struck. The tour guide was telling me about their national system, and then we drove by the hospitals. They're right next to each other, the public hospital and the private hospital, and you could tell which was which visually. The private hospital looked like a hotel, a very inviting place. The public hospital, unfortunately, looked like a building that was somewhat dilapidated. And that's what just frightened me, two tiers of care. Now, this is a Latin American country. Some might call it a third world country. But nevertheless, that's what I saw, and I would never want to see that happen in America.

Mr. KIRK. If the gentleman would yield. What you heard tonight is focusing on positive outcomes, making sure we reform health care, less defensive medicine, deploy health information technology, health individual savings accounts.

We have spent far less time criticizing the President and far more time outlining a new positive agenda. But to close tonight, I'd like to turn to Dr. MURPHY, who's been more in the health care system than all of us, to finish us out.

Mr. TIM MURPHY of Pennsylvania. When I look at this, I want Americans and all of us to imagine a system that's based upon cures and based upon outcome, a system where doctors are in charge of your health care, not insurance companies, not the government. And I know that both sides of the aisle are deeply concerned about this. It is not that one side or the other wants insurance companies or the government to win. We all want patients to win, Democrats and Republicans alike. But we must have a system that's focused upon this, not that creates incentives because we're paying people so low to do more and more tests, not to promote more and more medical procedures, but to really focus on this outcome. We can do this through these things we're doing, the patient and doctor in charge. Don't create more barriers. Make sure we have all the efficiency there for quality. We can do those things. Imagine what can happen. Imagine the possibilities. And let's just not throw it out and say it's too difficult; let the government run it.

With that, I yield back to my colleague, Congressman DENT.

Mr. DENT. Just in conclusion, I just think we want to say a few things. I think in our health care system we certainly want our system to be focused on prevention, not maintenance. We want cures, not treatments. The system should be about doctors, not lawyers. We want patients to be treated like they want to be treated, like human beings. They want to be treated like people and not some number, something abstract. They want to be treated like a human being.

And so, because at the end of the day, we all want our loved ones to be cared for. You don't want them to have to wait. You don't want to see your mother, like mine, who's 80 years old be told that she's contributed her whole life, relatively healthy, we don't want to tell her, I'm sorry, we're going to discard you now that you've reached a certain age. That's what we are concerned about.

So we're going to try to work, I think, in a bipartisan manner, try to work in a way that embraces a lot of ideas that we can all share. And short of a government takeover of our system, I think we can do that. We have the capacity to do it. The American people expect it of us, and I look forward to working with all my colleagues to come to that kind of result.

Mr. KIRK. I thank the gentleman, and we will be outlining a positive set of reforms that we think can attract tremendous bipartisan support this Tuesday, from the centrists.

Mr. PETRI. Mr. Speaker, today, President Obama is in my home state of Wisconsin conducting a town hall meeting to promote his health care agenda.

I know that the residents of my home state will tell him that they are struggling to keep up with the rising cost of their health care premiums, while others are simply unable to afford health care coverage.

Many people in my state have lost their jobs and fear that they won't be able to afford their children's medication or that an unforeseen illness will bankrupt them.

Some individuals who have insurance are simply staying in a job they don't like because their next job may not offer health care insurance.

Others who are happy with their insurance worry that any drastic reform will force them into a system that will limit their choice of doctor or access to medical treatment.

I agree with the President that it is time to fix the health care system in the United States so that all Americans, all my constituents, have access to quality affordable health care coverage.

However, I strongly believe that any reform that we consider in the House must be based on a few important principles.

First, it must give everyone access to quality and affordable health care.

All individuals should have the freedom to choose the health plan that best meets their needs.

Second, any reform should ensure a patient centered system.

Patients in consultation with their doctors should be in control of their health care decisions and not government bureaucrats or insurance agents.

If your child or parent is sick, you should have access to timely tests and treatments and not subject to waiting lists or treatment decisions dependent on anyone other than you and your doctor.

Third, our health care system must emphasize prevention and wellness.

Chronic diseases account for 75 percent of our nation's medical costs. By implementing programs focused on preventing such things as smoking and obesity-related diseases, we will not only save lives, but reduce health care costs.

And lastly, any reform needs to focus on getting rid of the waste, fraud and abuse that plagues our current system. Approximately $60 billion is lost due to fraud in the Medicare program alone. We can't afford to multiply that number through a government takeover of our entire health care system.

Our health care system needs to prioritize efficiency, transparency, and results.

I look forward to working with Members of both parties to ensure that these principles guide any legislation we will consider in the future.

GENERAL LEAVE

Mr. KIRK. Mr. Speaker, I would like to ask unanimous consent that Members have 5 legislative days in which to revise and extend their remarks on the subject of my Special Order.

The SPEAKER pro tempore (Mr. BRIGHT). Is there objection to the request of the gentleman from Illinois?

There was no objection.

HEALTH CARE REFORM

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentlewoman from Pennsylvania (Ms. SCHWARTZ) is recognized for 60 minutes.

Ms. SCHWARTZ. Mr. Speaker, I rise this evening to begin what I hope will be a Special Order time with my colleagues. It's a little earlier than we thought, so we're going to see as they make their way to the floor. Hopefully they will be joining me.

But, as you know, there has been a great deal of discussion about health care reform. We just heard a Special Order now from my colleagues on the other side of the aisle talking about health care reform and some of their thoughts about it, and I think sometimes we focus very much on controversial issues and some of the difficult decisions we have to make as we move forward, and let me start with what we're trying to do on health care reform, on this.

What we want to talk about tonight is some of the very important work we want to do as we really meet the President's goals.

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He has laid out to us the goals for health care reform, and they are really threefold. They are to make sure that we contain costs. The fact is that our businesses have said to us that the high cost of health coverage, providing health benefits for their employees, has gone up almost double digits every year. And what that really means is that we have doubled the cost of health care benefits to our companies in the last 10 years. That's unsustainable for our businesses, whether they are small businesses that are trying to be economically competitive in their communities or very large businesses that are really functioning on the global marketplace and really competing with companies that are in countries where health care is not an individual employer's responsibility and where costs are more controlled. So we know it's

an economic competitive issue. There's no question about that.

We also know that it is an issue for government. I serve on the Budget Committee. The costs, and we talk about this, for Medicare is really unsustainable if we don't do a better job of containing costs and improving quality and improving outcomes for our seniors. We're going to talk more about that this evening.

But we also know that it's a huge problem for our families. We hear all the time from our constituents about families that have break in coverage and then suddenly find themselves faced with buying a family policy with a preexisting condition, someone in their family with a preexisting condition, and the cost of that policy, if they can find one, is too high for them to be able to afford.

Typically, I know in the Philadelphia area, a decent insurance policy costs anywhere from $12,000 to $15,000 a year. Well, a family that's earning even $50,000, $60,000 a year, after paying their mortgage and paying their expenses and maybe trying to save something for their children to go to college and meeting all the taxes, local and State, really just don't have those kinds of dollars left for them to find $12,000 to buy a decent policy. So they're shut out, completely shut out, which is really a very significant problem when they want to go for health coverage. So we know cost is absolutely a major issue for our businesses, for our families, and for our government.

So what can we do about it? How can we actually ensure that we will contain costs and improve quality and also be able to extend coverage for the 47, almost 48, million Americans who do not have ongoing health insurance coverage? And the fact is we can do numbers of things, and we have been working hard on this to make sure that we create the kind of market reforms that will enable people to buy meaningful coverage that is affordable for them and that they will have the kind of coverage that will really matter.

We also know that we need to make some real changes in the delivery system. And, again, that's what we are hoping to focus on tonight. And what I mean by that, if for all of us who go to see doctors and nurses and spend time at all in a doctor's office either for ourselves or for our loved ones, we know, and our numbers bear this out, that, in fact, we tend to go to more specialists. We have very fragmented care. What we don't have is access to a primary care provider who knows us, who follows us, works with us when we get a serious disease, helps us know what it is that we need to be doing, helps us comply with recommendations, and really also helps us sort through if we need to see numbers of specialists.

So whether you are basically fairly healthy or have a major health care crisis or a chronic disease, we know that we cannot only get better quality care, help improve health status for all of us and each of us, but also contain costs.

And I'm happy to give you some of the numbers that we have in terms of some of the primary care shortages. We often talk about primary care physicians, but the fact is we also have a shortage of nurses, nurse practitioners, physician assistants, and so many of the health care providers that really should be there for us and want to be there for us but there is simply not enough of them.

The Council on Physician and Nurse Supply says the United States may lack as many as 200,000 needed physicians by 2020. So here we are saying that we want you to go see the primary care physician or nurse practitioner. We don't want to go to the emergency room. Look at the Massachusetts experience where they really worked very hard and effectively to extend coverage to the uninsured. What they found was people were still going to the emergency room because there simply were not enough primary care providers or clinics or community health centers in their communities for them to go to.

Let me go on with some other numbers, if I may. They estimate that there could be a shortage of 800,000 nurses by 2020; 46,000 of those physicians and nurses need to be primary care providers. The U.S. population rose 31 percent between 1980 and 2003, but the number of medical school graduates remained the same. So the population is growing. We're looking at a 30 percent growth in population, and the number of physicians is the same. And what is so interesting about that is I think for a long time we've heard we have enough physicians but they're just not in the right place. Well, I think we've gotten that a little bit wrong. There are simply not enough primary care practitioners, physicians, or other practitioners.

Interestingly, the number of medical students who are choosing primary care is steadily declining. Even amongst those who are specializing in internal medicine, I will say that in 1985, half of all internal medicine residents chose primary care; now only 20 percent do.

I was at a press conference this morning with Congresswoman KATHY CASTOR and Congressman JOHN SARBANES and a young woman who has just graduated from osteopathic school. And she talked about the statistics, and she said that most medical school graduates graduate with almost $200,000 in debt. Their first job as a resident, and still training actually, is usually paid about $40,000. So how do you train for another 3 or 4 years, make $40,000 a year, and pay $200,000? That's just medical school. You may have a course debt from college as well. So it is a major issue going forward to make sure that we have more primary care physicians.

Older Americans also are seeking primary care services twice as often as other age groups. So as the population is aging, and we know the baby boomers are coming, and we are talking about them, of course, in terms of Social Security, but the fact is we know that as we are aging and needing more health services, it is very, very important for us to have access to primary care providers.

Let me also talk about one of the reasons we need primary care providers, and that is all of us, but particularly those with chronic conditions. We think about needing health care when we get sick and have an episodic experience where we might need to go to the hospital and might need to see a physician, might even end up in the emergency room. But for many people, they have chronic conditions, and they need to have an ongoing relationship with health care providers so that they can get the kind of care they need, get the advice, get the right prescriptions, and then be able to work with their medical practitioners to be able to comply with that advice and to be able to make sure that they are healthy. And the number out there is that only 50 percent of Americans who do get health care comply with the recommended health care that they're told to comply with. So obviously we need some work here.

This is a shared responsibility. This is not only a responsibility of those who pay for health services and are reimbursed for health services and those providers but, of course, for patients as well.

So let me just say on chronic conditions, some of these numbers may surprise us. But the five most costly chronic conditions are cardiovascular disease, cancer, diabetes, asthma, and mental health disorders. Over 133 million Americans suffer from at least one of these chronic diseases, and over 75 percent of all Medicare expenditures can be attributed to patients with five or more chronic conditions. Just 10 years ago, these beneficiaries accounted for only 50 percent of the Medicare costs.

So something's wrong. We have to fix this problem. We have to make sure that people can hopefully prevent some of these chronic disease. We might be able to do that in a number of ways. I know there's a lot of discussion about wellness programs for prevention. We have seen some very good models. Particularly some of the larger employers, smaller employers, some of the insurance companies are really working hard to try to incentivize people to eat right, to exercise to be able to prevent some of these conditions and some of these conditions from worsening. But clearly we have a long way to go and we have much work to do to make sure we, again, help folks with chronic diseases be able to be healthier, to get better, to not have the disease get any worse. And, of course, in that process it will save them money and it will save all of us the high cost of taking care of patients.

Any of us who has ever visited a renal dialysis center knows that if we can do more to make sure that somebody who, for example, is diagnosed early as a diabetic follows the prescribed treatment, does try to eat right, exercise, really takes care of themselves, and gets good consistent health care and can prevent themselves from becoming more seriously ill and, of course, going into any kind of renal failure and needing renal dialysis is something that would save them many problems and would save us all a lot of the costs involved.

Just a few more numbers because I think they're pretty telling. Chronic conditions cost American businesses nearly $1 trillion each year in lost productivity. We don't even think about the number of dollars that are lost as workers take time off for serious illnesses. About $125 billion of this is due to lost workdays, and the balance is due to diminished capacity while they are at work. So for businesses it's not only the cost of the insurance and the benefits, but it's also a cost when their own workers are not being able to really work at the full scale of their potential and their capacity.

So we know that we can do more. Economic conditions, the health benefits, really taking serious action to make sure that we have enough primary care providers, and that we do a much better job of coordinating care for those with chronic diseases will really have a dramatic impact on the health status of Americans and on the cost to all of us. And that's really what we want to do.

I think that we have heard some others talking earlier about the need to do medical research. We believe very strongly in that, and we have already made a very good commitment to doing that by putting $10 billion more into NIH. We did that in the Recovery and Reinvestment Act, and that was very significant. Of course, we want to see better treatments and we do want to see cures. That takes dollars for medical research and a real commitment to the science of biomedical research into some of the new products and devices. But it also takes prevention and it also takes better coordination of care.

Patients with chronic diseases need to have access to primary care providers. We talked a bit about that. We need to be able to make sure that they get good ongoing chronic disease management.

And I have introduced legislation. It's House bill 2350, and I have to say it's got enormous support here in the House, 100 cosponsors. I'm very proud of that. And many others are looking another it, and I have only introduced it just a couple of weeks ago. The idea of that legislation is to make sure that we preserve patient access to primary care. And one way to do that is to increase the number of primary care providers by increasing the number of residency program slots for primary care. We're going to hopefully do that. And for more nurse practitioners and more nurses in this country. That would be very helpful. But another concept, and I see another colleague of mine is going to join us, which is just great, but just to finish this thought, there's also reimbursement for a concept called ''medical home.'' This isn't a place. This is a group of services. It's a commitment on behalf of the provider, the doctor, the nurse practitioner, the physician assistant to be able to provide a medical home so that you know you have ongoing care, particularly when you have a chronic disease. And we can talk more about that going forward.

But I want to thank my colleague for joining me. I see Congressman JASON ALTMIRE has joined us. He's also from Pennsylvania, from the other side of the State, from a community, Pittsburgh, which is known for its medical care, medical schools, and it has a lot of health care providers. But I bet and would imagine that Congressman ALTMIRE has some of the same experiences I do, that while we have great quality health care, it is also too often fragmented and is too often not accessible and too often not affordable for too many of our constituents.

So we're here tonight to talk about health care reform, particularly the commitment that we're making as we move forward on health care reform to expand and extend access to more Americans, to make it more affordable. It also means a commitment to fixing our delivery system, and that means a commitment to primary care.

I want to thank Congressman ALTMIRE for joining us, and I welcome his comments.

Mr. ALTMIRE. I thank the gentlewoman for yielding. It's been a pleasure working with the gentlewoman as part of the New Democratic Coalition. We are the co-Chairs of that group.

The gentlewoman hit it right on the head, that we do have the best health care system anywhere in the world if you can afford to get it. If you have access, and there are millions of Americans that have insurance and they like it and they have access to the system, our medical innovation, as the gentlewoman said, our research, our technology far exceeds anything available anywhere else in the world. Our quality at the high end exceeds anything available anywhere else. It's why people come from all over the world to the United States to get their transplants, to get their heart taken care of, to get their high-end, high-tech care because we do it better than anybody else, and there is no question about that.

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The problem is the costs are skyrocketing with our health care system. Every family, every business, every individual in this country is impacted by the cost of health care and not just with what you're paying directly for your health care costs—what your copayment, your premium or your deductible is. The cost of everything that you buy in this country is higher because of health care costs. We use the example of an American-made car. $1,500 of the price of every car made in this country goes to health care costs—to the health care costs of the workers who are involved in putting that car together.

It's more than that. It's every level of the supply chain, every segment. If you think about the company that manufactures the good, the people who ship the good, the people who receive it and stock the shelves, and the people who sell it, at every level, there is a component of cost that is increased because of health care costs of the companies involved in that. This is at every level of the supply chain.

If you think about every segment of our lives, health care is a part of that. What we are trying to grapple with here in this Congress over the next few months is how to preserve what works in our current system, because we don't want to throw the baby out with the bath water. We don't want to lose the good things about our health care system, but we do want to address the things that don't work. So we think about the fact that we spend $2.5 trillion a year on health care in this country, far more than in any other country in the world.

Yet, with some things, we don't get mediocre results; we get bottom-of-the-pack results when compared with other countries—in life expectancy and in infant mortality. We're not in the middle of the pack. We're at the bottom of the pack. We can do better. We're not getting our moneys worth, especially when you consider the 50 million Americans who don't have any health insurance at all. Now, when they show up at the emergency rooms, they get covered; they get treated, but the bill gets passed to the millions of Americans who do have health care coverage. The reason you pay $10 for an aspirin at a hospital is due to the cost shift that takes place, making up for the difference of the people who can't afford their health care. There are tens of millions more who live in fear of losing their coverage. They are one accident, illness or job loss away from losing everything, and that, in the United States of America, is unacceptable.

So we have very high quality at the high end, but we have very high costs, way more than any other country. We have millions of Americans who have coverage and who appreciate their coverage and who like it, but we have tens of millions more who don't have coverage or who are underinsured.

So the challenge we have as a Congress is how to fix what doesn't work—what's broken—and how to preserve what does work. We've put forward a plan, and we're in the very beginning stages. There is a lot of negotiation that's going to go into this, both in the House and in the other body, to talk about how we can achieve that goal—

but make no mistake. As the gentlewoman knows, we are not going to fail. We are going to pass a health care bill this year because the American people have demanded that we do that.

As I said, it affects everybody in this country. The cost increases that are double and triple the rate of inflation every single year are simply unsustainable. We are never going to get ourselves out of the budget crisis that we have over the long term, our annual budget deficit and our structural debt that we have, unless, as the President says, we bend that cost curve on health care. We have to bring costs more into line with the rate of general inflation.

Ms. SCHWARTZ. Would the gentleman yield for just a moment?

I think, when some of our constituents hear some of those words, they really want to know—and I think that's one of the things that we're really interested in pursuing here. They want to know: Well, does it mean I'm going to get less health care? Does it mean I'm not going to get what I need? Does it mean I'm going to go to the emergency room, and they're going to turn me away?

The fact is we're trying to be smarter than that. We want to say no. What we're saying instead is that we want to make sure you get the right services when you need them. I'm sure you hear from constituents who find that they don't go to emergency rooms because there simply aren't doctors in their communities. I remember when I was growing up that there was a general practitioner down the street. We all went to him. I'll bet there's no general practitioner there anymore. I know, in parts of my own district, we've seen some hospital units close. We've seen doctors' offices close. It just isn't the way medicine is practiced right now.

The truth is, with reimbursement to insurance companies and with what we've done under Medicare, we've not created any incentive for doctors or nurse practitioners to go and open offices in small communities and provide those kinds of services. Instead, we've encouraged them to become specialists, to really do the fancy kinds of things. While we need them and while we want to make sure we have those specialized physicians there and available for us and while that has got to be covered, if we only cover that, if we only focus on that, we've really forgotten sort of the simple things, you know, which are:

How do you really talk to patients and make sure that they understand what they need to do? How do we actually make sure that we have a shared responsibility instead of a patient's saying: Oh, I'm sure I can just go and get a pill for that. Wouldn't we all love that, to be able to take a pill and we'd all be fine. It takes more personal responsibility, and it takes a patient-doctor relationship. That's often what's missing is that ongoing relationship with primary care providers—that's both physicians and nurse practitioners—and it's one of the things we want to address.

I'm sure that the gentleman has heard the concept of medical homes. Maybe you'll want to talk about that, about the idea of an ongoing relationship, about the fact that we're really interested in this health care form of creating a new opportunity to reimburse primary care practitioners for that kind of ongoing relationship with patients so that they know which specialists to see and so that they can help people sort through the many medications they take. I was just going to give you one number, which my staff gave me earlier, which I was really quite struck by.

It said that medical beneficiaries with 5 or more chronic conditions see an average of 13 different physicians per year and are prescribed an average of 50 different prescriptions.

That's a lot to sort through if you're not an expert. It really is. Think about actually having someone you can talk to and say: Wait a minute, do I really need to take these? Should I still be taking these? Shouldn't I? You know, who do I ask about this?

I'm sure you've heard some of these stories from your own constituents and probably from some of your own providers as well.

Mr. ALTMIRE. I have, and I thank the gentlewoman.

There is a lot to talk about just with this one concept, with this one component of health care. Part of the issue that we'll, I'm sure, get into is that of computerized medical records, of having an electronic health record that you carry with you everywhere so you avoid this situation that the gentlewoman described where you have, as a consumer, 50 different medications when you show up at a provider's somewhere that's out of your hometown.

If I go to San Diego and put my ATM card in the machine, I can pull up all of my financial records safely and securely. I never think about privacy. If on that same trip I end up in the emergency room, they don't have my medical history. They don't have my family's medical history. They don't have my allergies, my prescription drug regimen. They don't have any imaging that I might have had taken—x rays and so forth.

There is no reason that health care has to be the only industry in the country that hasn't gone to an interconnected/interoperable health information technology system, which is part of where the gentlewoman is going.

The other part—and this is a great point—is we have to begin to have our reimbursement system structured in a way that we incentivize the quality of care rather than the volume of care. We should not just talk about how often the patient goes to see a doctor and then reimburse based solely on that. We should be reimbursed based on: What is the appropriate setting for the patient? Where would the patient rather be? Where is the patient going to get the highest quality care?

We don't do that right now in our health care system. If you have a chronic disease, there are some cases—and certainly it would be on an individual basis and in conversation with your physician—where it shouldn't be determined based on reimbursement, based on money, as to what setting in which you're going to get that care. It should be: What is the best outcome likely based on the setting that you get? If home- and community-based care is the best setting, we shouldn't provide a financial disincentive to get it there. If that's the most appropriate, cost-effective setting and, most importantly, that's where the patient wants to be and that's where his family wants the patient to be, then, by all means, we should incentivize that setting. We're not doing that today.

Ms. SCHWARTZ. If the gentleman would yield, I appreciate very much your raising the issue of health information technology. You're absolutely right.

The health industry has been so slow to really be involved—to really use the computer, to use information technology—in a way that so many other industries have been. As any of us know who started out in our professional careers not using computers, I think we sometimes were slow or were anxious to do it. We were nervous about that.

I remember someone who worked for me a number of years ago who resisted it completely. She said: Don't be silly, I know exactly what I'm doing. I take notes. I do fine. We finally told her she had to use a computer. We just told her that we were doing it. Just a few months later, I remember the computer system went down, and she was like: Oh, my goodness. How can I function?

Well, you can imagine this in health care, which has been so paper-driven and so labor-intensive, the idea that physicians would have this at their fingertips even within their own city or even within their own medical practice sometimes. I was talking with a medical practitioner who said: Sometimes—I don't know—a patient could have been in my office, seeing another doctor the day before, and because the notes weren't transcribed yet, I don't know happened—or 3 days ago.

Another example: A patient who is just visiting Geisinger health system in Pennsylvania—a great model. The primary care physician has the ability to see the hospital records while patients are in the hospital. So they don't have to wait 3 weeks for specialists who saw them in the hospital to write them a summary, have it dictated and mailed to the primary care physician 3 weeks later or 4 weeks later.

It turns out those 3 or 4 weeks are incredibly important, after discharge, for the patient to be following the advice of the physician and knowing what to

do. It's a very uncertain time. You need to be able to have contact with your primary care physician during that time, and the primary care physician needs to know firsthand what happened to you.

An electronic medical record is extremely important in helping a primary care physician provide the right care for you and prevent a re-admission, which is a huge cost for all of us. We've talked a lot about that in terms of infections, but there are a lot of reasons people get re-admitted to the hospital. If we can prevent that by the right kind of home care, as you pointed out, or by the right care and attention from a primary care physician, that is not only going to help that person stay healthier, but it is also going to help that person get the care he wants.

I know we talked about this, too, which is, in terms of improving quality, there are now critical protocols. We like to think that every one of our physicians knows exactly what to do for us. By and large, most of our physicians, fortunately, are pretty good. As for all of us, if you have to do five things for somebody when one comes to you because one has some particular health condition and you tend to do four of those five most of the time, you're probably pretty good. It turns out, if you actually do all five every time, your patients are going to be a whole lot better off for it.

So, you know, maybe we're not used to the fact that the doctor might actually look that up on the electronic medical record and have to check it off, but it turns out that it really makes a big difference when you really did remember to remind one to stop smoking and when you really did remember to tell a parent to put a child in a seatbelt. I mean all of those things may not seem so directly connected to what a physician was seeing one for, but it enables the physician to make sure one gets the care one needs: Remind them about mammograms. It's time. If a woman hasn't had a mammogram for 3 or 4 years, maybe it's time, not to mention making sure that they take the right medications and follow the right orders.

So electronic medical records are what—you're right—the new Dems have really championed, and we have, of course, a President who has championed it as well. We put in $19 billion in the Recovery and Reinvestment Act to really help push this forward in a much more ambitious way—the use of electronic medical records in our physicians' offices and in our hospitals and having them be secure, private and interoperable. It's absolutely key.

I don't know if you wanted to comment on that or on other issues related to primary care or on other things that we can do with the delivery system that really will help us be able to contain costs and to give better care to people.

Mr. ALTMIRE. I wanted to comment, following up on the gentlewoman's comment on quality of care and medical errors.

According to the Institute of Medicine, there are 100,000 people every year who lose their lives due to a preventable medical error. Needless to say, with each one of those individuals, there is a tragic component to their personal stories—to their families or certainly to their own losses of life. There is also a burden to the health care system of medical errors because there are hundreds of thousands more who, because of preventable medical errors, are injured. Their treatment costs more, and each one of those individuals, more importantly, has suffered a severe medical setback. Their families are impacted by that. Their lives may never be the same.

In the aggregate, when we talk about cost reduction, something as simple as preventing infection, as the gentlewoman talked about, or as simple as preventing medical errors through the use of information technology, these are things that are going to save billions of dollars for our health care system in the aggregate. More importantly, they're going to increase quality for every individual who enters our health care system and will prevent these medical errors.

So the gentlewoman is correct that, when you look at even that one segment of health care reform, you're talking about billions of dollars. You're talking about the quality component—impacting lives in a way that is exponential throughout the health care system, not just involving one person.

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Ms. SCHWARTZ. I was going to mention something else, too, that I think that's a really important and good point is that one of the other points that we make that we're also trying to do in health care reform in terms of prevention and chronic disease management is that so many health policies that people buy, the up-front costs are really on them and so that preventative services—the screening, the early intervention, the simple doctor visits that can reduce the incidents of disease and keep you out of the hospital and keep you healthy—sometimes that's what you have to pay out of pocket for.

Some people say, Good. You should pay out of pocket. I think we have to understand what we're doing in health care reform is very much about a shared responsibility.

We were talking about providing some subsidies for lower-income working people. Everybody is going to have to pay into the system. We're going to keep the employer-based system. We're going to help those who really are at a lower income be able to pay on a sliding-scale basis for health insurance either in the private system or public option. But the fact is that we should be creating incentives to get early care: not wait too long, not wait until they're sick, not wait until they go to the emergency room. And that's what we're going to do as well.

So I did want to just finish up by saying that this health care reform effort that we are engaged in is complicated, but it's also very important. We want to make sure that, again, our businesses are able to continue to provide health coverage for their employees, that families can afford it if they're on their own, and small businesses or individuals can afford to pay for health care, and that government can continue to meet our obligations under Medicare for our seniors, something so important.

And we're only going to be able to do that if we do a better job of incentivizing, providing reimbursement, for delivery systems, medical providers, doctors and nurses, and all of the many health care practitioners that are so important to us. We have to make sure that they have the reimbursement, they have the tools to be able to provide the care in the right settings in the community to help us, have the information we need, have the right medical device to work with us to be healthier.

At the end of the day, our hope, I believe, is not only that we will extend coverage, not only that we will contain costs, not only that we will improve quality, but at the end of the day, Americans will be healthier. And if Americans are healthier, we will, in fact, contain costs and be able to afford to make sure that we have no child in America without health coverage, that we don't have families who are bankrupt as a result of health coverage, that we don't have families worrying every day because they have one family member with a chronic disease and they can't get insurance and that they can't act responsibly. That is certainly something that we want to do.

It's a goal that the President has set out. It's a goal that many of us have worked for years on. We're working hard right now to make it happen, and I look forward to standing on this floor to have the opportunity to vote for comprehensive health care reform that will contain costs, that will improve quality, that will help enable every American to have access to affordable, meaningful health coverage in this country.

I yield back the balance of my time.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. HIMES (at the request of Mr. HOYER) for today on account of death in the family.

Mr. HILL (at the request of Mr. HOYER) for today until 1 p.m. on account of personal reasons.

Ms. CORRINE BROWN of Florida (at the request of Mr. HOYER) for today after 2 p.m. on account of district business.

Mr. BACA (at the request of Mr. HOYER) for today and June 12 on account of a death in the family.