The Second Chance Act will go a long way towards this goal by providing transitional assistance to ex-offenders reentering their communities. By focusing on the major impediments that face ex-offenders, the Second Chance Act seeks to reduce recidivism and give those reentering society a new opportunity to turn their lives around. This legislation addresses the need for jobs, housing, and substance abuse/mental health treatment, and it works to reunite families and provide the appropriate training and rehabilitation for these individuals.

This bill will increase public safety and give millions of ex-offenders a chance to be positive productive citizens. I strongly urge my colleagues' support.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF CONFERENCE REPORT ON H.R. 3043, DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 2008

Mr. WELCH of Vermont (during Special Order of Mrs. JONES of Ohio), from the Committee on Rules, submitted a privileged report (Rept. No. 110–427) on the resolution (H. Res. 794) providing for consideration of the conference report to accompany the bill (H.R. 3043) making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2008, and for other purposes, which was referred to the House Calendar and ordered to be printed.

□ 2130

WORKFORCE CAROLINA

(Ms. FOXX asked and was given permission to address the House for 1 minute.)

Mr. Speaker, I rise today to honor Workforce Carolina on its 20th anniversary of doing business in North Carolina. Workforce Carolina is a woman-owned business services company founded by Teresa Lewis that serves seven counties in the Fifth District of North Carolina. It assists employers throughout North Carolina's Triad region with job placement, employment screening, payroll and skills assessments. This company has been a growing part of the local economy and each year employs upwards of 3,000 people through its two offices in Mt. Airy and Elkin, North Carolina. In fact, it is the fifth largest employer in Surry County, North Carolina.

This year, Workforce Carolina was named one of the best places to work by the Triad Business Journal. The business journal also recognized Workforce Carolina as one of the fastest growing companies in the Triad in 2006.

I want to congratulate this fine company for its 20 years of services to its community and its commitment to excellence in the workplace. I wish all the good people at Workforce Carolina many more years of successful business.

NATIONAL BIBLE WEEK

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from North Carolina (Ms. FOXX) is recognized for 5 minutes.

Ms. FOXX. Mr. Speaker, I rise today to celebrate a book that has changed the course of history and left its mark on every level of our society. The Bible has been a God-given source of guidance for humanity for thousands of years and was a wellspring of wisdom and truth for the Founders of our Nation. As we approach National Bible Week, which is traditionally celebrated during the week of Thanksgiving, it is important to pause and reflect on how this Good Book has shaped the world, changed countless millions of lives, and brought humankind to a better understanding of our God and of our place in the world.

The Bible is a deep repository of fundamental and universal truth that has stood as a guide post for the generations. It teaches us how we ought to relate to our Creator and how to love our fellow human beings. During times of turmoil, confusion and strife, I can think of no more important source of guidance than the wisdom of this unchanging and inspired book.

The Bible offers us hope when circumstances are dire. The Bible is a source of strength when our human frailty brings us low, and when we are surrounded by darkness, as the psalmist wrote, the Bible ''is a lamp to our feet and a light to our path.'' In all of its transcendent wisdom, the Bible does not fail to connect to our human condition. It kindles our joy and beckons us to know God regardless of our place in life.

Throughout my life, I have drawn on the words of the Bible to lead me and inform my moral compass. The Bible is an unshakeable pillar of truth that provides the surest of moral foundations for society's founded on and reliant on its inspired content. The Bible has nourished a dialogue of our Nation's public square and has bolstered the development of a strong moral identity for hundreds of years.

I encourage my fellow Americans to dig deep into the Good Book and discover for themselves what riches God's word has in store for them.

AMERICAN MEDICINE TODAY

The SPEAKER pro tempore. 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. Mr. Speaker, I come to the floor tonight to talk a little bit about health care. Of course, we are enmeshed in the great State Children's Health Insurance Program debate here this week, that load having been taken by the Senate at the end of last week, the bill being sent off to the President, we expect a veto, and probably sometime before this week is over, we will, one more time, test whether or not that veto will be overridden or sustained. I suspect the numbers will not have changed from the last time when the veto was sustained. So we are going to continue to have this debate in front of us for some time.

I do want to talk about the State Children's Health Insurance Program in some detail. But I want to put it in context. I want to put it in the context of what is happening in American medicine today, the transformational process that is going on in American medicine today and how those rapid advances in science are being affected by the policies that we craft here in this body and indeed how that has happened several times during the last hundred years, and we may expect it to happen in the future, but why the decisions we make today in this body are so critical for the future of health care in this country not just for next November, not just for a year from now, but for decades into the future.

Mr. Speaker, it is so critical, so critical that we develop a near-term, a mid-term and a long-term plan or strategy when it comes to crafting our health care policy. Sadly, I don't think this House has really been engaged in that process. We have been more fascinated by the political aspects of the fight.

Mr. Speaker, indeed, medicine is at a critical crossroads. This is a time of great transformation within the science. Down one of these pathways is a whole new genre of personalized care, changes in information technology, changes in the study of the human genome, changes in protein science, changes in imaging, the speed of information transfer; and indeed a time of rapid learning all serve to increase value for the patient.

Late last week at a conference downtown, Dr. Elias A. Zerhouni, the head of the National Institutes of Health put it in terms of the four Ps. He described a type of medicine in the future which will be predictive, personalized, preemptive, and participatory.

Now, Mr. Speaker, down the other path leads to the continued expansion of the reach and grasp of the Federal Government. Could this path equate to increased value for the patient? Well, the answer might be yes, but history has not been kind to that experience so far for this type of trajectory. The trend tends to become process driven, intensely process driven to a greater and greater degree rather than creating a true patient-centered environment.

Medical care, in fact, could be rationed in some of the most insidious ways that medical care can be rationed, and that is in the treatment room itself. That is by not paying for the care, not paying for the imaging, not paying for the physician services,

having the physician not be there for the patient in the treatment room. That is the type of rationing that we may be talking about.

It becomes all about the transaction, very little attention being paid to delivering value for the patient. And, Mr. Speaker, no secret about it, I am a physician. I practiced for 25 years back in my home State of Texas. I will tell you, this is also injurious to providers. It is injurious to doctors. And that, in turn, increases an already existing problem with the physician workforce and aggravates an already existing supply-and-demand inequity. This, in turn, creates a further imbalance between workforce required versus workforce produced.

Prices are then set administratively rather than by the marketplace, and this disconnect heightens the insensitivity to market demands, and indeed, we end up with a system much as we see today where physicians are anesthetized as to the true cost of delivering the care that they deliver, and, in turn, the patient is unaware of the cost of the care that they receive. And this becomes a true hindrance to the transformational process itself. Again, the process becomes entirely transactional, and this hinders, or reverses, the transformational process.

Now, Mr. Speaker, I would like for us to consider three events, or three epics in the last hundred years where health care policy and changes in science kind of came together to alter, fundamentally alter, the way medicine is practiced and alter it forever into the future.

The first time would be early in the last century, 1910 to 1920, where significant advances in medicine including new discoveries related to immunizations, advances in public hygiene, discoveries of anesthesia and modern blood banking weren't too far removed from that era, but they did occur a little bit earlier. That was such a far cry from the way medicine had been practiced up even into the late part of the 19th century. Back then, the order of the day was burning, bleeding, and blistering; and those were accepted as scientifically proven ways to deliver value or to deliver care for the patient. So there was a rapid change in the science that was going on, and there also occurred that intersection of a sudden change in public policy that, again, altered the direction of medical care forever after then.

In fact, now the policy that was developed we pretty much regard as a State function. And it is ultimately a change in State policy. It did originate at the Federal level with the commissioning of what became known as the Flexner Commission, which subsequently delivered the Flexner Report. This report, delivered to Congress in 1910, characterized the uneven structure of medical schools across the country. Indeed, the variability of medical schools was truly startling. As a consequence of the Flexner Report, there was a standardization of medical school curricula at a time when the science was, indeed, rapidly advancing. This set the stage for the transformation of medicine literally out of the Dark Ages into the illumination of the 21st century.

Then let's skip forward several decades, Mr. Speaker, to the 1940s. And again we see vast changes occurring. Penicillin had been discovered a little bit before that. Back in 1928, Sir Alexander Fleming, we all know Sir Alexander Fleming, there is a big statue erected to him by the bullfighters because he obviously changed the way bullfighting injuries could be treated, but penicillin was discovered in 1928. It was really little more than a laboratory curiosity at first, this substance produced by a mold that would inhibit the growth of bacteria on an agar plate in a Petri dish, but only small amounts could be produced, and it was fairly labor intensive and extremely expensive. So it is a compound that showed great promise, but there really was no way amenable for treating large numbers of patients so its social impact was really quite, quite muted.

But then came the discovery of new fermentation techniques in this country in the 1940s. Suddenly, penicillin moved from a laboratory curiosity to a compound that was readily available, readily available in the clinics and dispensaries across the country, readily available and the price subsequently came down significantly. This new life-saving antibiotic was even available to treat our soldiers who were wounded during the invasion and the landing in Normandy in 1944. For the first time battlefield medicine had a way of combating infected wounds which obviously had a significant impact on saving life and limb.

Now, a similar story could be told about cortisone. It had been discovered prior to the 1940s, but the production of cortisone was very labor intensive. In fact, you had to derive it from the adrenal glands of oxen so it required someone going down to the slaughterhouse and collecting these glands and then doing whatever extractive process that was required to pull the cortisone out. So you can imagine that there just wasn't a lot of cortisone available and what was available was pretty expensive to produce.

But a bright young scientist name Percy Julian, and parenthetically, Mr. Speaker, we honored Dr. Julian here in this House in the last Congress, an African American scientist of great renown and turned out to be responsible for a great number of discoveries in the 1940s, 1950s and 1960s. And it was appropriate that this House honored his memory.

But Percy Julian discovered a way of producing cortisone in large amounts using precursors that he derived from a plant product, from soybeans. Thus, again, a medicine which had heretofore been only a laboratory curiosity or a research oddity became readily available, became readily available in large supply, and the price fell to within reach of the average patient.

So in the 1940s, we see the near-simultaneous introduction of large-scale quantities of an anti-infective agent, penicillin, and an anti-inflammatory agent, cortisone; and that was to forever alter the landscape of medicine.

□ 2145

But, at the same time, we saw the intersection, again, of a major policy change and how that policy change has affected and has impacted the practice of medicine now for decades into the future. In some ways, in many ways, Mr. Speaker, that change in policy, that social change that occurred in medicine at that time had just as profound an effect as the scientific advances of the 1940s. Of course, during the 1940s we were a country at war. The Second World War was raging. Because a lot of the workforce was tied up in fighting that war, there weren't many people left to do the manufacturing work in this country, but it was work that was required because, after all, they were producing for the war effort.

So, employers wanted to keep their employees working, they wanted to keep them happy, they wanted to keep them healthy, but the President issued wage and price controls so employers were not able to pay higher and higher wages. The President did this with all good reasons, to prevent an inflationary spiral from getting out of control. With wage and price controls on, employers looked around: Well, how are we going to improve things for our employees so they will want to stay here working for us and won't go off looking for work in some other location? They hit upon the idea of providing benefits to their employees, both health insurance benefits and retirement benefits.

Well, there was a lot of controversy over whether or not that violated the spirit and the context of the wage and price controls. So they did what all good people do; they went to court and eventually it worked its way up to the Supreme Court. In 1944, the Supreme Court ruled that indeed these health benefits that were being provided to employees could be provided without violating the spirit and the intent of the wage and price controls. Moreover, that these benefits could be supplied to the patient with pre-tax dollars; that is, they were not a taxed benefit given to the employee.

So, simultaneously, we had the era of employer-derived health insurance ushered in, which has proved to be exceedingly popular and endures to the present time. Although it has experienced some problems recently, it is still a very popular way for people to obtain their health insurance coverage. Also, near simultaneously, we began the time of the uneven tax treatment between employer-provided insurance as opposed to individually owned or individually provided insurance, which is paid for with after-tax dollars.

So then, Mr. Speaker, we fast-forward to 1965. Again, there were vast changes occurring in the science and medicine. At that time, new antipsychotic medicines were introduced, and for the first time the mentally ill could be treated with medication as opposed to simply restraining someone or holding someone in an incarcerated environment. So it truly changed the landscape of medicine in the mid-1960s.

Also, at that time you had the introduction of antidepressant medications. Although the antidepressants have undergone many, many changes since that time, for the first time medication was available to treat a condition of depression, and this opened up whole new worlds for treatment of patients in the 1960s.

Newer antibiotics were introduced to fight more aggressive infections. There was the beginning of the understanding that biochemistry played in the development of coronary artery disease, why high cholesterol had an impact and was important in the subsequent development of coronary artery disease. And, Mr. Speaker, conditions like malignant hypertension, which had claimed President Franklin Roosevelt the generation before, now saw newer medications that were available to treat this malady, medications that had not been previously available.

But, Mr. Speaker, again, there was that intersection of public policy which combined with rapid changes in the scientific arena to forever alter the landscape of the practice of medicine. In 1965 we saw the introduction of a program that we now know as Medicare, and then subsequently the Medicaid system was introduced in the years that followed. Now, for the first time, for the first time the Federal Government had an established role in paying for health care. Again, the medical world was forever altered.

Mr. Speaker, now in the present time we find ourselves in a highly political year. Health care is foremost in a lot of people's minds, particularly those that seek to lead the country via the office of the Presidency. The next administration is likely to be under significant pressure for the expansion of the Federal role in delivery of health care. Indeed, we see evidence of that now with the debate that is occurring over the State Children's Health Insurance Program.

Before we get to the State Children's Health Insurance Program, Mr. Speaker, history tells us that policy makers will, we will put the emphasis on the transactional and the administrative aspects of health care reform and we'll ignore the transformational process as it is occurring all around us.

Mr. Speaker, I think it is helpful to consider what is the unit of production of this vast American medical machine that is all around us. In its simplest terms, the unit of production is the interaction that occurs between the doctor and the patient in the treatment room. That is the widget. That is what the American medical system produces.

So all of our focus, all of our focus should be directed at driving up or delivering value at the level of the doctor-patient interaction. But all too often, all too often, our attention is diverted into other things. This, in turn, degrades the doctor-patient interaction.

Now, at the health fair's 25th anniversary symposium downtown last Thursday, Dr. Mark McClelland, former Director of the Food and Drug Administration, former Director of the Center for Medicare and Medicaid Services, started off his talk with: We want to know what works best at the lowest cost for each patient. In a nutshell, that is what personalized medicine is all about.

Right now we don't know. We don't know. But that concept defines a whole new era of the type of medicine that will be practiced in the latter part of our lifetimes, and indeed in our children's lifetimes and certainly in our children's children's lifetimes. That's the type of medicine that we will be practicing. Short-term gains in affordability, unfortunately, could lead to long-term stifling of patient access and interfering with the supply-demand relationship that occurs and exists in the medical marketplace. Certainly accountability may suffer with the subsequent reduction in quality because, quite frankly, the best and the brightest may self-exclude themselves from the medical workforce. Thus, we could have a situation where care is delivered by those who do not represent the best and brightest physicians or perhaps physician extenders or other paramedical personnel, and the overall quality of medical care to what, arguably, is the most challenging group of patients, our seniors, that might be further eroded.

Advancements in medicine might be placed in peril. Indeed, it is some of the tension in the current system, that hybrid system that is part public and part private. It is partly the tension that exists in that system that is a dynamic for change. Not all the change is good, but generally, generally it moves in the right direction.

Mr. Speaker, I'd ask us to consider for a moment the dilemma of health information technology. When I first came to Congress in 2003, the Department of Health and Human Services said it's going to develop a platform for the establishment of a national information technology effort. In fact, please, Congress, don't do anything right now because we are going to do this. We are going to establish this platform. We are going to get it right, and industry will follow what we do. Unfortunately, that reality has yet to be delivered.

Now, there are some bright spots. There is advanced informational technology within the Veterans Administration, but it lacks the interoperability with the system used by the Department of Defense, and this lack of interoperability may well have been the root cause for some of the problems encountered by our soldiers on medical hold at Walter Reed Hospital. Let me just give you an example of that, Mr. Speaker.

Mr. Speaker, of course The Washington Post broke the story, I believe, in January of this year about some of the treatment being received by some of our soldiers at Walter Reed Hospital. So, like many Members of Congress, within a week I took a trip out to Walter Reed Hospital, and indeed the physical characteristics of Building 18, the building in question, were deplorable, and the building was appropriately decommissioned and those soldiers were moved into more reasonable accommodations actually inside the campus of the Walter Reed Medical Center.

Building 18 was outside the garrison, it was outside the actual confines of the campus of the Medical Center, and, as a consequence, that made it desirable for some individuals. But the reality was the building itself was just not up to standards, not up to code, and realistically our soldiers on medical hold should not have been there.

What happens too, Mr. Speaker, is soldiers on medical hold, they are trying to decide if the injuries that they are there for which they are being treated are serious enough that they will now be discharged from the military and their care will transition over to the Veterans Administration system so it will be more of a disability-type of assessment that they undergo, or are their injuries such that they can in fact rejoin their unit. The individuals in that situation are placed on what is called medical hold, and there were facilities outside the garrison at Walter Reed Hospital to house those individuals on medical hold.

Now, here is a picture of Master Sergeant Blades, who took me around and showed me the rooms in Building 18 that were the point of some contention. But Master Sergeant Blades told me when I was there that the real problem he and his men were encountering, yes, the accommodations were crummy, but the real tragedy was the work that went into preparation of this medical record, the Department of Defense medical record, in getting it ready to send over to the Veterans Administration to perhaps make the case for the disability, make the case for what the disability allowances should be, what the disability payments should be, what care could be available at the VA hospital.

He said that he would spend hours and hours and hours preparing his medical chart, highlighting things with a yellow highlighter. This large chart in front of him, it looks about the size of the Washington, DC phone book, would then go sit on a desk for 2 weeks and then be lost and he would have to start all over again.

I said, well, wait a minute. I thought the VA system had this new fancy computer equipment and that this should no longer be a speaker. But as it turns out, Mr. Speaker, the Department of Defense can't speak to the computers in the VA system, and, as a consequence, it depends entirely on a hand-prepared record, and you see Master Sergeant Blades there preparing it as we visited that day at Walter Reed Hospital.

Here in Congress, the legislative process dealing with health information technology is completely stalled. We had a chance to act last year in the last Congress. The bills we were considering were to provide either grants or buying equipment outright for medical practices. But in the end, we couldn't get our work done, and the current legislative attempts that we see this year seem even more desperate and futile from those of last year. We have gone from bad to worse.

Considerable expense could be borne by individuals in private practice, physicians in private practice, trying to purchase or upgrade equipment. These informational systems and costs and learning of the operating of these new systems are significant barriers to entry.

Relaxation or moderation of what are known as the Stark laws could allow for hospitals and doctors to be cooperative and involve themselves in the investment in this type of technology. But barriers to entry for physicians are that the equipment is expensive. And in addition to the initial cost and the cost of maintenance and the cost of software and the cost of software upgrades, there is a problem: If there is no established criteria for interoperability, how is a guy out in private practice or a lady out in private practice who goes and buys a computer system from a vendor, how are they to know that they are making the correct purchase at all?

Now, that is the public sector. That is the government working on this. Remember one of the things I first said, the change of the speed of delivery of information is one of the things that is going to transform medicine. We are kind of stuck here and have been stuck here for 4 or 5 years.

What is happening on the private sector? Consider the experience of Aetna Insurance Company. A single company employing 34,000 individuals and has 15 percent of its workforce involved with information administration and maintenance. In fact, according to their CEO, if the Aetna Information and Technology Department was a standalone company, it would be one of the largest software development firms in the United States of America.

They have developed a Web-based electronic health record, not an electronic medical record controlled by the doctor, but a Web-based electronic health record that is controlled by the patient, the access is controlled by the patient, and that is available then to a patient anywhere in the country where they have computer access.

So, if they are traveling and they have got a medical condition that is under pretty tight control and good control at home and they have a problem, that information can be handed over to the treating physician in an emergency room at a distant location, because all that information is going to be available to them up on the Web. And when that patient returns home and returns to their doctor at home, the information derived, the testing done by that doctor in the different location, will be available to the patient when they return to their home for care.

□ 2200

Mr. Speaker, I have to tell you, I haven't always been a big believer in things like computerized medical records. Sometimes they are hard to learn. There is a learning curve associated with them. It takes some time to get up to speed with them. No one is interested in paying for the time it takes to get up to speed.

But in January 2006, taking my second trip down to the City of New Orleans after Hurricane Katrina came through there, all of the water came in, this is the basement of Charity Hospital. The water has been removed. You can't see in the picture, but there was still water about ankle deep. This is just one of hundreds of rows of charts as you might imagine a hospital of that size might contain.

This black here, they haven't been burned, this is mold growing on the medical records. This vault now is a hazmat site. Someone wanting to review a record for a patient would have to take extraordinary precautions not to inhale the spores from the mold when they opened the record. These records are unusable and unavailable and no one knows what has been lost here. There might be someone's leukemia, childhood asthma; those records are lost forever. This changed my mind on the concept of having an electronic medical record or, as Aetna has developed, an electronic health record that is owned and controlled by the patient and is Web-based.

Mr. Speaker, I ask which system now, remember my fundamental criteria: Do we deliver value to the doctor-patient interaction in the treatment room? Which system is delivering value to the doctor-patient interaction in the treatment room right now? Is that what we are doing at Health and Human Services, where we are trying to get things up and running, develop a national platform and one of these days we are going to roll this out? Or in the Halls of Congress, we are going to craft legislation if we can get the pieces right. But watch out, the unintended consequences of that legislation may turn around and bite you when you try to practice medicine a few years in the future.

Or the experience at Aetna U.S. Health Care. You have one system that is mired in entrenched bureaucratic wrangling, and the other one providing real data for real patients and advancing their health. Which system is making the maximum capital investment at the same time demanding accountability to deliver value for its covered individuals? Which system continues to hamper the growth and development of the technology that everyone acknowledges is necessary to bring medicine into the next generation?

I talked about a short-term, midterm and long-term strategy. That long-term strategy is the explosion in health infomatics that is going to bring us the type of personalized care we want in the future.

Now, Mr. Speaker, the American medical system takes a fair amount of criticism from around the world. I want to bring to the attention of this House the Washington Post and the Wall Street Journal today, two stories in two different newspapers today talking about some things that are happening when you export American medicine, American know-how, American technology half the way around the world.

From the ''World in Brief'' section under the heading of Afghanistan: ''Six years after the Taliban's ouster, medical care in Afghanistan has improved such that nearly 90,000 children who would have died before the age of 5 in 2001 will survive this year.'' That's thanks to the efforts of the United States Agency for International Development that has brought modern American medical technology to the country of Afghanistan. They still have a long ways to go, but I thought I would share that with the House.

Another story from the Wall Street Journal about how we export American technical medical know-how to other countries. This is actually in the ''Marketplace'' section of today's Wall Street Journal. The title is: ''Health care building booms in the Persian Gulf.'' It says that the region's families are recruiting brand-name U.S. medical institutions and private investors with plans over the next 20 years to more than quadruple the estimated $12 billion spent annually on health care. They are essentially trying to duplicate Harvard Medical School and its residency programs at the Massachusetts General Hospital in the City of Dubai.

As I stated previously, we are at a transformational time in medicine. There are changes occurring on many fronts. At the same time, we have the intersection of changes in public policy which can vastly affect the practice of medicine for years, decades into the future.

Mr. Speaker, there is a risk here. If health care policies are based on political expediency, and if they are not patient-centered, there is a risk of continuing to be beholden to the special interests and not empowering patients. There is a risk of delivering for the status quo and not delivering for the future.

Indeed, the transactional could triumph over the transformational. Prevention of this scenario will require development of, certainly with physician leaders within the house of medicine, they have to be engaged for their patients and not for the enduring bureaucracies or special interests. We do have some relatively new products that have emerged on the scene in the last several years. Health savings accounts and their precursors, medical savings accounts, are just a little over 10 years old, and they show some significant promise by putting purchasing power back in the hands of the patient and rekindling that doctor-patient relationship that has been so many times stifled by the current system.

Improvements to the health savings accounts could include methods for paying for preventive care and adding new coverage to include disease management for chronic conditions. In other words, move health savings accounts from the type of patient that is only going to purchase one because they don't think they will get ever get sick, to the type of patient who knows they have a medical condition but they want the power over their medical condition, and a medical savings account is a way to do that in an affordability fashion and still retain power over their illness.

Mr. Speaker, we should encourage new thinking by third-party payers. At some companies that is going on already. It could help move borders for affordability. A business that provides a premium reduction for individuals who engage in preventive practices and periodic screenings would represent a reasonable way to deliver increased affordability. It is a way of delivering value for the patient.

If the legislators and Federal agency personnel have the vision and discipline to focus on the long term, we may yet see delivery on the promise of the pending transformation in American medicine.

Mr. Speaker, former Speaker of this House, Newt Gingrich, in his book on transformation, I think his second principle of transformation where he asserts real change requires real change. What does he mean by that? He means in order to affect real change, you have to walk the talk. There has to be a culture and leadership not just embracing of the concept of change, but they have to act on it. They have to live it and breathe it and work it every single day. That is a valid concept, and I think the Speaker is right on the money when he brings that concept up.

But look at it another way. Real change requires real change. There is real change occurring in medicine, whether Congress knows it or not, whether Congress likes it or not, and whether Congress helps it or not. Real change is occurring in American medicine right now. Because of that real change that is occurring in the science part of medicine, real change is required here in this Congress, in the other body as to how we approach our health care policy so, again, we don't let the transactional become the enemy of the transformational.

Mr. Speaker, a short-term, a midterm and a long-term strategy are essential, and we must avoid sacrificing this concept and giving it all up for short-term political gain, which brings us back to the subject of the State Children's Health Insurance Program. When I think of health care policy, I try to put it in the context of what is delivering value for that doctor-patient interaction in the treatment room, not the cost, but what delivers value to that interaction.

What diminishes value? What happens if we have a significant negative effect on the physicians who are providing the care for our pediatric patients? Is there a cost to providers for shifting populations from commercial insurance onto public insurance? Well, I believe there is.

Mr. Speaker, I don't really know why and where insurance companies get the idea it is okay to only partially cover the cost of providing care, but I have a suspicion they get that because that's the way the Federal reimbursement structure works. That is the way it works in Medicare and Medicaid; and if we expand the reach and grasp of the Federal Government in the SCHIP program, I think we will find to the detriment that process is alive and well and subsequently we have the negative effect on the physician workforce.

Mr. Speaker, before I yield to other speakers, let me bring up this slide from the American Enterprise Institute. This points out at successive income levels, and these are rated at the percentage of the Federal poverty level, so here is between 100 and 200 percent of the Federal poverty level. This is about $41,000 to $42,000 a year. Here is between 200 to 300 percent of the Federal poverty level, so that is up to just over $60,000 a year. And 400 percent of poverty would represent a figure of over $80,000 a year.

So in the group between 100 and 200 percent of poverty, and this is the group that SCHIP was originally designed to cover, about half of those children have private coverage. If you move into the 300 percent of Federal poverty limit, they earn up to $60,000 a year, three-quarters of those kids already have health insurance. And nine out of 10 and 95 percent have health insurance. Why do we want to go and take these children who are already covered and bring them back into the SCHIP program? Are we delivering value to the patient? Are we furthering the concept of good patient care?

Mr. Speaker, I would point out that on the floor of this House 2 weeks ago when we had the debate on the new State Children's Health Insurance Program bill that we passed which was exactly like the one that the President vetoed and we sustained, when we were debating the new bill, I asked the chairman of the Committee on Energy and Commerce to enter into a colloquy with me, and he graciously did. We talked about State income set-asides. If the bill said that the maximum amount available for coverage under the program was 300 percent of the Federal poverty limit, so a little over $60,000, where again three-quarters of those children already have insurance, if that is our upward limit of coverage, were there income exclusions available to the State that could take that upper income level even higher, and I asked specifically about the cost of housing. And indeed within the bill was the language that States could exclude $20,000 of annual income involved in housing. And States could exclude $10,000 of annual income that is there for clothing. And States could exclude $10,000 of annual income that is available for transportation. Mr. Speaker, we are already over $100,000 in annual earnings for a family of four when we talk about this bill that was introduced and passed by this House.

Mr. Speaker, I am just a simple country doctor and there is so much about the budgeting process that I don't understand that I am so grateful that I have been joined by the gentleman from New Jersey (Mr. GARRETT) who sits on both our Budget Committee and our Committee on Financial Services. I think he is going to provide us all with some valuable insight as to some of the numbers involved in this process.

So I do now want to yield the floor to the gentleman from New Jersey (Mr. GARRETT).

Mr. GARRETT of New Jersey. I thank the gentleman from Texas for yielding. I thank the gentleman also for bringing this issue once again to the floor. I was in my office earlier this evening when you began your remarks, and I have heard you on the floor on numerous occasions speaking to medical topics.

□ 2215

We appreciate very much your background, the expertise that you bring.

And on that point, I should just say that on my 3-hour trip from New Jersey traveling on good, old reliable, semi-reliable, slow Amtrak, I had the opportunity to read a number of your articles that you have written. I would commend anyone who is listening to us here tonight. I should ask the gentleman, is much of this material I read, one a position paper, another is called Addressing America's Health Care Challenge: A Solution, are these articles by any chance up on your Web site? Can I commend the audience here that listens to us tonight to go to your Web site and look to find these things?

Mr. BURGESS. Yes. You're very kind to point that out, and those writings, as well as several other musings and lamentations are available on my Web site. The bulk of the writing on the Web site is devoted to health policy because obviously that is one of my interests and one of my passions. So

there's a good deal of information available; www.house.gov/burgess will take, scrolling back through the previous stories will give someone an insight as to what's available on the Web site.

Mr. GARRETT of New Jersey. I appreciate that, and just a couple of them, Addressing America's Health Care Challenge, with that and what you've talked about here, as I put the expression, you step back for a moment and look at the bigger picture, which is what I'm going to talk about in a moment. So I think this is a good one.

Another one is the cure to the physician crisis, and I'm not going to get into it here. This article gets into it pretty well to say, you can do all that you want to do when it comes to the issue of health insurance, but if we don't have enough docs out there such as yourself and other docs out there, physicians that are out there taking care of the patients, it's not going to mean anything.

When I'm back in my district and I tour my hospitals, what is one of the first complaints or concerns that I have, and I bet it's the first complaints and concerns that you hear from your hospitals, is a shortage of nurses. And whether it's long-term care facilities, hospitals or clinics, they say we just can't get enough visiting nurses, we just can't get enough trained nurses as well.

If we don't get that aspect of the problem solved, everything else that you and I and the rest of Congress talks here tonight and in the future will mean nothing because we're not getting the providers to the patients.

So, again, I just wanted to start where I should probably end, and I think I will in a little bit, thank you for your work in this area.

Where you left off and some of the points you were touching about goes along this line, and that is, that you have to look at some of the bigger picture.

In my office, I was looking at some data, and one of them is on data from the World Health Organization, and I think this is interesting. Again, regardless of what we do on health insurance and regardless of what we do in the government, whether it's in the Federal level, the State level or anything else, here's what they tell us. Here's what the World Health Organization tells us. That if Americans, and I guess the world community as well, but Americans in particular, would address three areas, smoking, eating disorders and eating, what your diet is, and exercise, if you address those in a logical coherent manner, presumably after consultation with your physician, 80 percent, an amazing number when I read it, 80 percent of Type 2 diabetes could be addressed and resolved. Eighty percent of heart disease could be resolved. Forty percent of cancer issues could be resolved.

Nothing about buying insurance. Nothing about spending more money. Matter of fact, you'd probably end up spending less money if you ate right and didn't go to McDonald's as much as I do. Those three areas.

The one on diabetes, I just had the opportunity in the last week to 10 days to have folks from that organization come and speak to me back in the district, and they pointed out a statistic. Approximately a little less than one-third of the dollars that we spend on Medicare goes to diabetes or diabetes-related injuries or other illnesses that are related to it.

So can you imagine, if we were able to resolve that issue, how we would be able to address our health care costs in this country. Costs being one factor, but obviously, the bigger factor is improving the quality of life.

So you're right on the target when you say how do we improve the health quality of individuals in this country first and foremost; and secondly, how do you do that through a proper physician relationship.

As I come to the floor this night, and I always make reference to this mark, here we are in November, the 11th month of the year, and we have to ask ourselves what has now under the new Democrat leadership wrought when it comes to the issue of health care in this country.

Somebody else pointed out some numbers to me the other day. I think it was this past week. So far the ledger is 106 bills have made its way to the President's desk. Forty-six of those bills have been to do with the naming of post offices and Federal buildings. Forty-four just have to do with Special Orders and special days and the like. That's almost two-thirds. Ninety bills out of 106 of no real major significance, and here we are at the floor tonight I think addressing something that is of major significance, second perhaps only to what our colleague TIM WALBERG and others were talking about as far as their faith issues, and that is the quality of life and the health of the citizens.

This, though, is not a new issue. President Clinton, when he was President of the United States, said that he had an answer to this problem, and it goes in a totally different direction that you were addressing before. His solution was larger Federal Government intrusions into this part of the economy. It's approximately what, one-fifth of the overall spending of the GDP on health care. He wanted it to be even larger and more of a centralized control, government-controlled health care, if you will, socialized health care.

And he told us back at that time how he intended to bring this country, that he realized after HILLARY's failure to address the issue through her secretive meetings that we heard about later on, he said how can we get there. He said we can get there through a centralized, government-run health care system incrementally. First, we'll insure and control the health care for indigent children, then all children and for indigent adults, and then for all adults. So all of us eventually will come under the control of the Federal Government.

That means we were basically putting that very personal, that you referred to before, and you know as well from the doctor side, we all know from the patient side, the placing of doctor-patient relationship under the control of the Federal Government, bureaucrats, faceless, nameless, maybe very nice people and well-intended, but bureaucrats.

I scratch my head to think when people actually advocate such a government control. This is the same Federal Government that we saw handle the Katrina situation and FEMA terribly, loss of life, loss of homes and what have you, that Federal Government. This is the same Federal Government during this past summer when families were trying to go on vacation and asked the Federal Government to do one of its basic functions, issue visas so families could go on family vacations. The government couldn't get the visas out the door. This is the same Federal Government that to this day we're still arguing and debating on this floor how do we close and secure our country's borders so that illegals and terrorists and drug traffickers can't come into this country. That same Federal Government can't control this, but they want to control our health care delivery system.

So he told us how he was going to do it, and one of the charts up that you have, I have a variation of it, but if I could just ask the gentleman from Texas to put that one chart back up with regard to the coverage. It tells us how he was going to do it, and they're now trying to do it through SCHIP.

By very definition, a middle-class entitlement means that you are going to be providing an entitlement, in this case, health care, for people who are making over or at the middle-class level of income and above. Well, we know that the poverty level is, for a family of four is around $42,000. I'm not sure if that's showing that on that chart, for a family of four is around $42,000. We also know that the median or the middle range of income in this country, again for a family of four in this country, is around $48,000.

So, by definition, if you're going to be providing a benefit to people over that level, over $48,000, then you're providing a middle-class entitlement. It's no longer talking about poor children first. I know there was another chart, benefits should go to poor children first. We're no longer talking about the indigent. We're now talking about just about everyone.

A family of four making over 300 percent makes around $62,000. So by definition we're saying, under the proposal that came before the House with regard to SCHIP, we want to provide benefits to a larger group of people, to a middle-class entitlement. And who is going to pay for that is the next question that should come to mind.

Well, the plan that is in place to pay for those various ranges, and without my far glasses it's hard to see them, says that that is going to come out of various sources, but one of the biggest sources will be smokers. And the interesting thing about this is that in order to get enough money to provide for that level of coverage, not just for the indigent anymore, but people above the 200 level of poverty, 300. As you know, in the State of New York they tried to go up to the 400 level of poverty, which means around $84,000 a year. In order to do that, they will have to look to smokers, which is fine on the one hand until you get into the weeds a little bit on this issue. And the Heritage Foundation did a little bit of study and said how many people do we have to actually have start smoking in this country in order to come up with that money, and they found out at the end of the day that we will actually be looking to find 22,000 more smokers in this country in order to fund this program.

Now, you are a physician and you could probably speak ad nauseam that smoking is harmful for your health, and actually it's most harmful probably for little kids more than anybody else. But in order to fund this program for the indigent poor and also for a middle-class entitlement, a government-controlled health care system, they will be looking to say we need 22,000 more children in this country in order to start smoking tomorrow so that we will have funding for this program down the road for the next few years.

It's an absurd situation, and it's even a little more absurd when you think about who actually does smoke in this country. This is a little bit of a sad situation. Lower income individuals smoke to a higher percentage than upper income individuals. And in fact, if you look at the numbers, it's something like this. People who make under $10,000 a year, so very low-income people, pay twice as much in taxes from smoking than people who make over $50,000 a year.

So what are we really saying? We're saying that we need 22,000 more kids to start smoking to pay for this program. And who are those people that are actually going to pay for it? The lowest of the low-income people who are smoking are going to pay the biggest percentage of their income towards this program.

It's an absurd situation to fund it, and it goes back then to the final point, and I'll close and I'll yield back to the gentleman, as I think our time is coming to a close. It's an absurd funding formula to come up with for a government-run program. And unfortunately for the advocates of the program, the money runs out. The money runs out.

You see on our little chart here, starting, if this program, as proposed by the other side of the aisle, Democrat side of the aisle, it would start in 2008, and there's little kids being encouraged to sign up. Indigent children are being encouraged to sign up for this program. I notice this picture does not have the children smoking. So, to be actually correct, we should have the children smoking, because they're encouraging them to smoke in order to pay for this program, but it would only last for 5 years. Then, after the 5 years, the funding is cut off almost entirely, 80 percent. That's why we have the chart go demographically down, and the kids are left hanging, in this case parachuting.

Why this is bad is twofold. One is because we're leading people to believe that we're actually setting up a program that's going to be paid for perpetually for the children. And two, who is this child that's now left jumping off of this cliff here? As your previous chart showed, he may very well have been a child who was already covered by your insurance. And your chart shows 55, 75, 80, 90 percent of the children had insurance prior to this program coming along, but now they were encouraged to join into this program and go into it, give up their prepaid plans under their father's programs, mother's programs, company plans, what have you. Five years from now under this program, it's designed to fail. They will jump off. They will not have anymore government program, and they also will no longer have any private insurance.

So we are setting up a system, encouraging kids to smoke in order to pay for it, and leading them to have to basically fall off the cliff in 5 years without having any health insurance at all.

At the end of the day, and I'll close on this, I commend the gentleman for leading us to look at this issue from a larger perspective, to ask a basic question. It's not so much about health insurance; it's about health care. And it's not so much of whether you have the coverage to provide you with insurance; it's whether or not you're actually going to have a doctor or a nurse out there to provide those services for you. And it's not so much as whether the government is supposedly going to do it, because we know at the end of the day they can't, by the numbers; it's whether or not at the end of the day we can come up with something to actually make sure that the patient is in control with his doctor of the delivery system and that it's the best care in order to provide the services to them, and at the end of the day the quality of life of those individuals as well.

I commend the gentleman from Texas for bringing this to the American public's attention tonight, and I look forward to reading more of his material, as well both on-line and in person.

□ 2230

Mr. BURGESS. One of the points that I probably did not make eloquently enough tonight is that the practicing pediatrician, not the pediatrician in an academic setting, not the pediatrician in a federally qualified health center, but the pediatrician is out there with a mix of different payer groups in his practice or her practice.

The average reimbursement for a child on the SCHIP program is about 30 percent less in my State of Texas than it is for one of the commercial insurances. If we take those children off of commercial insurance and move them to an SCHIP program, we are negatively impacting the bottom line of the pediatrician who is providing the care. We can only do that for so long before they will decide that they have got something else that they might do.

Mr. GARRETT of New Jersey. You make a perfect point. Again, it goes to what we were saying before. It doesn't matter whether you have insurance or not. It matters whether or not there is actually a doctor who will be there to take the insurance.

How many individuals that you know, senior citizens that you know right now that are Medicare or Medicaid, and they went out to find a doctor to treat them for their ailment, and they found out there are no longer doctors in their community who are taking Medicare or Medicaid patients. They had all the great socialized programs, coverage, that they needed. They just didn't have any doctors who would pick it up.

You are explaining the same thing very eloquently. The same thing will happen to these poor indigent children. We lead them down the road to believe that they actually are going to have coverage now, that think that there is going to be a doctor there to take care of them. If their reimbursement rates are anything like they are for Medicaid, there may not be a doctor there to deliver the services.

Mr. BURGESS. One of the things before the time completely leaves us, I just want to draw attention to a recent poll put out by U.S.A. Today that does show that the plurality of Americans, a majority of American citizens, believe that the benefits in the SCHIP program should go to poor children first, and that's not to the children at the upper-income levels that we were showing on the other slide. That is the group of children for which this program was originally intended, that is children whose parents make too much money to qualify for Medicaid, yet not enough money to reliably afford their health insurance.

When this program was first enacted in 1997, by a Republican Congress with a Democratic President when this program was first enacted, that was a group of children that the Congress was trying to help. The concept of poor children first is one that the American people embraced.

In fact, I introduced legislation earlier this year, H.R. 1013, that would have put the children back in SCHIP and removed adults from the program. Now, I am grateful, very grateful that the Democratic majority has now embraced that concept and at least their

latest iteration of the SCHIP reauthorization bill said that there will be no adults on the program within one year of the enactment of the bill.

It's a bittersweet victory because there are so many other aspects of the bill that are flawed that Mr. GARRETT has just alluded to. The funding mechanism absolutely disappears in the fourth year of the program. The funding mechanism itself is based on a belief that there will be an increasing number of smokers in this country, and public policies that I support to decrease the number of smokers and decrease the number of young people who begin this habit.

It makes no sense to be saying we are going to fund this entire program based upon that type of tax and, on the other hand, try to put our maximal effort behind trying to reduce the number of smokers in this country. It is certainly a conflicted mindset that the Democratic majority seems to be propounding here.

One of the other things that I do want to bring up just before we close, another poll from U.S.A. Today that the American people are concerned, are concerned that the program as proposed would pull those children off of private health insurance and put them onto a government plan.

Then as Mr. GARRETT so eloquently pointed out, then the funding dries up, and where are you then? At the same time, if you have driven pediatricians out of practice because of lower reimbursement rates, you have now the trifecta, the triple whammy, where health care for children may be seriously jeopardized in the mid-term or the long-term because of the fact that we are sacrificing for political expediency today.

TERRORIST ACTIVITIES IN LATIN AMERICA

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

Mr. SERRANO. Mr. Speaker, I rise today to speak about an issue that troubles me quite a bit and I think should trouble a lot of the American people. Certainly it should concern Members of Congress.

A resolution was passed this afternoon by voice vote dealing with the alleged involvement and behavior of the President of Iran, therefore, the Government of Iran, in Latin America and supporting, according to this resolution, terrorist activities in Latin America.

Let me briefly read the opening statement of this resolution, the title, if you will: expressing concern relating to the threatening behavior of the Iranian regime and the activities of terrorist organizations sponsored by that regime in Latin America.

Well, just to deal with language itself, we know that when our government calls another government a regime, it is not saying anything positive about it. It is, in fact, confronting it in some way. But I think that as unnoticed as this went by, as I said it was passed on a voice vote, as unnoticed that this went by, this puts us in a situation, the Congress, the American people, our Nation, on a road, on a path to a very dangerous situation in the future, perhaps in the near future.

We all know how concerned the administration is and how concerned some Members of Congress are about the possibility that Iran could be involved in activities that would be hurtful to us. I want to correct that. I think all Members of Congress are concerned about that possibility.

But I think we are also concerned about the fact, many of us, that there seems to be a drumbeat towards war with Iran, a drumbeat that says, basically, some of the same things that were said when we were taken off to war against Iraq. Just about everything that was told to us at that time happened not to be true. History will tell whether, in fact, we were lied to, or whether the information was so bad that the administration had no choice but to pass that on to us thinking that it was correct.

But there are many who feel that we were lied to. Again, history will have to deal with that.

My concern is that this resolution today moves away from just a concern about the behavior of the Government in Iran and begins to suggest that there are neighbors of ours, and, yes, I say neighbors, because that's what the Latin American people are, neighbors of ours, that could be involved in this behavior, behavior which would be dangerous to the United States, behavior which we all should be concerned about, behavior that, perhaps, would lead us to get involved in Latin America in a way that we haven't been involved for a long, long time.

But I think in order to understand where we are with this issue, we also have to have, I think, an understanding of how history repeats itself, how some things that we are hearing now we have heard before. For close to 50 years now, we have had a very strong lobbying effort in this country against a Cuban Government. The so-called anti-Castro lobby has been very strong, and that lobby has been very influential in getting many Members of Congress and Presidents, present and past, to feel that the only path towards changes in Cuba is to continuously attack and confront the Cuban Government. To the dismay of many people, I am sure, and with all due respect to many people, it is no secret that for the most part that lobby, this effort, has come out of anti-Castro groups who, for the most part, live in the State of Florida.

Well, something very interesting has happened in the last few years. As Latin America has elected leftist-leaning leaders, people who propose to put forth a modern-day socialism, as they call it, 21st-century socialism, but people who have been elected and reelected as they have emerged, they have decided that it would not be improper for them as leaders of those countries to have a relationship with the Cuban Government.

Well, that upsets the same people who have been upset with the Cuban Government. The fact that some new governments in Latin America would now be friendly to the Government in Cuba would upset these folks.

Our policy towards Cuba has been heavily influenced by this anti-Castro movement. I can't tell you how many times in the 17 years that I have been in Congress and have tried to change that policy. I have been told by Members of Congress on both sides, Democrats and Republicans, liberals and conservatives, I have been told by them, I agree with you, you are right with this policy having to change.

But I think we have to continue it, and most of them will tell you, because the lobbying effort, out of a couple of communities in this country is so strong, that I really don't want to face that. Right on the House floor they have told me, I don't want to face that, I will just go along with this policy, as outdated as this may be, as inefficient as that may be, because it hasn't changed anything in Cuba, not that we should necessarily be changing things in another country. But now we find that those same folks have now picked new targets.

Chief among those targets, top of the list, is the President of Venezuela, Hugo Chavez, who has over and over again shown his friendship to President Castro of Cuba, and that irritates the folks who support ending Mr. Castro's stay in Cuba. Those folks then have started to say the same things that they have said for years about Mr. Castro.

Now, the fact of life is that the Cuban Government, the system in Cuba, and the system in Venezuela, for instance, are totally different, totally different. But not to those folks who simply would want to get rid of one. They now feel that they have a target which is the President of Venezuela.

That target then, I think, leads us to situations like today, where a resolution presented here speaks of putting together all these groups who have one thing in common. They speak out against our government, they say things we don't like, and who happen to have been visited or received telephone calls or offers of help from Iran.

Now, Communist China, and I use that title, that phrase, that word, so we understand what we are talking about, are involved in the economy of every country in Latin America; but you don't see a resolution on the House floor condemning Communist China for being involved in Latin America.

□ 2245

Why? Because they're a big trading partner of ours. And secondly, let's be