soul, a proud dad, a proud husband and a wonderful son.

Mr. Speaker, for much of the history of war, the number of soldiers struck down on the battlefield has been dwarfed by those killed by illness and disease. Thankfully, modern medicine has made the scourge of disease far more remote for our soldiers today, which makes the death of Private Randy Stabnik, also of the Indiana Army National Guard, all the more painful.

On February 17, Private Stabnik died from pneumococcal meningitis, a rare and unexpected death. After Randy had joined the National Guard, his family could see how much he was growing to love his service. His dad Jim, when asked about his son's service, said, ''When he came home for Christmas, I could tell he missed it. He missed the lifestyle. He missed his friends there. He loved it, but missed his son. They were very, very close.''

His son Nathan, only 8 years old, lost his 28-year-old dad. This is part of the tragedy of war. Soldiers fight and die to protect those they love, and we must never forget the burden of sacrifice borne by the loved ones who are left behind.

His son and his family should know that Randy cared deeply for them. His mom said shortly after his death, ''Randy was Mom's baby, Mom's angel. He was my heart.'' And her angel, he remains. But he is also an angel for the entire Nation.

Mr. Speaker, ultimately the greatest memorial to these fallen patriots, to Cameron, to Joey and to Randy, will not be my words nor anything we can build or bestow. Our greatest honor for them will be to look not toward them but to look where they looked, to seek what they sought. If we work for that same good for which they gave their lives, if we create a nation at once more just, more secure, and more free, we will be a brighter beacon in a frequently dark world; and we will have given our fallen brothers and sisters a true memorial worthy of them.

Thank you, Mr. Speaker.

I yield back the balance of my time.

MESSAGE FROM THE SENATE

A message from the Senate by Ms. Curtis, one of its clerks, announced that the Senate has passed with an amendment a bill of the House of the following title:

H.R. 627. An act to amend the Truth in Lending Act to establish fair and transparent practices relating to the extension of credit under an open end consumer credit plan, and for other purposes.

ADDRESSING THE HEALTH CARE CRISIS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentleman from Tennessee (Mr. ROE) is recognized for 60 minutes.

Mr. ROE of Tennessee. Thank you, Mr. Speaker. We're here this evening to begin and continue a very important debate in American society. I think it's probably one of the most important social debates we've had in the last 40 years in this Nation since the debate on Medicare in 1965.

We're here tonight as a Physicians Caucus to discuss health care reform. My background, I spent 31 years practicing medicine in Johnson City, Tennessee, in the First Congressional District. As I've watched our health care system change over the past 30 years, it really spurred me to run for Congress, to come here and be part of this great debate that will affect every American citizen.

I recall when I made my decision to go to medical school, I wanted to be a family practitioner. Somewhere along the way, I discovered I had a great knack and a love of delivering babies. I have delivered almost 5,000 of them, many of whom are now grown. One of the great advantages you have as an obstetrician when you run for Congress is that you can deliver your own voters. There is some advantage to that.

We have a health care problem in America. Some call it a crisis. For some, it is. For others, it's cost. Certainly we know that there are great concerns about the cost of health care.

In the next hour we're going to discuss how we're going to address this health care crisis. We can ensure that every American can get the care they need, protect individuals from costs that can bankrupt them and make health insurance portable so that you don't lose your coverage just because you change jobs or move from one State to another.

We can also take the profits out of health care by reforming the health insurance industry to bring about a patient-centered approach to providing health care. Enacting a public plan will not bring about this type of change, and I'm going to go into that in some detail from the experiences we've had in the State of Tennessee with our Tennessee Medicaid system called TennCare.

If you think you won't be affected by a public plan, consider this: A recent analysis of this plan by the respected independent firm Lewin Group estimated that 70 percent of individuals who have health care coverage through their employer would lose those benefits in favor of a public plan. Now this plan could very easily become a Medicaid-type plan.

When supporters of a public plan say they want the public plan to compete with private plans, the facts show that what they're really saying is that they want Washington bureaucrats to take over the health care decision-making.

I want to talk for a while or speak to you a little while about the principles that House Republicans have put forward to start the debate over how to bring about patient-centered health care.

I want to mention a couple things before we start. Health care affects all of us, whether we're Democrats, Republicans, Independents, or whether we're totally apolitical. At some point in time in your life, you're going to have to make decisions about how I receive and get health care for myself or my family.

We're going to start this evening by giving another opinion or another view of the health care plan and how it is to be administered and obtained. The principles that we're going to talk about for health care reform are, number one, make quality health care coverage affordable and accessible for every American regardless of preexisting conditions. In a country that spends 16 percent of its GDP, over $2 trillion a year, on health care, I think there's no question that we can provide a basic health care plan for each American.

Now what I mean by basic health care, it's not a plan where you can get hair transplants or face-lifts or all this. But if you are out there injured in an automobile wreck or have a heart attack or have a gallbladder that goes bad, you can get basic health coverage and care.

I think this is something that all Americans believe in. I think we now have crossed that bridge and believe we can do that. I think the differences we're going to have in this great debate that we're going to have are, how are we going to accomplish this very noble task? In a few minutes I will go through how we tried this in Tennessee, and how it was not successful. But I think it can be.

Most Americans also fear, I think rightly so, that a basic health problem—it may be leukemia or a cancer of some type—can bankrupt the family. Certainly we don't want a situation where a family, through no fault of their own, develops a disease process, and then you use up all the family resources you've saved in a lifetime to provide care for your family.

The second principle we'll talk about is not a government-run health care plan. This eliminates coverage for more than 100 million people who receive insurance from an employer, and it restricts patient choice of doctors and treatments and results in the Federal Government takeover of health care.

Let me sort of explain how this worked in Tennessee. In the early nineties and mid-nineties, the big debate in this country came along about controlling health care costs or managed care. We were going to control costs through deciding who and what care was appropriate and so on. Well, that didn't work. Health care costs have continued to escalate in spite of managed care, and managed care basically has moved the pay to providers over to the third-party payers.

In Tennessee we had a very noble plan. We wanted to cover everyone in our State, and we're not a wealthy

State, so it was a noble goal. Right now in the State of Tennessee we have TennCare, which is our Medicaid plan. We have the uninsured, we have Medicare, and then we also have the private health insurance coverage. About 60-plus percent of Americans are covered by private health insurance coverage.

In Tennessee when we applied the TennCare solution, which was a managed care solution with multiple third-party payers at that time, the plan was not fully vetted and thought out well. One of the things I've said the entire time I've been here, Let's do this health care plan right. Let's not do it fast. I think one of the mistakes we made in Tennessee was going too rapidly with this plan.

So we instituted this plan, and what we found out was that 45 percent of the people who applied for TennCare and were granted it had private health insurance coverage. Well, I went to the providers recently, hospitals and other providers, and I said, What percent of your costs does Medicaid or TennCare pay in your particular facility? And the resounding answer was, about 60 percent. So you have a significant percentage of people now who have given up their private health insurance and have gotten on the public plan, which only pays about 60 percent of the provider costs. You also have the uninsured who pay some percentage of their own costs, and Medicare pays about 90 percent of the costs.

So as you shifted more people from the private plans to the TennCare plan, you forced the private health insurers to charge more for their plan. That's what happened. What I can see happening in the public plan is exactly this. It's going to be described, we're going to have a plan that's competitive. It will be very rich in benefits. And what happened was, in Tennessee the actual TennCare plan was richer in benefits than I could afford to provide my own office staff and myself because of the costs.

When you have politicians deciding what goes into a basic plan, it will become richer and richer and richer. What will happen in the public plan—and you'll hear the buzzwords. It will be competitive. If you like your own health insurance coverage, you can keep it. You don't have to give it up. Just keep what you have.

Well, what will happen is this: Businesses will make a perfectly logical decision. What they will do is—and this is small business because in businesses in this country with over 200 employees, 99 percent of those have health insurance coverage.

So this is what will happen. You have the public option plan, the government-run bureaucratic plan that will have a lot of benefits, except it won't pay the cost of care. And when that happens, the cost of private insurance once again will be forced up, causing more and more and more businesses to do away with their private health insurance plans and put it on the public plan. And really over time—and I think a very short period of time—you will see the public plan, along with Medicaid and Medicare, become the only options available.

Now why do we think that this is not a good idea? Well, we've looked at public plans, and I have studied these extensively in foreign countries. In England, Canada, Sweden, Norway, Germany, France, Italy, other major European industrialized nations.

□ 1730

And this is what you would find. The way costs are controlled are by rationing care. In other words, when you have used up all the public dollars that you have dedicated for health care, you have to create ways. An example is in Tennessee. What we did was we simply shrank the rolls. We realized if so many people got on the public plan, the TennCare plan, that the State no longer could afford to budget for it. Our health care costs were more than education in the State. So what the Governor did, along with the legislature, is just cut the number of people off the TennCare rolls.

Well, for instance, in Canada, if you have a heart attack, your average time to go to the operating room is 117 days. They simply ration their care in Canada. And they have great physicians there. As a matter of fact, in the last decade, 11 percent of the Canadian physicians have moved to the United States. I have several very close friends who are Canadian physicians and colleagues. And they do a wonderful job. The president of the Canadian Medical Association once stated that a dog in Canada could get a hip operation within 1 week, and a patient there, it took between 2 and 3 years, simply because of lack of government funds to provide all of the benefits that the government had promised.

So in this particular plan, the one thing that I want as a physician, that I have utilized for years, is that you want to maintain the patient-physician relationship. The one thing that is absolutely mandatory, in my mind, is that the decisionmaking between patient and physician is paramount. Doctors and patients should be making health care decisions. Some government bureaucrat should not be deciding whether you get your hip replaced or your aging parents get the care they need.

I'm going to stop at this point in the principles, and there are lots to talk about tonight. And I see my colleague, Dr. FLEMING from Louisiana, is here. And I would like to yield him as much time as he feels is necessary.

Mr. FLEMING. Well, thanks to my colleague and the gentleman from Tennessee, Dr. ROE. Dr. ROE certainly has a lot to bring to the table being a physician for many years and also having quite a political background being mayor of a city and actually having balanced a budget and even having a surplus, something we don't see very often these days. And so I thank the gentleman for that.

Yes, I wanted to make a few comments, as well, regarding this health care debate that is coming to a head here very soon. Patients are very simple in what they want from health care. Certainly they want choice. They want affordability. They want control. And they want good results. And I think that that is quite reasonable. And certainly on the other side of the aisle where there is a debate about a single-payer system, really a government-run system, I think that there is not any disagreement about the fact that we want everyone to have access to health care, and we want everyone to have access to good health care.

I think where the debate begins to fall down is that in our opinion on this side of the aisle, we feel that a government-run system is not a well run system. It is an inefficient system. It is a wasteful system. We have many, many examples of why that is true. We don't have to even turn to health care. We can look at any system that has been run by government, and not just the United States Government. Cities and States all reveal considerable waste because it is the nature of the system itself. On the other hand, in the private system, there is the administrative ability to remove fraud, waste and abuse.

I will give you an example. Today with Medicare and Medicaid, we recognize that there is fraud, waste and abuse. Everyone knows it. Many politicians get up and clamor that they will be able to remove it, but none has been able to do that. The reason is because of the nature of government itself. Government cannot remove fraud, waste and abuse. In order to attempt to do so, it has to build, first of all, a large bureaucracy. It has to catch the offenders. With that, there has to be prosecution of the offenders. And when you get down to it, you only find the very most egregious small percentage of those who are actually committing fraud, waste and abuse. So you get really a small tip of the iceberg. So much more is underneath that a government can never get to.

On the other hand, if you look at a private business, private business has all sorts of ways of finding fraud, waste and abuse and removing it administratively. For instance, a physician who is practicing inefficient medicine in an organization, in a private organization, he can be reeducated, or she can be reeducated, or just simply removed entirely from employment. But government is unable to micromanage individual behavior. And every time we attempt, we simply run cost up. And I will give you another good example of that. If you look at the post office and compare it to FedEx or UPS, you will see these private companies run so efficiently and so profitably. And yet, of course, the post office does not run efficiently. There are long lines. And that is just one way to control cost, and

then, of course, ultimately we have to pay higher rates.

So I think that we really have to look at the endemic problems within a private system versus a public system when we see that really there are only two ways to control cost in a public system. And we are attempting one of them and have been doing so for the last 20 or 30 years, and that is price controls, price controls on the providers, the hospitals and the doctors. And that would be a wonderful thing perhaps, at least for consumers, if it worked. But what goes up faster than health care every year? Nothing that I'm aware of. It is the one part of the economy where we have price controls, the only one, and yet it goes up faster than anything else.

Well, what is the only other way we can control costs? That is rationing. And you say, well, we are not rationing care today. Look at Medicare and Medicaid, still a reasonably smaller percentage of the total health care system here, and it is able to provide good service to recipients, even though they are government-run programs, only because you have a much larger private system that is able to keep it supported. Now if we expand that to a large, government-run health care system, it is going to make up 17 percent of our entire economy. Where are we going to get the money to prop that system up? Where is it going to come from? And so what we are going to end up with is the same place where Canada, the U.K. and all the other countries that have gone to a single-payer, government-takeover-run system, and that is that there is going to have to be cuts. When we get up to a point where budgets have to be evaluated, we are going to have to make cuts. And when you make cuts, that equals rationing.

Mr. ROE of Tennessee. Will the gentleman yield for a moment?

Mr. FLEMING. Yes

Mr. ROE of Tennessee. Here just a minute ago, we heard a debate on the floor about how we are going to have to redo Medicaid and Medicare. And we have a system already that has promised up to as much as a $70 trillion promise that we have unfunded, a government system that we don't have the money to pay for now, and we are thinking about starting another one, another government system. And you mentioned rationing of care. It brings to me the thought of breast cancer.

As a physician in our practice, we average seeing one newly diagnosed breast cancer per week. And when I began my practice over 30 years ago, half the women, approximately half the women, died in 5 years after being diagnosed with breast cancer. It was a terrible, and still is, a terrible diagnosis. And one of the great miracles of medicine is we haven't cured that disease, but we have improved the life expectancy for a woman diagnosed early to a 5-year survival rate of 98 percent. It is a wonderful story to tell. When a patient comes to my office, and she says, Dr. ROE, how am I going to do? I can say, look, you're going to have some tough times. It's going to be hard. This therapy is going to be difficult and tough. But you're going to make it. And you're going to live. And you're going to get through it. And I'm going to be through it with you.

What has happened in England is that the best results they had ever was a 78 percent 5-year survival rate. And they quit doing routine screening mammograms in England. And the reason they quit doing that is because there is a false positive rate. That means the test says you have something wrong, you go and have a more sophisticated biopsy. It is called a ''wire-guided biopsy.'' It requires a radiologist. It is a fairly sophisticated, as you all know, procedure. But what happens is that that costs more than the screening mammogram. So now they just wait until you develop a lump that you can feel. And as most physicians know, that is about 2 centimeters or three-quarters of an inch.

I don't think the American people are going to tolerate that for their families. I know I won't tolerate that for my family. I don't want a government decision based on the amount of money whether my wife or my daughter can have a mammogram. I yield back.

Mr. FLEMING. I thank the gentleman from Tennessee, Dr. ROE, for his excellent comments.

What you're pointing out is that rationing is not just about inconvenience, although there is a lot of inconvenience where someone has to wait 6 months to get a surgery, elective surgery or something like that. But it also means accepted death rates and accepted morbidity rates so that people go unable to work because they need a hip replacement or someone dies waiting for needed surgery for a disease disorder. They go delayed diagnosis for a tumor which is going to end up in much more cost down the line because it wasn't prevented or diagnosed earlier. So rationed care I think is unacceptable to the American mind. And I would just say that if we go towards a government-run system, we have to be willing to accept the fact that we will have rationed care. I don't see any way around that.

I do want to just sum up before I yield, and that is that I think that in evaluating the American psyche today when it comes to health care, we find that 83 percent of Americans like the health care the way it is. They like their insurance coverage. They like the doctor that they see. They are happy. The problem that we are talking about today is the 47 million uninsured. And who are these people? Well, statistics tell us that probably 10 million or so of those are illegal aliens. And, of course, that is a whole other debate. We need immigration reform. There is also probably half that number who are young adults who are healthy who elect not to get any health care insurance coverage. And so we have a real challenge before us to entice or to incentivize them to join, because if they join into the plan, we can work through preventive health care and early diagnostic care to prevent them from disease down the road, and also their dollars up front will help fund the last 10 million, which is the most critical 10 million, and that is older adults who are not Medicare age who do not have affordable accessibility to health care coverage, and therein lies a problem. They are not the poor. They are not the elderly. And they are not people that work for corporations. They are small business owners and their employees, a critical 10 million population that are finding their ways into the emergency rooms late in their illness with outcomes poor, far more cost required. And of course we physicians and hospitals have a mandate to provide care to them regardless of their ability to pay, which is a noble American concept. But the problem is, that cost has to be passed on to others, taxpayers, those who are paying their insurance subscription rates. And I'm sure we, as Americans, are willing to do that to an extent. But if you take those same dollars and you allow these people to get insurance and early preventive care, have a medical home, a family doctor, those costs will collapse. They don't have to be the high-price, low-yield kind of care that they get through the emergency room.

And lastly, I think it is important that we look at reforming health care laws where we can allow physicians and hospitals and other providers to come together to begin to work together and to compete to lower the overall cost of health care rather than having it being dictated from Washington, which as I pointed out, is really a very poor way to try to cut costs.

And then finally, that we do away, remove from the lexicon, the idea and even the verbiage that says ''preexisting illness.'' There should never be that term used ever again.

□ 1745

In conclusion, I just want to emphasize the need to remove the term ''preexisting illness'' from the lexicon and that we make it easy and affordable for all Americans to access the health care system; but as I say, I think we all tonight would agree that that is done much better through a private plan rather than through a government plan. I know that we hear some rhetoric about, well, let's have both a private plan and a public plan—and I'm sure that my colleagues tonight will expand on this—but if you have one plan that's controlled and subsidized by the government, whose responsibility it is to be sure that there's an even playing field in the competitive arena, we know that the public plan will always receive advantages and benefits, and the private plan will then atrophy. I think it's far better to work through the private arena and to let

the government do what it does best, and that is to protect its citizens and to ensure an even playing field.

With that, I yield back to my friend from Tennessee.

Mr. ROE of Tennessee. Thank you, Dr. FLEMING, and thank you for those great comments.

For the public, we have had, for the last several weeks and months, a physician's caucus that has met now sometimes one and two times a week to discuss this ongoing health care debate. With us tonight here is one of the leaders in that caucus, Dr. PHIL GINGREY, who happens to just have the same specialty as I do, and he has been very heavily involved in the health care debate over the past several years, so I will yield now to Dr. PHIL GINGREY from Georgia.

Mr. GINGREY of Georgia. Mr. Speaker, I thank the gentleman for yielding. It's a pleasure to be on the floor with my colleagues, with my physician colleagues, who are part of the GOP Doctors Caucus. I think, among us, we have something like 335 years of clinical experience, so we do feel that we bring to the body, to this great House of Representatives, some useful information, some practical information, not highbrow, academic, research-based information. I think we're just talking about, for the most part, the meat and potatoes practice of medicine, different specialties.

We just heard from our colleague from Louisiana, Dr. FLEMING—a family practitioner for many years. Dr. ROE from Tennessee is a long-term practitioner of obstetrics and gynecology, as am I, and we have a number of orthopedists in our GOP Doctors Caucus. So we bring a broad spectrum of experience.

You know, as we look at this issue of health care reform, the main thing is the urgency that the Democrat majority has placed upon it to the extent that the Speaker, the majority leader, and the President want a health care reform bill by the time that we leave here for the traditional August recess. Here we are in mid-May, so we're talking about, maybe, 2½ months away. It's going to be awfully tough to do that. Although, Mr. Speaker and my colleagues, we have been doing a lot of work on both sides of the aisle. Unfortunately, it has not been done in a bipartisan way. Those of us in the minority, the Republican Party, have really not been privy to too many details about what is in the Democratic majority's plan for health care reform; but we can read; we can watch television; we can listen, and we can pay attention. Indeed, there have been some trips over to the White House to commiserate with the new Commander in Chief, our President, about ideas.

The former majority leader of the Senate and the almost Secretary of Health and Human Services—and I'm talking about Senator Tom Daschle—wrote that book called ''Critical'' where he kind of outlines what he thinks the blueprint for health care reform should be. So we're getting little inklings.

I'll tell you, Mr. Speaker, the main thing that we're opposed to, and I think that I speak for all of my colleagues, I know, in the Republican GOP Doctors Caucus but probably for most of my colleagues on this side of the aisle no matter what their profession. We do not want to overreact to a problem, to a problem of too many people not being able to afford health insurance, to an overall problem of the cost of health care and to those insurance policies, 150 million of them probably provided by employers. Many of these employers are small, mom-and-pop companies, and they just can't afford it. They can't afford to continue to pay those premiums that are increasing by double-digit rates from year to year.

So that's the problem, and we all understand that people don't have access because they can't afford it. In some instances, they don't have access because they have preexisting conditions, but we don't have to overreact. I don't know why it is that, in Congress, everything has to be a knee-jerk response where you just absolutely have to throw the whole kitchen sink at every problem. It may be because the media, in some instances, ginned it up almost to the point of hysteria. Then there are a lot of public opinion polls taken and a lot of push, and the next thing you know, you've spent $2 billion in preparing the country for swine flu and in producing a vaccine that probably will never be used, and if it is used, it will have the potential of doing a lot more harm than good.

I don't want to say that we overreacted to Katrina. I don't think we did, but—gosh—we did buy a whole lot of trailers, sitting somewhere down there in Louisiana, that are soaked with formaldehyde because the construction was rushed.

You know, in a lot of instances up here, we create, I think, more problems than we solve. There was an old adage, Mr. Speaker, in OB/GYN—and I think Dr. ROE has probably heard this one, too, because he's also an OB/GYN practitioner. Most people want to say, ''Don't just sit there. Do something.'' How many times have we heard that expression up here? I mean, people will call and say, ''For goodness sakes, why don't you all do something? Don't just sit there. Do something even if it's wrong.''

For Dr. ROE and I, our motto was ''Don't just do something. Sit there.'' I'm talking about late at night when you're waiting for a lady to have a baby, and if you just leave her alone, she'll have that baby, and all you'll have to do is catch it, and if you start meddling and trying to push things and rush things and overreact, you cause some problems, don't you, Dr. ROE?

I yield to the gentleman.

Mr. ROE of Tennessee. We used to say, ''Smoke a long cigar.''

Mr. GINGREY of Georgia. ''Smoke a long cigar.'' That's right. A ''covered wagon'' I think they called those things back when I was a kid.

Mr. Speaker, that's what I want to bring to this discussion tonight. We need to be very careful not to overreact. We don't need a government-run program to solve this problem. We do have too many who are uninsured. There are various and sundry reasons why they don't have health insurance. Yes, some of them are not poor enough to be eligible for Medicaid, so they missed that safety net. They're not old enough to be eligible for Medicare, so they missed that safety net. They just have enough money, but they can't afford expensive health insurance. We can do things to help them without turning this great health care system that we have—lock, stock and barrel—over to the Federal Government.

Right now, part of the reason for lack of access and affordability is that the private market and the physicians who practice in that venue have a tendency to do too much. Maybe they order too many tests. Maybe they order duplicate tests because they don't know that the doctor down the street or in the next county had done the very same test a month ago. There are no electronic medical records for at least 300,000 doctors in this country, so we're a long way from having fully integrated electronic medical records where, every time that patient comes into your office or into the emergency room, you know exactly what they've had, what you should order and what you shouldn't order.

So that's all part of the problem, but we can deal with this without having a government default program, because what happens is, in that instance, you're going to say, well, I'm going to solve this problem because the doctors and the hospitals are doing too much and are running up the cost, and so you turn it over to the Federal Government. What do they do? They do too little. They do too little. They begin to ration just like they do in other countries, like in the U.K. and like our great friends to the north and like other countries that have experienced that for many years. The only way they can pay for those systems is by rationing and by long queues. What happens? If they can afford to, a lot of those people come to this country for care. A lot of their doctors move to this country where they can practice medicine and can make a decent living.

So I just wanted to touch on that. I will yield back to Dr. ROE, who is controlling the time.

My friend from Georgia, Dr. PAUL BROUN, is on the floor. I know he'll want to talk and will want to bring some intelligence to this issue, but let's just say this as my closing remarks:

I don't want to just do something even if it's wrong. I'm willing to sit there, to think and to hear from a lot of different folks who are experts on how we can best solve this problem, on how we can deal with this, whether

they're the hospital associations, whether they're the insurance companies, whether they're the pharmaceutical companies or whether they're the doctors who've practiced for many, many years. I think we can come up with the answer, and I think we can do it a whole lot better.

The final expression that I'll throw out there, Mr. Speaker, to you and my colleagues is the one that everybody has heard: ''Don't throw the baby out with the bathwater.'' We are on the verge of doing that. That would be a horrible thing for this country to take a great health care delivery system that needs some tweaking and that we can do in a bipartisan way without turning it over—lock, stock and barrel—to the Federal Government. They do a lousy job at running a lot of programs, and I certainly don't want them deciding what needs to be ordered and to come between the doctor and the patient in the exam room.

With that, I'm going to yield back to Dr. ROE of Tennessee.

Mr. ROE of Tennessee. Thank you, Dr. GINGREY. Thank you for those comments.

I think one of the things that has concerned me the more I have watched this system and have watched this debate go on is, since I've been here, I've had one of the health care think tanks in my office about every week or so to discuss this issue, and it is incredibly complicated. That's why we cannot do it rapidly, because it is so complicated.

I'll now recognize my colleague from Georgia, Dr. PAUL BROUN.

Dr. BROUN.

Mr. BROUN of Georgia. I thank you, Dr. ROE, for yielding me some time.

I want to make sure that the American people know what we're talking about. We on the Republican side are offering alternatives for the health care financing problems we have in America, and they are huge. People cannot afford to buy insurance. There are a number of people who are struggling just to have halfway decent health care insurance coverage, and that is a huge problem that we need to fix, and we need to do it as quickly as we can.

I agree with Dr. GINGREY, my colleague from Georgia, that we can fix that system. We need to, and we need to do it as quickly as we possibly can. Yet what's being proposed from the other side of the aisle, from the Democrat side, is to set up a Washington-based health care system where health care decisions are going to be made by some bureaucrat here in Washington, D.C. That bureaucrat will tell your doctor how he can deliver your care—what care he can give you and when he can give it to you.

What that's going to do is take away your choice. You may not have a choice of your doctor. You may not have a choice of what hospital you go to. You may not have a choice of whether you can even get some kind of procedure or a test or not. What it's going to do is it's going to delay your being able to get those tests and those procedures even if the Federal bureaucrat says that you may have them.

We can't go down that road. It's going to destroy the quality of health care. It's going to destroy the health provisions that you're getting today as an American. I don't want that, and I'm sure you don't want that. I'm sure Dr. ROE doesn't want that. I'm sure no physician, at least on our side of the aisle, wants that kind of a health care system to deliver your health to you by some Washington bureaucrat. We've got to stop that, and it's up to the American people to do so.

We're offering alternatives, many alternatives. I know one of our colleagues I talked to today is introducing a bill tomorrow that is going to be a health care reform bill. Our health care working group is developing a plan. I'm developing one in my office also that's independent of everything else, but we need to develop a solution that is patient-centered, not Washington-centered. We need to develop a plan that gives the American people the choice—the choice of their doctor, the choice of their hospital, the choice of whether they get a procedure or not. It should not be made by some Washington bureaucracy or bureaucrat or Federal bureaucrat anywhere, whether it is in Atlanta—in my own State—or in Knoxville or anyplace else.

□ 1800

We've got to develop a health care system that is patient-centered to give patients the choices that they deserve and they desperately need. We, as Republicans, are going to give you that opportunity. The opportunity is not going to be available from the other side of the aisle. They're developing a socialized medicine program, a Washington-based health care system to give your health to you by some Washington bureaucrat, not by a doctor.

And the American people need to know that very clearly, Dr. ROE, because they have a choice. Is it a choice between a Washington-based health care system, or is it a choice of a patient-centered health care system where those decisions are made in the doctor-patient relationship? And that is what we're offering.

And I'm just encouraging the American citizens all over this country to write their Congressmen, write their Senators and demand a patient-centered health care system. Demand that our alternatives are heard.

NANCY PELOSI has blocked—she has been an obstructionist for every single alternative that we've offered whether it's for energy, whether it's for environmental issues, whether it's spending, whether it's straightening out this economic situation, as well as the health care solution. She has been an obstructionist. She's blocked every attempt we've made to deliver to the American people alternatives that make sense from an economic perspective as well as a market-based perspective.

So we need to give our plans the light of day. And the American people are going to have to demand that, Dr. ROE. It's the only way it's going to happen. And I encourage people to contact their Members of Congress and demand that we slow this steamroll of socialism, as I'm calling it, this rolling over—the financial services industry is rolling over the car manufacturing; it's rolling over now the health delivery system. And we, as Americans, need to demand that all alternatives are heard, that we have the time to put something in place that makes sense to give patients the choice that they need.

So I congratulate you for doing this. It's absolutely critical for the future of health care. If we continue down this road that the Democrats have taken, it's going to destroy the quality of health that we deliver as physicians to our patients, that you did as a practitioner for so many years and I have, also, for so many years. So I thank you so much.

Mr. ROE of Tennessee. Dr. BROUN, thank you for your comments.

And just to summarize and sum up. I think our time is just about gone.

This is just the beginning of this debate. It is a very important debate for the American people. We just got through a few of the principles tonight. We will continue those at another time.

But I thank Dr. BROUN for being here, and I thank the Speaker.

I yield back the balance of my time.

FURTHER MESSAGE FROM THE SENATE

A further message from the Senate by Ms. Curtis, one of its clerks, announced that the Senate concurs in the House amendment to the bill (S. 896) ''An Act to prevent mortgage foreclosures and enhance mortgage credit availability.''.

RECESS

The SPEAKER pro tempore (Mr. HEINRICH). Pursuant to clause 12(a) of rule I, the Chair declares the House in recess subject to the call of the Chair.

Accordingly (at 6 o'clock and 5 minutes p.m.), the House stood in recess subject to the call of the Chair.

□ 1828

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. HEINRICH) at 6 o'clock and 28 minutes p.m.