great example is the Government Oversight Committee, which has done really yeoman's work in trying to make up for the complete absence of oversight during the past several Congresses. The Oversight Committee held a hearing, very well attended, very highly publicized hearing a few weeks back with the CEO of Blackwater, who came before Congress, Blackwater, the private security firm which has basically created a privatized military in Iraq today.

Blackwater came before us, the CEO of Blackwater came before us the other week, and we asked him simply this. We said, tell us how much profit you are making. Tell us how much profit Blackwater is making off of U.S. Government contracts and said, You know what? It's none of your business. I can give you an estimation. I think we are making about $85 million a year in profits off of $850 million in contracts. But, basically, it's none of your business, United States Congress.

There weren't a lot of people on the Republican side of the aisle, on that government Oversight Committee that blinked at that suggestion, because that has been the practice in this Congress over the past several years. That has been de rigueur, as a matter of course here, that we don't ask any questions, that it is okay that Blackwater security, a private military operating in Iraq, can make $85 million in profit off of doing what we know the United States military could do themselves.

So it's endemic when you talk about private tax collectors, it's endemic when you talk about the issues such as PAYGO that Representative WASSERMAN SCHULTZ raised and certainly in spending on the war. Time after time again we have seen no fiscal responsibility here, and time after time this Congress, Mr. MEEK and Ms. WASSERMAN SCHULTZ, is shedding light on that misused taxpayer funds, but passing legislation like the bill that we passed today, which changes the course, and we start spending tax money wisely once again.

Mr. MEEK of Florida. We are going to start closing out here, and this is something we don't ordinarily do. We are going to end up leaving 10 minutes left open. I mean, there is just so much information we want to share, but we know that the House has to continue, but I want to recognize Ms. WASSERMAN SCHULTZ.

Ms. WASSERMAN SCHULTZ. In helping to close us out, I do want to direct people to the charts and the other information that we have talked about here tonight. Our Web site can be reached by going to www.speaker.gov, and you will find the 30-something link right on that Web page, www.speaker.gov. I can only hope that the next time we meet, which will be the day before we cast that children's health insurance vote, to decide who is for kids and who is not, to override the President's veto, that we will be able to report that we have picked up those 15 Republicans who have found their way and would be willing to do right by our Nation's kids. It has been a pleasure to join you here this evening.

Mr. MEEK of Florida. I want to thank the Members for what they have done this far, the majority of the Members in this House, and that is including some of our Republican friends that have voted for a number of these measures that the American people want, Republicans, Democrats, you name it, those that are involved in other parties and those that are thinking about voting. We have to show that we are a functional House and that we can be able to provide the leadership, when necessary, to be able to run the country in a way that it should be operated, especially on appropriations and on the finance and tax hand.

I want to thank the Democratic leadership for allowing us to have the hour.

HEALTH CARE IN AMERICA

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

Mr. BURGESS. Madam Speaker, I appreciate you letting me come to the floor tonight to talk, as I often do, about health care, the state of health care in our country.

This is a unique time in our Nation's history. We are kind of coming up on the 2008 Presidential campaign, and the reality of unfettered election-year politics intersects harshly with the perennial challenge, the perennial challenge we face in this House, how do we refine, transform, transform this Nation's health care system.

The history of health care in America over the last century and the very beginning of this century, it's a fascinating, fascinating subject. Medicine is a very highly structured, highly ordered, scientific-oriented, disciplined, scientific process, the scientific method. And then coupled with a number of governmental policies, we would like to think that they are science driven, we would like to think that they are fact based, but oftentimes they are more emotionally based, and how those policies interact with the scientific basis of the fundamental world of medicine and how, when we enact those policies and what seems like with every good noble intention in the world, how those policies then affect things decades into the future in ways that most people who enacted the policies would have had no idea what became of them.

Now, last century, in the 1940s, really a pivotal year in health care, medical care in America, both from a scientific aspect and from the policy aspect. From the scientific aspect, it was a time of great discovery and great excitement.

Mr. Alexander Fleming, the famed British scientist, isolated penicillin in 1928 in his laboratory, didn't quite know what he had or what to do with it. Certainly the substance produced by this mold in a petri dish inhibited the growth of the microorganism staphylococcus, a known cause of infection. For the first time, mankind had an agent to battle these unseen microscopic entities that plagued mankind for centuries.

Now, 1928 is not exactly 1940, and I referenced 1940. What happened in 1940 was American scientists, American scientists in this country, recognizing the value of this discovery, elucidated a method for mass production of penicillin. Penicillin, which had been a miracle drug before but available in very small quantities only for a very select few was now suddenly available for everyone, and available cheaply.

This affected our soldiers, who landed at Normandy on D–Day in 1944, the wounds that they suffered, which otherwise may have become infected and caused serious disability or even death were now even amenable to therapy with an antibiotic. Therapy with an antibiotic is something we now just take as almost second nature, just for granted. We get sick, we go to the doctor, they write a prescription for an antibiotic, we take it, we get well. In the 1940s, this was almost unheard of. So this was truly a breakthrough in the 1940s in the scientific realm in medicine.

Another discovery, that had actually occurred earlier, the discovery of cortisone. A very potent anti-inflammatory, cortisone was actually taken from the adrenal glands of oxen who were slaughtered. It was a very laborious, labor-intensive process to get small amounts of cortisone, so it really wasn't something that was amenable to treatment.

Then in the 1940s, a scientist that we, in fact, honored in this House during the last Congress, an African American gentleman, Percy Julian, who was a biochemist, not even a physician, a biochemist who worked heavily with soybeans and soybean products elucidated a method to mass produce cortisone, cortisol, which had not been able to be produced other than in very small quantities before, and now suddenly, again, it's available to very large numbers of people at a very reasonable price.

These two entities, antibiotics, anti-inflammatory, introduced in the 1940s changed forever the practice of medicine not just in America, but worldwide. What else happened in the 1940s? Obviously, World War II.

The Supreme Court made a decision in the 1940s that affects us to this day. During the Second World War, President Franklin Roosevelt, in an effort to keep down problems with inflation, it was a wartime economy, and he was worried about inflation taking hold and taking off, said we are going to have to have wage and price controls.

There was a lot of demand for labor in this country. We were producing materiel, things that were needed on the

frontlines in the war. Yet the workforce were all off fighting the war, so employers who were lucky enough to have employees to work wanted to keep them and keep them happy. How do you do that? You pay them more money. But the President said we better not do that or we are going to have trouble with the inflation.

Well, employers, being enterprising and ingenuous sorts, said, let's then offer benefits. Let's offer health care benefits, let's offer retirement benefits. A decision by the Supreme Court in the 1940s said, yes, you can do this. It does not violate the spirit of the wage and price controls. Not only that, you can pay these with pretax dollars.

So the era of employer-derived, employer-based health insurance was born, turned out to be enormously popular. People liked the idea, and, for decades into the future, that was the model that was followed in this country.

Then, fast-forward another 20 years and we are in the mid-1960s. What other health care policy happened at that time? Well, it was the institution of the Medicare program by President Lyndon Johnson. The Congress at that time who said, You know what? We are going to provide protection for our seniors.

Now, at that time, they provided protection for the doctors in the hospitals. Prescription drugs came 40 years later in the 108th Congress when we enacted the prescription drug benefit, but think how the interposition of the Medicare policies changed the fundamentals of how health care is paid for in this country.

The Medicare and Medicaid programs of the mid-1960s meant all of a sudden the government is in a position to finance a large portion of health care provided in the United States. Now, prior to the Second World War, most health care was paid for at the time of service and was a cash exchange. With the advent of employer-derived health insurance and the position of a large governmental program, most health care now is administered through some type of third-party arrangement.

That's useful in that it protects the individual who is covered by insurance from large cash outlays, but there is a trade-off. The covered individual is generally unaware of the cost of the care that he or she receives, as well as the provider, who remains insensitive to the cost of the care that that provider orders.

This arrangement has created an environment that permits really rapid growth in almost all sectors of health care and the cost of health care. America's challenge in the early part of the 21st century, America's challenge becomes evident. How do we improve the model of the current hybrid system that involves public and private payment for health care but at the same time anesthetizes most of us as to the true cost of that care?

□ 1945

It's also perhaps wise to consider that any truly useful attempt to modernize the system, the primary goal really has to be, first off, you protect the patient. You protect the person, not the status quo. And we also need to ask ourselves if the goal is to protect the system of third party payment or to provide Americans with a reasonable way to obtain health care and allow physicians a reasonable way to provide health care for their patients. Sometimes, with some of the legislation that I see come before my committee, Energy and Commerce, I wonder if we don't forget that fundamental rule.

In health care, the basic fundamental unit of production is the interaction that takes place between the medical professional, the doctor and the patient in the treatment room. That fundamental interaction, Madam Speaker, if you will, is the widget. That's what this large health care machine produces. And sometimes that concept also gets lost in the process when we talk about how do we reform health care.

The current situation subsidizes, makes payments to those indirectly involved with the delivery of that widget and, ultimately, that drives up the cost. Now, currently in the United States, about half of every health care dollar that's spent originates here in the United States Congress.

The United States gross domestic product, we spend about 15 percent of that on health care, and half of that expenditure is generated from the Congress. The gross domestic product currently is about $1.6 trillion. Medicare and Medicaid systems pay for or cost about $600 billion in aggregate. You've got the Federal prison system, the Indian Health Service, the VA system, all of the other interactions that the Federal Government has with paying for health care amount to about half.

What's the other half? Is it all private insurance? No, of course it's not. There are a certain number of people who are uninsured.

Private insurance, to be sure, occupies a significant percentage of that half that's not paid for by the government. Some is paid for by the individual. Some of it is self-pay, and I would include health savings accounts, medical savings account in that self-pay group because I think that's an important concept that sometimes gets lost in the discussion.

And finally, let's be honest. There is a good deal of care that is delivered that is simply a charitable offering by doctors, nurses, hospitals, a charitable offering that is given to patients who lack the ability to pay.

Again, the test before us, protect the people, not the special interests. Madam Speaker, we ought to define that which ought to be determined by market principles and that which, of necessity, must be left in the realm of the public provider, the government realm, and how, in all of this process, we preserve individual self-direction instead of establishing supremacy of the state.

Additionally, we must challenge those things that result in distortion of market forces, especially those market forces in health care, and acknowledge that some of that distortion is, in fact, endemic. We'll never be able to subtract it out of the system. Some of it is hidden. We'll never even know that it's there, and since it's hidden, or we can't subtract it out of the system, it's not readily changed. So recognize that and acknowledge that we're not going to change that part, but also recognize that there's part of it that is actually easily amenable to change. And the key here is how to maximize the value at the production level.

Again, I go back to that fundamental unit of production, the doctor-patient interaction in the treatment room. Yes, I know it may be the emergency room, the operating room, but that fundamental unit of interaction, how do we maximize value at the production level?

How do we place a patient who exists on a continuum between health and disease, how do we move that patient more in the direction of health and slow that movement in the direction of disease?

How do we allow physicians an appropriate return on their investment, their investment of time, their skill, their intellectual property? And that opens up a host of questions relating to future physician work force issues.

How do we keep the employer, if the employer is indeed still involved in providing health insurance for an employee, how do we keep the employer to continue to see value in the system? They get a quicker return to work for their injured or ill employee. Perhaps there's increased productivity, better maintenance of a healthy and more satisfied work force. All of these things are of value to the employer, and that ought to be recognized.

In regards to health insurance, how to provide a predictable and managed risk environment, remembering that insurance companies themselves, of necessity, they tend to seek a state of monopoly, and if left unchecked, that's the direction in which they're going to move. If that is a good thing, okay. If that needs to be monitored or regulated, we need to be willing to provide that regulatory expertise as well.

And finally, how do we balance the needs of hospitals, ambulatory surgery centers, long-term care facilities and the needs of the community, as well as the needs of doctors, nurses and administrators?

Now, Madam Speaker, individual legislation, H.R. 2583, H.R. 2584, H.R. 2585 deal specifically with medical work force issues. And as some of the hubbub around the current health care debate dies down, I hope we get a chance to actually articulate and debate those issues.

Another bill, H.R. 2203, that was introduced in the 109th Congress would

provide low-income Americans with a direct subsidy to help pay for their health care and many others that would chart a path to true reform in our health care system.

But let's keep in mind some principles when we talk about legislation. And I would say the first principle that Americans, at least in my estimation from 25 years of practicing medicine, what do Americans value in their health care system?

They value that freedom of choice. They want to go see the doctor they want to see. They want to see them when they want to see them, not when the system says they can come in. When hospitalization is required, you know, no one objects to incentives, but freedom of choice must remain central.

Another principle that certainly a number of people talk to me about is a principle of ownership. Madam Speaker, I had a medical savings account before I came to Congress. The whole concept of having what we now call a health savings account or a medical IRA and being allowed to accumulate savings, a nest egg, dollars to offset future medical expenses, is a fundamental desire of many Americans, and I think we should encourage that.

These dollars that are then dedicated to health care should be properly owned by the individual. And guess what? When this individual leaves this life, those dollars stay in that individual's estate and they don't go back to any governmental body upon the death of the individual.

Another principle would be independence, the preservation of autonomy. The patient or the patient's designee should ultimately be responsible for their care or the ability to decline medical intervention.

Another principle that I think we need to keep foremost in our minds is that of high standards. One of the underpinnings of the American medical system has always been high standards of excellence and nothing, in any future change, should undermine that. And, in fact, the pathways to facilitate future growth in excellence should always be encouraged.

Again, it gets back to delivering value for the dollar. Innovative approaches. We Americans pride ourselves on innovative approaches. American medicine has always been characterized as embracing innovation and developing new technologies and treatments. Clearly, this must be preserved.

Madam Speaker, we just came through the FDA reauthorization bill earlier this year. The whole purpose, years ago, with the development of the Prescription Drug User Fee and the Medical Device User Fee Act was to provide additional funding so that inventions and discoveries and intellectual property that was developed, whether it be a pharmaceutical or a medical device, would not sit so long in the approval phase and could be brought, not just to market, but to be able to help patients more quickly.

The difference between practicing medicine in the 1980s, when we had the old system, and the 1990s, under the new system, was phenomenal, and the ability to deliver drugs and devices to the patient public was, in fact, vastly increased. I was grateful to play a small role in the reauthorization of the FDA process when we did that earlier this year.

In fact, Madam Speaker, we heard a lot of talk just a few minutes ago about the SCHIP bill. I would hold out the FDA legislative process as a model which this Congress should follow because that was truly a bipartisan process. The SCHIP bill that came through this House that everyone is now holding their breath waiting to see whether or not the other side has the votes to override a veto, but the reality is that bill came through this Congress in what I consider a very pernicious way that is likely to poison any future attempts at bipartisan cooperation because here was a bill that was simply thrown across the transom, rammed through committee, rammed through the House on a party-line vote. Then we go back to the Senate. Well, we can't really do a conference committee. So what do we do? We take up a brand new bill. But we don't bring it back through the committee. We don't bring it back through the subcommittee. No. We come right to the floor and take it or leave it. That's not the way America wants to see this Congress operate. America wants to see this Congress operate as it is supposed to operate. They want to see my committee, the Committee on Energy and Commerce, have a subcommittee markup on the bill. There might be a good idea out there on the Republican side. There might not, but there might be.

And what reason could anyone in this body give for saying, we're just not going to do that? They say it was in the interest of time.

Madam Speaker, every single Member of this body who stood in this House in January of 2007, raised their right hand and swore an oath to defend the Constitution, knew that at the end of September, what's going to happen? SCHIP expires. It was a 10-year authorization. It started in 1997. Time's up at the end of September. The fiscal year is over. So we all knew this was coming. Why did we leave it till the last minute? And then why did we bring such an imperfect product through and then ram it through at the last minute, without any of the usual consultative advise and consent that goes on at the subcommittee level and the committee level. I frankly don't understand.

If people are watching this process, if people are able to dig beneath the political rhetoric, they ought to be outraged at the way this was handled. But I'm getting off message.

When we talk about principles for health care reform, one of the things that we really have to focus on is timeliness.

Madam Speaker, we always hear about American comparisons to other health care systems around the world. But consider this: Access to a waiting list does not equal access to care. This was the message delivered by the Canadian Supreme Court to its medical system in 2005. We must diligently seek not to duplicate the most sinister type of rationing than that that exists in a system of nationalized health care which prevents citizens from getting care because it just simply takes so long to get to the doctor or get that needed procedure or get that needed hospitalization.

Another principle that really, I think, we ought to spend some time discussing and debating, not everyone agrees with this, but really this ought to be a market-based solution and not an administrative solution. The pricing should be based on what is actually indicated by market conditions, and not that that is assumed by an administrator, either an administrator at a private insurance company or an administrator at a Department of Health and Human Services or Center for Medicare and Medicaid Services.

Madam Speaker, we hear a lot of talk about mandates. Mandates, in general, in my opinion, lead to a restriction of services. State mandates cause more harm than good and impede competition and choice and drive up the cost and limit the availability of health insurance.

Employer mandates. We've heard various reform schemes that have been talked about that deal with employer mandates. That was the crux of the Clinton plan in 1993. Individual mandates, some of the things that have been talked about at some of the State levels. But employer mandates and individual mandates are likewise restrictive. A discussion of mandates should include an accounting of cost and whether those mandates limit the availability of insurance for those who may operate a small business, those who may be self-employed or self-insured. Remember, Medicare part D, the prescription drug program from 2 or 3 years ago, achieved a 90 percent enrollment rate with education, incentives, competition, and not a single mandate. We must not forget that lesson because that's been a highly successful program and one that, in fact, enjoys very high popularity in the population that it serves.

The concept of premium support. Premium support is kind of like a tax credit, kind of like a voucher, but not quite.

Let's be honest. Our Tax Code is complicated enough as it is. We don't need to layer more complexity on the Tax Code. I know that's a topic for a different discussion, but when we're talking about health care reform, I'm not such a big fan of tax credits. But if there is the ability for, whether it be the SCHIP program or the Medicaid program, to help someone buy down

the cost of that health insurance premium so they can, in fact, afford an insurance policy, I think the concept of premium support is one that this Congress really ought to investigate. In fact, that was an amendment that I had for the SCHIP process, but, again, we weren't allowed to amend that bill in subcommittee, full committee or here on the House floor.

□ 2000

You know, on the concept of the premium support, one thing that we could think about doing is some individuals receive some additional help to the earned income tax credit. Well, what if we made it not just a good idea but a requirement that people who receive money on the earned income tax credit that some of those dollars are actually earmarked for their health insurance? Maybe an idea worth exploring.

Another principle is that of antitrust enforcement. It has to be balanced. If the Federal Government picks winners and losers, we're going to further distort and make the playing field unlevel, and as a consequence, we are going to thwart our best efforts for health care reform. Creating winners and losers via the antitrust law actually erodes the viability of the American health care system.

Well, what about talking about some of the policies that actually may affect some change? For health care within the public sector model, the transformation after the experience with Medicare part D has been instructive. Six protected classes of medication, which were required of all companies who wish to compete and participate in the system, allowed for greater acceptance by the covered population and greater medical flexibility when treating patients. At the same time, the competitive influences brought to bear in that part of the program, indeed, have managed to control costs. In fact, the projection of the cost of the Medicare part D program is $130 billion less over that moving target we call the 10-year budgetary window. It's solely the result of competition. It is likely we will get some additional benefit, some additional cost relief by more timely treatment of disease and delivering more value for the health care dollar. But those concepts, those savings are going to necessarily appear later in the timeline of that process. But just from competition alone, a substantial amount of dollars savings were achieved under the part D program.

Madam Speaker, one of the most important lessons learned in the Medicare part D program is that coverage can be significant without the use of mandates. Ninety percent of seniors now have some type of prescription drug coverage, and this was achieved how? By mandates? No. But by creating plans that people actually wanted. What a concept. You don't mandate you have to do it. You build something that people want, and they come to it. We ought to follow that model more often when we are talking about health care reform in this country.

Ninety percent of seniors have prescription drug coverage, and providing that coverage means that incentives to sign up in a timely fashion had to be provided. And, indeed, that worked. It emphasized that the personal involvement responsibility was there to maintain some type of credible coverage if it already existed or to buy into credible coverage during the open enrollment period. And, in fact, people accepted that and behaved accordingly.

Employer-derived health insurance I think will be a significant player in the American health care scene. A lot of writers who write about health care insurance say the employer-based model is passe. It's dead and gone, never to return. I don't know that I agree with that. Certainly it is still a very viable presence, a very robust presence in the insurance market today. And while again there are some problems, it is hard for me to see that the day is coming where that will completely fall by the wayside.

I think that's because it adds value. It adds value to the contract between the employer and employee. It rewards loyal employees and builds commitments within the organization. Businesses can spread risk and help drive down cost.

Now, one of the features that is inherent in that model is the proposed associated health plans that the previous Congress and the Congress before that have voted on on several occasions. We have never been able to get that concept to pass in the Senate, but maybe it's time to look at that again. Associated health plans are allowing small businesses of a similar business model to pool together to get the purchasing power of a larger organization. It gives, say, a group of Realtors or a group of doctors' offices the ability to go out and perhaps achieve some of the same kind of discounts that Verizon or AT&T or Wal-Mart get because they are such big employers. This is a very powerful concept to put in the hands of employers.

In fact, it was a concept that was so good it was actually first proposed on the floor of this House by Bill Clinton in 1993 in his September speech to this body when he outlined his proposals for health care reform. Associated health plans were part of that reform package. I don't know what happened to them on the way to the end of the legislative process, but somewhere along the way, people stopped talking about them. But they are a good idea. Again, the concept has passed this House twice, in the 108th Congress and 109th Congress. It's a mystery to me why we don't take it up again. I think that is something the American people would be interested in our doing, and, goodness knows, they would like to see us work on something meaningful when it comes to health care.

Now, regardless of whether the system is public or private, what have we seen in the way that information is transferred and handled? Have there been any changes in the last 100 years? Yes, I think so. Are there going to be changes in the next 25 years? I think you can bet on that. Vast changes in information technology are going to occur whether doctors want them to, whether hospitals want them to, whether insurance companies want them to. Those changes in how information is handled are going to occur, and they need to be facilitated. We are coming up to a time of rapid learning, and because of improvements in health care technology, the ability to manage databases, retrieve data in a timely fashion are going to be critical for the delivery of health care and protection of patients in the future.

Madam Speaker, if I could, let me just share with my colleagues in the House a picture. When I was first elected to Congress in 2002, I have got to say I wasn't a big believer in electronic medical records. They are kind of cumbersome. When you are first learning them, they really slow you down. Your productivity suffers because you have got to learn this system.

But 2 years ago at Charity Hospital in New Orleans, one of the venerable, venerable health care institutions of this country, the whole city of New Orleans was hit with Hurricane Katrina and then the flooding to follow the hurricane. Well, here is a picture from January 2006. So 5 months after the hurricane, the water has been pulled out of the city. Here is the medical records room at Charity Hospital. These records haven't been burned. This black stuff here, that is black mold. You could not send anyone in there to retrieve data off of one of these charts without imposing a significant health risk. I don't know what's contained within there, maybe a bone marrow transplant, childbirth, kidney transplant, heart attack. All of that information lost to the ages because they were contained on paper records.

Again, I wasn't a big believer in electronic medical records, but walking through the records room at Charity Hospital that day, how many hours have I spent in the records room doing my medical records when I was on staff at various hospitals. It looked a lot like our records room at Parkland Hospital back in the 1970s.

These records are lost. This patient's data are now forever irretrievable. And at some point we are going to have to come up with a system that allows that data to be stored in an area where it is not vulnerable to this type of degradation and that it is readily retrievable. And then guess what. If a patient is being seen in New Orleans and treated for a condition but they happen to travel to Fort Worth, Texas, and their medical records are needed, they are accessible online and immediately available to the treating doctors in the destination city.

Another issue that I think we will have to pay some attention to is quality reporting. In my opinion, quality reporting should be voluntary, but it is important. Programs need to be generally available. They have got to be accessible to the medical personnel who desire to participate.

Currently, I think in all 50 States, we have got quality improvement organizations, and they currently do a good job. They provide information, timely information, information back to the provider as to how the care was delivered. Was it delivered in a timely fashion? Was it delivered in a fashion that was utilizable?

There are other ways of establishing quality. Legislation that passed in this House last time to establish a medical home also will result in the accumulation of some quality and some utilization data. I think that data needs to be available to the treating physician. It doesn't have to be widely disseminated publicly, but you make that data available to the physician, and physicians being naturally competitive sorts are going to ask the question, Well, that's interesting. I wonder if I could do better or how have I done in comparison to the people around me? And that will be useful information to provide to physicians and hospitals.

Any of the quality reporting methods that are out there have to be generally available and accessible to all of the physicians practicing in a community. Yes, I would like for it to be voluntary, but if it is not generally available, ultimately it is not going to be useful.

Now, this approach was a component of the Medicare physician update proposal by, at that time, Chairman JOE BARTON of the Energy and Commerce Committee. He offered that late in 2006. I think it is a concept that should be revisited.

Within the individual market, and, again, within the individual market I would include self-pay and also that individual who is the owner of a health savings account, within that portion of the market, transparency of information is critical, and that is another area where we are going to see rapid evolution and rapid change. It is going to require that there is adequacy of the reports that detail the information about cost, price, and quality, and they are not all the same. This information has to be linked to data detailing things like complications and infection rates.

Web-based programs. We have got a good one in my home State of Texas. Web-based programs will begin to build databases and actually build familiarity with the consuming public so that these will become useful in the future. And www.txpricepoint.org is a Web-based program that is up and functioning in Texas. It's just beginning. Some people will look at it and say, well, that information is really pretty rudimentary, but currently it allows patients, say, in my home county of Denton County where there are four hospitals, to compare the costs of treating a fractured femur, episode of childbirth. How do those four hospitals compare in the area? Is there one that is significantly cheaper or one that is significantly more expensive than its counterparts? Maybe if that information is present, then to begin to ask the questions why and for the consumer to begin digging a little deeper and finding out more information about the hospital, whether or not they want to choose that hospital for their care. Again, not for people who have Medicare, Medicaid, SCHIP, or private insurance, but for the individual who is paying out of pocket or the individual who has a health savings account with a high deductible so, again, is probably paying out of pocket for a portion of their care. This is a useful exercise, and, again, I encourage people, particularly people in my home State of Texas, www.txpricepoint.org.

Now, crafting a readily affordable basic package of insurance benefits perhaps modeled after what we already do in the Federally Qualified Health Center program is another important opportunity for reform that this body could look into. Currently, Federally Qualified Health Centers are required to provide a basic level of primary care. They also provide dental and mental health services. Providing a basic package of benefits along this line that is affordable and available with the option of adding on additional benefits at additional costs, that could be a powerful option for many Americans. This could remove some of the influence of some of the special interest groups, which I talked about earlier, and, again, allows us to focus on the patient and certainly allows a functioning business model to replace some of the draconian institutional standards that are now required.

Providing a truly affordable basic package of benefits, that coverage which insurance companies then would want to market to segments of the uninsured population, you've got to believe that companies like Aetna, United look at 47 million people who are uninsured and say that's a potential market share. If we only had an affordable product that we could deliver to that population, we actually could perhaps provide a good deal of coverage for that population.

Madam Speaker, let's not forget that care that is truly charitable: Organizing and providing a tax credit for donated services by doctors, nurses, even hospitals, I think that is something that is fundamental to the American psyche and something to be readily embraced by the American people.

□ 2015

We could provide additional protection under the Federal Tort Claims Act, perhaps a legal safe harbor from lawsuits where, in good faith, charitable care is provided and, in effect, allow providers who are retired or semiretired to return and fill some of the vacuum for indigent care.

I had an acquaintance whose father is a physician. Hurricane Katrina hit, obviously, the next-door neighbor State of Louisiana, but a lot of people left Louisiana and came to Texas. There were a lot of areas that were strained in their availability to deliver health care in that time 2 years ago.

This acquaintance's dad was a physician. He was a retired physician, no longer carried insurance, and said, well, I'm going to go down to the shelter where these people are being received and offer my services. And my friend was quite concerned about his dad and said, you don't have insurance. If you go down there and something bad happens and you get sued, you have no coverage for that. Maybe we ought to provide a mechanism for providing that coverage for someone who truly, out of the goodness of their heart, wants to respond to a national emergency, wants to respond to their country in a time of need, allow them the opportunity of doing that.

And along those lines, we ought to have a system of emergency credentialing so that when people just show up on a scene of a disaster, whoever is in charge, the first responders in charge will have a way of quickly and rapidly assessing whether this individual, indeed, possesses the credentials that they purport to have. And that would go a long way towards alleviating, frankly, some of the confusion that occurred on the ground in various health care sites, not just in Texas, but back in Louisiana as well.

Madam Speaker, the late President Ronald Reagan used to say, ''trust, but verify.'' Trust the market to make correct decisions, and to the extent that distortions can be removed, remove those distortions, but remember that some guidance from market principles will always be required, whether the system is completely public or completely private.

Finally, as part of this discussion, there must be a rational breakdown of the numbers of the uninsured. We want to talk about, how do we cover the uninsured? We don't have accurate numbers, not for the total number of the uninsured, but who comprises that population? We just say 47 million uninsured. And we're happy to talk about that in a political sense, but we need the data on the breakdown of those numbers so we know how to better craft policies that will provide coverage that's needed for those individuals. Is it just that some people aren't bothering to buy insurance? Maybe we craft a policy that would encourage them to do that.

I don't like mandates. I prefer incentives. Other people may like mandates. But let's have that discussion. But if we don't know how big the population is who just choose not to have health insurance but has the means to pay for it, we will never be able to enter into that discussion because we don't know. We just say 47 million uninsured. We hit each other over the head with it.

We go home at the end of the day and feel like we've done a good job, the American people say not so much.

Finally, just a point of contrast. And we've heard it a lot because of our health care discussions this week. My good friends on the other side of the aisle want to expand a culture of dependence on the state, while on my side of the aisle we want to expand the number of individuals who actually own and direct their own care. Which system would you choose? Which system gives you the greater liberty, the greater freedom that we all treasure and cherish as Americans? The answer for me is obvious.

Finally, Madam Speaker, we talked about this a little bit at the beginning of this discussion, but the concept of American exceptionalism. The American health care system has no shortage of critics, critics throughout this body, critics throughout the city, critics throughout the world, but it is the American system that stands at the forefront of innovation and new technology, precisely the types of system-wide changes that are going to be necessary to efficiently and effectively provide care for Americans today and on into the future.

Now, Madam Speaker, I would rather this information not be widely disseminated, but from time to time I pick up and read the New York Times. An article in the New York Times from October 5, 2006, a year ago, by an individual named Tyler Cowlan, he writes, ''When it comes to medical innovation, the United States is the world's leader. In the past 10 years, 12 Nobel Prizes in medicine have gone to American-born scientists working in the United States, three have gone to foreign-born scientists working in the United States, and seven went to researchers outside this country; 15–7, America, the rest of the world.''

He goes on to point out that ''five of the six most important medical innovations of the past 25 years have been developed within and because of the American system.'' Now, comparisons with other countries may be useful, it may be information that we want to go out and seek and consider when crafting health care policy, but it is important to remember that it's the American system that's always reinventing itself and always seeking to improve itself. It is precisely because of the tension inherent in our hybrid system that creates the impetus for change. A system that's fully funded by a payroll tax, well, that's what they've got in Sweden. I think it's 7.1 percent that they pay on their payroll tax, and it funds their health care system. But quite honestly, Madam Speaker, there is no reason for them ever to seek improvement; and as a consequence, a system like that faces stagnation.

And indeed, if such a system, if it becomes necessary to control costs, guess where they look? Doctor, they look at you. They look at the provider. You know this. It's happening in the Medicare system, cuts projected for as far as the eye can see. Make no mistake about it, if the Democrats are successful with this SCHIP system that they are proposing to vastly expand, it's going to drive kids off of private health insurance onto an SCHIP program. The difficulties faced by providers within the Medicare system on an ongoing basis are certainly witness to this.

The fact is, Madam Speaker, the United States is not Europe. American patients are accustomed to wide choices when it comes to hospitals, physicians and pharmaceuticals. Because our experience is unique and because it's different from other countries, this difference should be acknowledged and embraced when it comes time to talk about reform or transformation, whether it's contemplated in a purely public or private health insurance model within this country.

One final point that's illustrated in a recent news story that was covered by a national Canadian television broadcaster about a Canadian Member of Parliament who sought treatment for cancer within the United States. The story itself is not particularly unique, but the online comments that followed the story I thought were pretty instructive.

To be sure, a number of the respondents felt that it was unfair to draw any conclusion because this was, after all, an individual who was ill and was seeking treatment. No argument with that concept. I hope she got the treatment that she sought, and I certainly pray that she got better. No one could argue this point. But one writer summed it up, ''She joins a lengthy list of Canadians who go to the United States to get treated. Unfortunately, the mythology that the state-run medicine is superior to that of the private sector takes precedent over the health of individual Canadians.''

A further comment from another individual: ''The story here isn't about those who get treatment in the United States. It's about a liberal politician who is part of a political party that espouses the Canadian public system and vows to ensure that no private health care is going to usurp the current system. She is a Member of Parliament for the party that relentlessly attacked conservatives for their ''hidden agenda'' to privatize health care. The irony and the hypocrisy in that position supports the notion that the rich get health care and the rest of us wait in line. All because liberals' fear-mongering that does not allow for a real debate on the state of the health care system in Canada.''

One final note from the online postings, ''It's been sort of alluded to, but I hope everyone who is reading this story realizes that, in fact, we do have a two-tiered system in Canada. We have public care in Canada. And for those who have lots of cash, we've got private care in the United States, which is quicker and better.''

Well, Madam Speaker, a little over a year ago, maybe now a year and a half ago, Alan Greenspan came and talked to a group of us one morning before he left Capitol Hill. And as it often happens with Chairman Greenspan, the talk came around to entitlements and entitlement spending. And the question got around to Medicare, how are we going to pay for Medicare. And the chairman acknowledged this is going to be a tough problem. But after he thought about it, he also said, ''When it comes time, I think that the Congress is going to end up doing the right thing and it will find a way to pay for Medicare.'' He said, ''What concerns me more is, will there be anyone there to actually deliver the services that you want?'' That's a pretty profound statement, and one that certainly has stuck with me for the past year and a half or more.

Now, in March of this year, back in my home State of Texas, the official magazine of the Texas Medical Association, Texas Medicine, put out a story. In fact, their cover story that month was, ''Running Out of Doctors.'' I think that's something we need to pay some attention to in this body. With all of our discussion about health care reform, all of our talk about changing the system this way or that way, more public, less public, more private, less private, if we ain't got the docs on the front line, it doesn't matter what we do because the care won't be there for the patients. We see this in the Medicare system. There is probably no other issue that I deal with with more frequency than the program cuts that are going to happen to Medicare physicians, again, literally, as far as the eye can see; 5 percent cut this year, 5 percent cut next year, oh, by the way, we've got to make up that 10 percent cut from last year. The problem is, the formula by which we pay physicians is different from the formula by which we reimburse hospitals, HMOs, drug companies and nursing homes.

Bear with me for just a moment because, wouldn't you know it, I have a poster that illustrates that. And I apologize, this one has gotten a little bit dated. The 2007 number has an asterisk beside it because that was projected, and now we're well into 2007.

This didn't happen because we held it back at zero. So it looks like there is no recording here for physician reimbursement under 2006; in fact, it was held at zero. Again, by a last-minute maneuver last year, we held it at zero for 2007 as well.

2002, pretty big cut. We did some last-minute changes in 2003, 2004 and 2005, which prevented the program cuts. We were unable to come up with any additional money in 2006 and 2007. Now, for 2008 and 2009, move this bar graph over a notch for those 2 years because that, after all, is what we're looking at, Medicare Advantage, hospitals, nursing homes, they're basically reimbursed on a cost of living adjustment, it's called the Medicare Economic Index. Physicians ought to be reimbursed on the

Medicare Economic Index, but they're not, and we need to fix that. It's not easy to fix it. It's going to cost some money. The Congressional Budget Office puts a very big number up there. Deep down in my heart I don't believe it's a real number, but nevertheless, we do need to be sensitive to that fact and we do need to fix it.

I would encourage Members to look at H.R. 2585. It is a way to sanely repeal the sustainable growth rate. It doesn't do it next year, waits a couple of years to do it, but because of some adjustments to the baseline, physicians won't, in fact, take a cut for 2008 and 2009. We need to keep them involved. And then in 2010, the SGR is repealed, with savings that are going to occur over the next 2 years. And we know savings are going to occur in the Medicare program over the next 2 years because that's the history that we've seen in the last several years.

The trustees' report that came out just this past June had some good news and some bad news. The bad news was, we're still going broke; but the good news is we're going to go broke a year later than what we told you last year. The reason is because 600,000 hospital beds weren't filled in 2005 that they thought would be filled in 2005. And why weren't they filled? Because the doctors were doing a better job. They were keeping people out of the hospital. Maybe the prescription drug benefit was allowing them for more timely treatment of disease, to treat disease earlier. So we didn't push them on that health disease continuum in the arena of disease, we kept them on the side of health. Things that are done in ambulatory surgery centers that are billed to part B, the physicians' part of Medicare, are actually savings that accrue in part A. Let's take those savings, sequester them, wall them off, a lock box, like we used to talk about back in 2000. Remember that? Put those savings in a lock box and use them to offset the cost of repealing the SGR in 2010.

□ 2030

That is the type of innovative thinking that is going to be required to get us out of this conundrum. And why is it important? Again, Alan Greenspan said, ''What worries me more is not how you pay for it, but is there going to be anyone there at the bedside to provide the service?''

I don't want to make light of what is a very serious situation. Yeah, there will always be someone there at the bedside, but I don't know that you want to look up and find it is Dr. Nick who is delivering your care, Dr. Nick, the famous physician from Springfield, Somewhere, U.S.A. who can do any operation for $199.95. That may be the physician of the future. We don't want to leave that legacy for our children. We need to correct this situation now. We can do it in this Congress if we just have the political will to work together to get this done.

Now, my time is almost up. This discussion on health care is likely to consume the better part of the next 2 years of both dialogue here on the floor of the House, dialogue on the Presidential campaign trail, and indeed dialogue in the general public. The United States is, indeed, at a crossroads. It is incumbent on every one of us here who believes, who believes in the American system of providing health care, that we be educated and we stay involved and we be committed to being at the top of our game every single day, whether we agree on every principle or not. We have to be on the top of our game every single day.

This is one of those rare instances where it is necessary, certainly on my side, to be prepared to win the debate because we don't have the votes to win much of anything in subcommittee, committee or the House floor. But it is an important topic. It is one of that the American people believe that we should be involved in.

If we adhere to the principles that I have outlined here this evening, I think that ultimately we are going to post a win for the health of the American people and for generations yet to come. That is the central task in front of us.

FISCAL RESPONSIBILITY AND THE WAR IN IRAQ

The SPEAKER pro tempore. Under the Speaker's announced policy of January 18, 2007, the gentleman from New Hampshire (Mr. HODES) is recognized for 60 minutes.

Mr. HODES. Mr. Speaker, I am delighted to be here tonight to talk about a number of issues that are of grave importance to this Congress and to the people of this country. I will be joined by some of my colleagues tonight who represent districts all over this country.

We are going to talk about a number of things tonight. We are going to talk about fiscal responsibility, which means money. It means we are going to talk a little bit about how in this Democratic majority Congress we have now taken a new responsible approach to spending the taxpayers' hard-earned tax dollars, because that is one of the main reasons that the taxpayers of this country sent a new Democratic majority to Congress, because they saw what had happened under previous Congresses. They saw that the Congress had engaged in borrow-and-spend policies that had left us with huge deficits, where before we had big surpluses, now we were running out of balance. And everybody knew that they couldn't run their businesses that way. They couldn't run their homes that way. And so they sent us to Congress to make a change about what we were going to do.

We are also going to move to talk about health care. We are going to talk about health care for kids because that is an issue that is very, very current. The President has vetoed a fiscally responsible, that means responsible with the money of the taxpayers, bill that would provide health care for the neediest kid in the country. He has vetoed that legislation. He said he doesn't want to have health care for our kids by vetoing that legislation.

We are going to be coming up for a vote in not too long about that. So we are going to talk about what it means for kids and for health care, and we are also going to sort of compare that to what is going on with the spending on the war in Iraq because the President and his administration have come and said they want to spend $191 billion more this year on the war in Iraq but they don't want to spend $35 billion to insure our kids.

I will just talk briefly now, and I have got a chart up, that shows you where we were when we started this Congress, what had happened with the mess. It is an example of what we were sent to fix, because this chart shows public borrowing by the administrations and the annual average of what we had to borrow to run our government. What you can see is where we came in to Congress. What we saw was, if you take a look down here in the lower corner, we started with President Carter. That little blue line shows that we were borrowing about $50 billion. Then you can see what happened under Presidents Reagan and Bush. Then you can see over here that under President Clinton we were able to handle the taxpayers' money in a responsible way. In fact, President Clinton, who was a Democrat, handled money so responsibly for the taxpayers of this country that when he left office in the year 2000 we were looking at budget surpluses over the next 10 years in the trillions of dollars. But when the Republicans took control, when President Bush came in, in 2000, he turned that upside down and topsy-turvy, and what we were left with coming into this Congress was the fact that President Bush was borrowing about $300 billion during his first 6 years. He had turned surpluses upside down into huge deficits that left us in the hole as far as the eye could see.

That is what we came in with. We came in with that, and we had to restore fiscal responsibility. Now, ''fiscal'' is a big word. It just means being responsible with the hard-earned money that the taxpayers of this country send to Washington so that an effective government honors local control but is able to get the projects done and run the programs that the people of this country expect. They expect us to be stewards of the public trust. By that, I mean they expect us to be honest about how we are spending their money. They expect us to use their money wisely. They expect us, just like they do at home and in their businesses, to balance things out and not spend more than we take in. And they want to make sure that we are spending their money wisely.