numbers by implementing pro-active anti-HIV campaigns. As a result, its infection rate has been reduced from 30 percent in 1990 to 5 percent in 2003.

This is a country that is making real strides toward peace. If we remain passive while the Lord's Resistance Army marches on, we can be sure that the public health, education, technology, and agriculture infrastructures will deteriorate.

Mr. Speaker, we must take this all-important step to learn as much as we can about what is happening in Uganda if we are to respond appropriately in the future. For the reasons stated above, I support S. 2264.

THE TURKISH INVASION OF CYPRUS, AND DEMILITARIZATION OF THE ISLAND

HON. ROBERT E. ANDREWS

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 21, 2004

Mr. ANDREWS. Mr. Speaker, yesterday, July 20, 2004, marked the 30-year anniversary of Turkey's invasion and occupation of Cyprus. Since 1974, United States policy on the Cyprus problem has been unsuccessful in its efforts to influence an agreeable resolution to this division. On May 1, 2004, Cyprus became a member of the European Union of families as a divided and occupied nation, its northern part being under illegal Turkish military occupation. The potential reunification of Cyprus is at a critical juncture. The Greek Cypriot ''no'' vote of 76 percent and the Turkish Cypriot ''yes'' vote of 65 percent is strong evidence of the unfair and unbalanced nature of the current version of the Annan Plan. If the yes and no votes had been close to the 50–50 mark, it might be argued that the plan is fair and balanced. At this point, however, no reasonable person can make such an argument. Accordingly, the United States and the United Nations must re-examine the key provisions of the Annan Plan in an effort to remedy the deficiencies that now plague the plan and obstruct the potential reunification of Cyprus.

One deficiency of the Annan Plan is its failure to demilitarize Cyprus. There is no need for Turkish or Greek soldiers to remain in Cyprus. The United States should insist on full demilitarization now. The final Annan Plan actually provides for the permanent presence of 650 Turkish troops on Cyprus with the right of ''intervention'' by Turkey, a guarantor power under the 1959–1960 London Zurich agreements. With Cyprus now a full member of the EU, there is no need for Britain, Turkey or Greece to remain as guarantor powers.

Quite inexplicably, the Annan Plan does not provide for the immediate demilitarization of Cyprus. It provides for the gradual withdrawal of Turkey's 35,000/40,000 troops over 14 years with 650 remaining permanently. Earlier versions of the Plan did not authorize any Turkish troops to remain.

There is no security problem for the Turkish Cypriots. The opening of the Green Line for crossings in Nicosia since April 2003 has allowed Greek and Turkish Cypriots to interact on a regular basis, and this period has passed without major incident.

As long ago as July 25, 1978, former Republican Senator Bob Dole proposed demilitarization on the Senate floor during the Senate debate on the amendment, which passed, to remove the remaining arms embargo on Turkey. Dole voted against lifting the embargo and noted that ''[n]egotiations between the two communities have remained stalemated over the presence of the Turkish occupation force.'' He stated:

> The great need for demilitarization of Cyprus, involving withdrawal of both Greek and Turkish forces, must be stressed. . . . Once demilitarization of Cyprus is achieved, then the intercommunal talks between the Greek and Turkish Cypriot communities over the territorial and political settlement will proceed much more smoothly. This must be the goal of all parties: to achieve demilitarization of Cyprus as soon as possible.

It is beyond dispute that this aspect of the Annan Plan would actually serve to decrease stability and security on the island because it fails to fully demilitarize Cyprus at the same time that it also affirms intervention rights for Turkey. These provisions of the Annan Plan must be changed if the plan is to be accepted by both parties, and carried out to successfully achieve a peaceful, unified Cyprus.

RECOGNIZING THE SCHOOL FOR INTERNATIONAL STUDIES AT ST. MICHAEL'S COLLEGE

HON. BERNARD SANDERS

OF VERMONT

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 21, 2004

Mr. SANDERS. Mr. Speaker, every day the media bombards us with stories about how dangerous the world is. War and terrorism are, tragically, a part of our modern condition. Yet this picture of international antagonism is so incomplete as to give us a false picture of the globe we inhabit. Fortunately, there are continual efforts, heroic efforts, to bring people together.

In fact, though often unrecognized by the mass media, international cooperation and efforts at mutual understanding take place every day. It is important that we recognize those who do the essential and heroic work of building the bridges that unite the international community.

Today I want to recognize the fine work of the School for International Studies at St. Michael's College, a private liberal-arts college in Colchester, VT, as the school celebrates its 50th anniversary. During the past five decades, over 15,000 international students have studied English at the St. Michael's campus in Colchester.

Founded in 1954 with a small program that taught four students from Puerto Rico, Quebec and Colombia, the program quickly grew to include students from 20 countries.

In 1957 the program welcomed 100 Hungarian refugees, known as Freedom Fighters for their 1956 uprising against Soviet troops, to the campus to learn English. The program was so successful that in 1962 a master's degree in Teaching English as a Second Language (MATESL) was established. Today, the School for International Studies has a worldwide reputation as a leader in language teaching pedagogy.

By the 1970s the program was teaching language students from over 40 countries around the world.

Nor has the growth and scope of the program slackened in current years. Recently the program has welcomed its first students from Vietnam and Egypt, and has developed partnerships with institutions in Poland, Thailand, Greece, and Colombia. Students from more than 65 countries have studied in the Saint Michael's School of International Studies.

This week Saint Michael's College President Marc vanderHeyden presided over a celebration of this 50th anniversary, joined by speakers from some of Saint Michael's partner schools, Kanazawa Technical College of Japan, the Hellenic-American Union of Athens, both the International Christian University and Surugadai University of Tokyo, and the Gimnasio Vermont of Bogota.

To St. Michael's College, and to its School for International Studies in particular, a proud state and proud Nation say: Congratulations on working for half a century to bring people together and to build better communication between nations. We wish you well for the next half-century as you continue this vital work.

INTRODUCTION OF THE QUALITY, EFFICIENCY, SAFETY, AND TECHNOLOGY FOR HEALTHCARE TRANSFORMATION ACT

HON. PATRICK J. KENNEDY

OF RHODE ISLAND

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 21, 2004

Mr. KENNEDY of Rhode Island. Mr. Speaker, I rise today for Josie King. Josie was a vibrant eighteen-month-old who suffered a terrible accident and, thanks to the incredible advances in medicine, was saved and preparing to go home from the hospital.

Before she could, though, the same health system that saved her then took her life. That sweet little girl was lost to a series of entirely preventable mistakes in one of the finest hospitals in the nation, if not the world.

Politicians like to say that the United States has the best healthcare system in the world. But we don't. What we have is the best medical talent in the world, the best medical technology in the world, the best facilities in the world.

But the system itself is a mess.

The best healthcare system in the world would not allow nearly 100,000 people like Josie King to die in hospitals of preventable medical errors.

The best system in the world would not leave the United States ranked 28th in the world for infant mortality, in the company of Cuba, Hungary, and Slovakia.

The best system would not leave almost 75 million people—nearly one in three people under 65—without health insurance at some point over a 2 year period, especially when the National Academy of Sciences has documented that people without insurance have worse health and die sooner.

The best system wouldn't waste 30 cents on the dollar, or 1,400 dollars per employee per year, on care that does nothing to improve clinical outcomes. That's a 2 billion dollar tax on employers and taxpayers in my home state of Rhode Island in 2004, and an estimated 77.44 trillion dollars for the nation over the next decade.

And, one thing I know for certain, Mr. Speaker, the best healthcare system would

not give patients barely a coin-flip's chance whether they receive evidence-based, scientifically accepted care in appropriate situations.

Mr. Speaker, I rise today to introduce legislation because our health care system is not the best in the world. Our health care system produces great medicine but it produces great medicine unevenly and with massive inefficiencies and frequent mistakes. We can do better.

There's a saying: ''Every system is perfectly designed to produce the results it gets.'' We need to redesign the health care system to produce better outcomes at a better value. We need nothing short of a transformation so that delivering the highest quality health care becomes not only the overriding goal of the professionals within the system, but of the system itself.

How do we get there? Today, I am introducing a bill called the Josie King Act to put in place three pillars of a transformed system: A fully electronic, integrated, paperless healthcare system; a new emphasis on improving the science of better care, from the evidence base underlying medical treatments to the creation of a new cadre of health quality experts; and new methods of measuring the quality of care and new payment practices so that providers are compensated for the quality of care they provide, not just the quantity.

We're in the information age, and nowhere is information more important than in health care. Yet we ask doctors to practice medicine in the dark.

Our healthcare system is made up of thousands upon thousands of independent providers, each with its own records and no way to communicate with each other. Patients see multiple doctors, very rarely with anybody other than the patient as the traffic cop.

Since the right hand doesn't know what the left hand is doing, it's no wonder that 54 percent of serious chronic disease patients say they have been sent for duplicate tests or procedures within the last year.

In fact, it is estimated that 20 percent of labs and x-rays are ordered because the previous results can't be found. One in seven hospitalizations occurs as a precaution because patient information is unavailable.

Handwriting errors and other human mistakes cause deaths and injuries. The chances of being administered the wrong drug or the wrong dose in the hospital is around seven percent. Adherence to evidence-based medicine is shockingly low—barely 50 percent.

Why? It's not because the doctors and nurses and other health care personnel aren't skilled or committed or careful. It's because we practice 21st century medicine on a 20th century platform. Right now, less than five percent of doctors' offices use electronic medical records there's no way for even those doctors to easily share information.

The information revolution has transformed financial services, manufacturing, retail. Even hide-bound politicians are adapting campaigns and elections to the new tools. We need I.T. to transform medicine as well.

Making our health care system fully electronic, with networks to share all information that patients choose to share, will create new tools for doctors and nurses to let them use their skills more effectively.

Each provider would have a complete record for the patient, so there would be no more duplication of tests and procedures.

Computerized decision support systems would catch possible errors and help remind health professionals of new advances in evidence-based practice guidelines.

Patients would have access to important health information in a way that can allow them to be active participants in their own care.

A national health information infrastructure will also be a critical public health tool, helping the CDC and other public health agencies quickly pick up on and respond to outbreaks and acts of bioterrorism.

As we build these health information networks, security and privacy must be paramount. In fact, we can and should make a new information infrastructure safer than the status quo, with paper records that can be read by anybody and are easily accessible.

Not only could creation of this health information infrastructure dramatically improve patient care, it could save us billions of dollars—dollars our health care system can scarcely afford to waste. The independent Center for Information Technology Leadership prepared a report for the Department of Health and Human Services estimating the savings at $87 billion per year as we eliminate duplicate tests, unnecessary hospitalizations, and the many errors that plague our system today.

If electronic health systems are so terrific, you would think we'd have them by now. But here's the trouble. Most providers, especially physicians in small practices, have little financial incentive or wherewithal to make substantial I.T. investments.

In order to fix that, we need to recognize that putting in the information technology we need is a community-wide, infrastructure challenge. The benefits of achieving a widespread health information network for the community as a whole are tremendous, easily providing enough return on investment for all to gain.

But to get there, all of the health care stakeholders will have to work together to figure out how they're going to divide up the costs and the savings of putting electronic systems in every provider's office and of establishing the network. It needs to be a community-wide approach.

The model is being built in Rhode Island. Work is underway to pilot the development of a comprehensive health information network, and when it is in place, Rhode Island will be showing the future to the rest of the nation.

Building on this model, the Josie King Act lays out a phased process that will provide seed money and leadership to get the process rolling across the country and help every state and region build its infrastructure. With this proposal, we can get virtually the entire healthcare system networked in a decade.

When we have an electronic health information system, all kinds of other possibilities for transformation become possible. The Josie King Act not only would put I.T. in place, but would help establish new systems to take advantage of it.

Information systems create new opportunities for developing and using the evidence base. The Josie King Act would promote research into the comparative effectiveness and value of drugs, treatments, and technologies so doctors will have more and better information.

But as we expand our understanding about what constitutes good medicine in a given situation, we need to improve how that knowledge is used. How would we react, Mr. Speaker, if the airline lost half of our bags? Or if every other computer in our offices had to be returned to the manufacturer due to defects?

Well that's what we have in medicine—a defect rate approaching 50 percent in many cases, according to research from the RAND Corporation. We need to challenge the culture and systems that we have, because they are simply not good enough.

Information technologies can be powerful tools to drive out errors and improve efficiencies, as we have seen throughout our economy. But they are the tools, the means not the end. We also need leaders committed to redesigning health care delivery. The Josie King Act would begin training this new cadre of health care leaders with scholarships for graduate study in health care quality and efficiency.

To improve quality and efficiency, we also must be able to accurately measure quality and efficiency. The Josie King Act will help standardize performance measurement and use the new electronic clinical data so that, for the first time, consumers and payers can have a single source for an apples-to-apples comparison of all providers' quality, efficiency, and patient satisfaction.

Over time, these performance measurements can help us redesign payment practices so that doctors and hospitals are rewarded, not penalized, for improving patient outcomes.

The status quo is just not a sustainable option. We deserve a health care system that is as good as the quality of the medicine it can provide. That means thinking critically and creatively about what kind of health care system we want and how we build it.

Mr. Speaker, I would be remiss if I did not take a moment to acknowledge the great leadership and commitment on this issue of the former Speaker of this House, Newt Gingrich. There is nobody thinking more critically and more creatively about health care delivery than he is. Speaker Gingrich has been a terrific teacher and partner tome in this effort, and it is the great fortune of this nation that he has turned his prodigious talents to fixing what ails our health care system.

We can transform the health care system. It's an ambitious goal, but our reimbursement rates are too low, our premiums are too high, and our health outcomes are too uneven for us not to meet this challenge. We owe it to Josie King and her family to make sure that our health care system follows the Hippocratic Oath: first do no harm.

I look forward to working with my colleagues on both sides of the aisle on the Josie King Act, and I hope that we can do the hard work to build a health care system that's every bit as good as the extraordinary medicine it can produce.

STOCK OPTION ACCOUNTING REFORM ACT

SPEECH OF

HON. JIM KOLBE

OF ARIZONA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, July 20, 2004

The House in Committee of the Whole House on the State of the Union had under