed physicians in Somalia, Zagreb, Macedonia, or Haiti.

Just this past December 1994, the life of a 26-year-old soldier was saved in Macedonia. This is not so terribly unusual, except that two of the physicians contributed their diagnostic and treatment expertise while observing the patient on a television monitor at the Casualty Care Research Center in Bethesda, MD. Through Operation Primetime, the battalion surgeon with the 1/15th Infantry Battalion, part of the United Nations Observers in Macedonia, maintained telemedicine links with military medical specialists in Europe and the United States.

The military medical personnel saved that soldier's life by employing medical care forward—once again demonstrating their function as force multipliers. I am very enthusiastic about the possibilities of expanding telemedicine initiatives even further both in our military settings as well as in appropriate civilian settings.

RETIREE HEALTH BENEFITS

The last area of military medicine I will address is the continuous erosion of health care benefits for our military retirees and their eligible family members. As the services strive to improve the access and quality of health care through innovative, business-like plans, the massive civilian and military cuts combined with the decreasing health care dollars seriously threaten their future ability to provide health care services to the full spectrum of beneficiaries.

The MHSS has embarked on a new managed care plan for non-active duty beneficiaries called TRICARE. The comprehensive health care benefit under TRICARE will maintain or enhance the scope of services that eligible beneficiaries receive today. The MHSS's capability to provide everyday health care will improve with TRICARE, a plan centered around military hospitals and clinics and supplemented by networks of civilian care providers.

TRICARE presents an opportunity to clearly define military medicine as essential to force readiness, as well as to improve benefit security and choice of delivery for military beneficiaries. There are parts of this plan, however, that concern me. The TRICARE plan requires our retirees to share in the cost of care, and the greater the choice of physicians they desire, the greater the degree of cost-sharing.

This is wrong for two reasons. First, it violates the contract we made with these former servicemembers when they agreed to serve their country in our Armed Forces. We promised them access to free care in our military treatment facilities in exchange for lower wages and often a career of sacrifices during the time of their service. There was no fine print about modest enrollment fees and lower out-of-pocket costs.

Second, I pick up the Wall Street Journal and read that, ''HMOs Pile up Billions in Cash, Try to Decide What to do With it,'' as was reported on December 21, 1994. I am outraged that our military retirees, many on fixed incomes, will contribute to these organizations' dilemma. The largest of these are for-profit organizations, growing so fast that they overtook nonprofit HMOs as the dominant force in managed care, as reported by the New York Times, on December 18, 1994.

The Nation owes our military retirees and veterans what they were promised. Soldiers, sailors, airmen and marines, their families, retirees and their families, veterans, and surviving family members—these are the people who comprise the military family. Despite pressures to take a short-sighted view, we must honor our obligations to those who have served faithfully. The Congress and the citizens of this country must do so not only because it is the right thing to do, but because if we do not, we will soon be facing a far more serious crisis—another truly hollow force.

We cannot, must not, have contracts that ask more of our retirees and veterans. Any such contract today that does that must be declared null and void with the contract we made with them in years past. We cannot have contracts that restrict access, compromise care, or ask them to make more of a contribution. We placed no such restrictions on our service men and women when we sent them to foreign shores.

Lest we think that our servicemembers' tours of foreign shores are a product of days gone by, let me remind you that today we have more than 300,000 servicemembers serving overseas in 146 countries and 8 U.S. territories. In fact, deployments for the Army have increased threefold since 1990 and more than 700 Purple Hearts and two Medals of Honor have been

awarded since November 1989. The military is growing yet another generation of veterans and retirees who have served their country when their country called upon them.

I commend the MHSS for their advances in a standard benefit for all beneficiaries, for their commitment to medical advances such as telemedicine, and for the hard work in which they are engaged as they attempt to right size military health care. However, I caution them that I am watching. I will not tolerate a health care system sized on the backs of our retirees, a system that listens more to shortsighted budget analysts than to good business practices, and to any contract that violates the contract this country made with the men and women who served when called and have already paid their dues.

Madam President, the real bottom line is that the overall health of the entire voluntary military depends on the health of the Defense Health Program. A compromised military health system will rapidly lead to a compromised military capability. I greatly fear that we are heading down that course. For example, I find it truly alarming that for the first time in our Nation's history, the emergency defense supplemental bill is being offset dollar for dollar from its own defense budget. How long will it be before the Department gets wise and when the President says go to Haiti or Bosnia or wherever, the military says, ''No, thank you, we can't afford it''. I have been involved in our Nation's defense for more than 30 years as a Member of Congress and I have traveled extensively around the world during those many years and I absolutely believe that the best way to prevent war is to prepare for war. The only way to prepare for war is to maintain a healthy, robust military. And absolutely critical to that endeavor is a healthy, robust military medical health system. Let us not forget the painful lessons learned in the past; let us not have another Task Force Smith; let us not repeat the same mistakes. Let us work to ensure a safe and secure future for this great Nation of ours.

I would like to acknowledge the contribution of my Congressional Nurse Fellow, Lt. Col. Barbara Scherb, who prepared this statement. Colonel Scherb is an Army nurse who is currently assigned on a 1-year fellowship in my office.

REPRESENTATIVE RICHARDSON'S SUCCESSFUL HUMANITARIAN MISSION TO IRAQ

Mr. BINGAMAN. Madam President, on another issue, I rise to congratulate my friend and colleague from New Mexico, Representative BILL RICHARDSON, for his recent trip to Iraq that resulted in the early release from prison of two Americans, David Daliberti and William Barloon.

Madam President, we have all been affected by this story. We agonized with the families of these two Americans since their arrest in March when they inadvertently crossed the Iraqi border while trying to visit friends at the United Nations observer post in Kuwait. We recoiled when we learned that their sentence would be 8 years in prison. We watched as others tried to negotiate a solution to the crisis, including the wives of Mr. Daliberti and Mr. Barloon, who visited their husbands in a Baghdad prison. And we worried as a nation when we received reports that both men were experiencing heart trouble that required hospitalization while in the prison.

We have now learned, however, that Representative RICHARDSON has been doing more than simply listening to the news coming out of Iraq like most of the rest of us. He met eight times with the Iraqi Ambassador to the United Nations in New York, sometimes catching a flight from Washington early in the morning so that he could return before votes were cast in the House.

These visits established a feeling of trust that allowed Representative RICHARDSON to travel to Iraq, where he pressed Saddam Hussein for the release of the captive Americans on humanitarian grounds. As with any negotiation, we now know that there were moments of disagreement and misunderstanding with the Iraqi President. Representative RICHARDSON persisted in arguing that releasing these men at this time was the right thing to do.

Madam President, in a world with a seemingly endless number of intractable conflicts and troubles, from Bosnia to Rwanda to North Korea, it is with a sense of relief that as a result of Representative RICHARDSON's successful humanitarian mission to Iraq, we have one less crisis hanging over our country and over the two families that have now been reunited.

All Americans should be proud of Mr. Daliberti and Mr. Barloon for their courage and strength over the past 5 months. I am especially proud of my friend and colleague from my home State of New Mexico for his remarkable achievement in winning their release.

Madam President, I yield the floor.

COMPREHENSIVE REGULATORY REFORM ACT

Mr. KENNEDY. Madam President, on a matter that the Senate has been debating over the period of the last 9 days, regulatory reform bill, it has been temporarily laid aside for now, but I rise at this time to call the attention of my colleagues that the bill contains an unfortunate and unwarranted provision that would drastically undermine fundamental food safety standards in current law. I intended to offer this amendment yesterday prior to the time that the bill was set aside.

I want to speak briefly to this issue. I hope the issue would have been addressed by those in the process of considering the regulatory reform bill, or have an opportunity to address it when the legislation comes back. It addresses one of the very serious failings of this legislation. I want to take a few moments of the Senate time to address it.

This is a different issue than the meat inspection question we debated last week. It involves the unfortunate and unwarranted provision that would drastically undermine the fundamental food safety standards that exist in current law.

America has the safest food supply in the world. Families go to a supermarket to purchase meat or vegetables, to buy baby food or apple sauce for young children they do so, secure in the knowledge that what they buy, and any additives contained in them, meet strict safety standards enforced by the Department of Agriculture and the Food and Drug Administration.

When contaminated food inadvertently reaches the public, these agencies have the power they need to protect the public health. The basic food safety standards were enacted into law many years ago. Today, they are relied on and taken for granted by the American public. That is absolutely how it should be. No one has to give a second thought to the safety of the food that they eat today—and they should not have to start to worry about it tomorrow.

The safety of American food not only benefits consumers, it provides a competitive advantage to the U.S. food industry in the global markets. The label ''Made in the USA'' on a can or jar of food is a signal to people everywhere that the product meets the highest standards of safety and cleanliness.

Two of the cornerstones of the Federal food safety law are contained in section 409 of the Federal Food, Drug, and Cosmetic Act. The relevant language of that section reads as follows: A food additive shall not be approved ''if a fair evaluation of the data before the Secretary fails to establish that the proposed use of the food additive, under the conditions of the use to be specified in the regulation, will be safe: Provided, that no additive shall be deemed to be safe if it is found to induce cancer in man or animal * * *.''

This provision is known as the Delaney clause. This simple statement is the basis for the establishment of safety for the food supply in the United States. These two provisions together deal with food safety and also the limitation of carcinogens in pesticides, in food coloring, and in other areas as well, but food additives primarily.

What we have done in this proposal that is before the Senate is changed both of these standards. I wonder why? I wonder where the call is across the country for people that say our food is too safe? I think few would ever have had the circumstance where anyone