then as they compare that against where this is coming from, is it worth adding to the Federal budget to take from Social Security, to take from our children and grandchildren, to tax small businesses and to tax every family on their energy bill? These are the questions that Americans are pondering. These are the questions we are fighting.

And I will finish with my friend from Georgia (Mr. BROUN).

Mr. BROUN of Georgia. I thank the gentleman for yielding. One other place that they are proposing taking money from is from our defense, from procurement. They are going to take away from our troops, and that is absolutely the worst thing to do. We live in a dangerous world. And we hear people talk about we have got to support our troops. But they want to take away the procurement that is absolutely critical for us to have a strong national defense. Constitutionally, that is the major function of the Federal Government. And the liberals want to take money away from our troops who are fighting for our freedom, who are giving up and their families are giving up sometimes their lives, their limbs and a whole lot of sacrifices that they are giving. And what we are hearing from the other side is they want to take away from our troops and take away from our defense.

The anti-missile defense system is another area that they are talking about taking money from. Just last week I went and watched a rocket shoot down another rocket, a SCUD missile. It was just a phenomenal test, and they want to cancel that, which is going to make us less secure as a Nation. We can't continue down this same road. We have got to stop it.

Thank you.

Mr. SCALISE. I thank my friend from Georgia. And that is why, we are living in challenging times, but that is why we are proposing alternatives. As we have talked about the problems of this budget, we have good alternatives we will be talking about more throughout the course of this year.

And I thank the Speaker for allowing us this time.

HEALTH CARE REFORM IS NEEDED

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

Mr. GINGREY of Georgia. Mr. Speaker, I thank you. And I thank our side of the aisle for having the opportunity to speak to our colleagues, both Republicans and Democrats tonight, about a very, very important issue. The team that just spoke, Mr. Speaker, on the floor of this House about much of the spending and the plans and the too much spending, too much taxing, too much borrowing theme, which is absolutely what the American public, Mr. Speaker, needs to know about, including the plans and the spending and to have a comprehensive health care reform plan that we would vote on, we literally, Mr. Speaker, would vote on before this body and the other body goes on the traditional August recess. That is what, just barely a little more than 4 months away. And the big question is not do we need health care reform? I think my colleagues, and particularly my colleagues on this side of the aisle, who are doctor Members of this body, who are with me tonight to discuss this, the issue of health care reform, we do not disagree, Mr. Speaker, and my colleagues, that this needs to be done.

Nobody, whether Republican or Democrat, whether majority or minority, would want to see 47 million people in this country to have no health insurance whatsoever, and maybe another 25 million that are underinsured. And, yes, indeed, it could happen to one of my adult children and their young families. They all have decent jobs, but one major illness away from being underinsured and possibly ending up in a bankruptcy court, facing foreclosure on their homes and these kind of crises that we all agree we need to avoid.

So the reform of the health care system is not really a question of whether or not this side of the aisle agrees. We do agree. It is a matter, though, of how we do it and when we do it, and what we can afford to do. And I think that what the President has proposed so far is, just as we hear about his overall budget in a 10-year projection, and the numbers that we received over the weekend from the Congressional nonpartisan budget office, of unsustainable debt, deficits that will lead to possibly doubling of the national debt within 10 years. It is something that really has to be addressed.

Well, Mr. Speaker, tonight, we are here with, I am leading the hour, but I am very pleased that some of my colleagues on the GOP Republican Doctors Caucus have joined with me. And I wanted to set the tone for what we will talk about during this hour, and that is about physician work force; and will we have the manpower, when those 47 million hopefully do have health insurance, and the under-insured are fully insured, where are we going to come up with the doctors, the health care providers, to be able to provide that care?

Having a plastic card, Mr. Speaker, that says you are covered and you have access doesn't guarantee any individual that they are going to be able to have a provider who is going to see them.

□ 2200

And my fear is that they will not be able to have that access, particularly if the majority is successful in their plans to have a government default option to go along with, let's say, Medicare and Medicaid and TRICARE and veterans' health care benefits and the CHIP program. It is just adding one more responsibility of the Federal Government to control all of health care, and that is really what we are going to talk about tonight.

As I walked over here, Mr. Speaker—I was walking in the building, into this great Capitol House Chamber, the people's House—there was an emergency, and I saw physicians from the office of the House physician—paramedics, nurses—sprinting to the ambulance that is parked right outside this building for just such an emergency. I thought to myself, you know, thank God for the health care system that we already have. We definitely can improve upon that, and we will talk about that tonight, but thank God that we have that ability to respond in that manner.

It makes me think, Mr. Speaker, of the tragedy that occurred up in Canada in regard to this famous actress—and I will not mention her name—the tragic death of that actress after what seemed like a fairly routine, snow-skiing fall in which she got up, dusted herself off and said: I am fine. I do not need any medical care. Let me just go back to my resort hotel room. I am fine. Of course, that is what she did, and we all know now that 2 hours later, when she began to get into trouble and, maybe, passed out and a 911 call was made, it was 4 hours later that she was finally seen at a major medical center that could respond to this subdural hematoma that she obviously had developed. By that time, she was brain dead, and a life was lost, not just a life of a famous person and a prominent person but a mother of young children and of a devastated family.

So when we, Mr. Speaker, hear this talk about a single-payor system, of a government-run system not unlike the Canadian system—I am not necessarily picking on Canada. They are our good friends and neighbors to the north, but the same thing could be said, I think, about the system in the U.K. or in Taiwan or in any of the other countries that have a national health insurance, government-run program. If this accident had occurred, I think, out in Colorado in the United States, that young mother and famous actress would be alive today.

So these are some of my thoughts as we begin to discuss. I call on my colleagues, the doctor colleagues, who are with me tonight. I want to ask my colleagues to focus their attention on this first poster. It is titled ''A Second Opinion,'' and then, of course, it is subtitled ''Strengthen the Doctor-Patient Relationship.'' That is what we want to do, and that is what we will talk about.

With this second opinion theme, I think, most people associate a second opinion with a medical opinion, and understand that, when they go to the doctor, sometimes a second opinion is very, very valuable. In fact, I think almost always it is very valuable. So it is important when the other side of the aisle—when the majority party—says or some of their news media, co-conspirators, if you will, who support a

national health insurance program or any major issue that the majority party is promoting says, well, the Republicans, all they are is a party of ''no,'' they do not have another alternative. They are just saying, well, we are going to stand in the way of something that we do not like because the majority party has presented it, and this is all political.

Mr. Speaker, nothing could be further from the truth, and that is certainly true in regard to the health care of this Nation. This second opinion theme could apply to energy; it could apply to what the previous team was talking about in regard to the budget and spending. We do have a plan on the Republican side on all of these issues and, if you will, a second opinion Republican plan on health care.

So, with that sort of setting the theme, I want to go ahead and recognize my colleagues. I am going to first call on the gentleman from Pennsylvania, my classmate who has been with me here in the House—and we are now serving our fourth term—and that is Dr. TIM MURPHY from the great State of Pennsylvania.

Dr. MURPHY, I would like to give you an opportunity to talk about some of the issues that you have been focusing on, not just as part of the Republican Doctors Caucus but since you came to Congress some 6½ years ago. I will yield to the gentleman from Pennsylvania.

Mr. TIM MURPHY of Pennsylvania. I thank the gentleman from Georgia, not only for your leadership in health care but for your time here.

You know, we have many times discussed the issues involved in health care, and although I hear many people talk about the issue of accessible and affordable quality health care, very often the solution offered in this body by government is more government, and that is health care is expensive, so let's have someone pay for it—the government. Along those lines, Medicare and Medicaid oftentimes list it as, because so much is spent there—and I think Medicaid is $350 billion a year there. Between Medicare, Medicaid and the VA, almost half of the Federal mandatory budget is spent.

The question is: Are they effective? Are they efficient? Does it have quality-based health care?

I want to bring up just a couple issues here and emphasize the importance of that doctor-patient relationship. I am a psychologist. For many years, I have worked for hospitals in the Pittsburgh region in the pediatric, maternity and general medicine settings, but I have always had a strong relationship in working with a wide range of physicians and with other health care specialists, recognizing it is a team and in letting the team do their work that you really end up with some significant savings in quality of care. Let me talk about a couple of ways that that does occur.

A recent report sent out by the New England Health Care Institute noted that the U.S. really spends more on health care than any other nation on Earth, and many times people talk about the negatives of our health care system in terms of higher rates, for example, of infant mortality, but there are concerns about how that data is reached. I will not go into that now.

What I do want to point out, however, is that out of this $2.3 trillion health care system, which is very expensive and gets in the way of a lot of families affording health care, one of the deep concerns, perhaps, is that 30 to 40 percent of those health care dollars are wasted. $600 billion to $700 billion is what is listed in this report. Let me name a couple of things that go into this. If we let the doctor-patient relationship take supremacy over this and let physicians make decisions for what patients need, there are some changes we might see.

First of all, unexplained variations in the intensity of medical and surgical procedures, including but not limited to end-of-life care, the overuse of coronary artery bypass surgery and the overuse of percutaneous coronary procedures has the potential of avoidable costs of $600 billion. The misuse of drugs, overprescribing and underprescribing: some $52 billion. The overuse of non-urgent Emergency Department care: the savings could be $21 billion. The overuse of generic antihypertensives: a potential savings of $3 billion. The list goes on.

Now the question is: Why would these conditions exist?

Well, actually, government, itself, stands in the way in many cases, and sometimes, well, it is the way health insurance is set up, but if the issue were instead that physicians could be the ones who are moving forward in this, I believe a lot of savings could take place. I believe what we should be doing as a legislative body is finding ways to break down those barriers and really helping to improve. One of the points to be made by a number of the doctors here on the floor tonight is about having more physicians involved. Let's take one of those aspects.

Having a health care home is important, and one of the health care homes for people in some areas has to do with having a community health center. Now, community health centers provide great quality of care with a wide range of medical services, as my colleagues note. Yet there is a shortage of physicians, in part, because it is not the best paying position in the world, but many physicians want to help. The strange thing about this is that, in a wide range of health care areas, if you work at a community health center, your medical malpractice insurance is paid. If you volunteer, you are on your own, and so these clinics say, We cannot possibly afford that. There are different kinds of malpractice insurance that is not important to get into at this point. We have tried a number of times to allow it so physicians could actually volunteer—so psychologists could volunteer, so dentists, podiatrists, social workers, and nurse practitioners—but no, the government says, We cannot let you do that.

There are also areas, too, that come up here in terms of how we could let disease management work. Here is one of the strangest things that happens with Medicaid:

You know, one group that has a great deal of problems is that of people with severe diabetes. The severe diabetics, if they have problems with the circulation in their feet, for example, the real tragedy might be that they might have their feet amputated, but isn't it strange that Medicare and Medicaid will not pay for that physician or that nurse to monitor the patients closely—to call them, to work with them, to do more than just give them a pamphlet, but to work closely with them to keep them out of the hospital, to make sure that they are getting their insulin, to make sure they are monitored for their weight, et cetera, but we will not pay for that? We will pay $50,000 for that tragic surgery that could have been avoided, but we will not pay money to help when they manage the care.

Now I might say that there is a recent study that came out that, I believe, is filled with methodological flaws, saying that disease management has some questionable applications. Unfortunately, they focused on those who oftentimes had the most severe illnesses. As I am sure many of the physicians here tonight can attest, the real value is getting to that patient early or when the complications begin to show up rather than to wait until the end. I know, in my career as a psychologist, I had a patient who is now a deeply depressed, suicidal inpatient. When you could have been working with them years before, it makes a big difference in their outcomes.

We have to make sure that the system that we allow here with health insurance and with physicians working with patients really allows for a great deal of predischarge planning, of working closely and individualizing that care and for making sure that it is there.

Let me mention a couple of other things as we proceed forward. Recent legislation under the House set aside nearly $2 billion to help physician practices have health information technology. A good idea. The question is how it is done. If that health information technology is merely paying for keeping hospital records on a computer, that is not going to be enough because that is a passive system that only makes it a little easier to pull up records rather than having to wait for the records to arrive.

What we need is a smart, interactive system that is portable for the patient so that records follow the patient, not so that patients follow the records. We have to make sure it is private, that confidentiality is protected, and we have to make sure it is personal so that the relationship between doctor

and patient is what is paramount here. That physician and information they are obtaining and what they are writing whenever they have a diagnosis is a smart record that also helps provide information to that doctor about best practices, about feedback, about prescriptions, and even about the feedback of whether or not that patient got that prescription and if he is following through. It is all of those things. In today's world, because there is a shortage of physicians and because insurance with Medicare, Medicaid or private insurance oftentimes does not pay for having the physician actually work to follow up with the patient, then that health IT is just one, big, expensive thing on the desk of the physician, and it is not really providing the care they need.

Let me mention one other thing here, and that has to do with point of care lab tests. The system we have designed is one where—and because some physicians have been found when they own the labs—the concern was were they overprescribing lab tests. I would love to hear some input from my physician colleagues on that, too. So what did they say? They said, Let's not allow physicians to do this at all, where sometimes the most valuable thing is if the physician says, I need an x-ray; I need a lab test; I need this information right away. Instead, they have to send that patient out to a lab or send the information out. It could be a couple of weeks before they would get it back.

The best way to improve patient compliance is quicker information. Even to allow, for example, pharmacies and drug stores to provide some of this lab information would be more valuable. All this feeds into the system that part of the way to save the $600 billion or $700 billion worth of loss in the health care system is to put the tools in the hands of those who provide the health care. Make sure there are enough physicians. Make sure they have the tools they need so that as they diagnose, as they prescribe, as they work with other colleagues in the health care field that that information is shared in an effective way that is personal, that is private, that is portable, and actually that is permanent, too. These are not records that are lost as a person moves on to another health care plan or whatever they do in life.

Part of what we are doing here as the GOP Doctors Caucus is operating on the idea that we are all gathered together here to really work on making sure that we are developing patient-centered, patient-driven health care reforms based on quality, access, affordability, portability, and choice. Over the coming months, you will hear from us continually speak about this because we believe we have a health care system that can be based upon those, that can save massive amounts of money and that can save hundreds of thousands of lives. That needs to be our goal, not only to do no harm but to make sure we put health care back in the hands of those making those health care decisions. In so doing, we go at the very thing that people are raising the concerns about, and that is making health care more affordable and more accessible with quality as the underlying point.

With that, I yield back to the gentleman from Georgia.

□ 2215

Mr. GINGREY of Georgia. I thank my colleague, my co-chairman of the GOP Doctors Caucus and of all of the important points, Mr. Speaker, that Dr. MURPHY brought to us. That point he made about the doctor-patient relationship being paramount I think is the most important. And that is our concern that if we go to a government-run, totally government-run system, that that will be sacrificed and that will be sacrificed badly.

Before I yield to my colleague, Dr. FLEMING from Louisiana, Mr. Speaker, I wanted to draw my colleagues' attention to this next slide in regard to the supply/demand crisis.

Even if nothing changed under the current system, we already have a shortage. And it will only get worse as we approach the year 2025. There are a lot of reasons that. Growth in an aging population. There is an immense physician shortage on the horizon. It is expected by 2025 to be a shortage by 125,000 physicians, and the demand for care by that time will increase by 26 percent.

Now, the bulk of the shortage—and these are statistics from the Association of the American Medical College; this was a center for workforce studies back in 2008, so just a year ago—but the bulk of that shortage, in fact, 37 percent of the projected shortage, is in primary care physicians. And I don't disagree with President Obama and the majority party in regard to the need to get more primary care physicians, to have these medical homes that we talk about, to stress wellness. And that is so important.

So it couldn't be more timely for me to call on Dr. FLEMING, who—he specializes in family practice, and has for a number of years, in south Louisiana.

And it is indeed a pleasure to yield time now to Dr. JOHN FLEMING.

Mr. FLEMING. I thank the gentleman for yielding. And also I want to thank Doctors MURPHY and GINGREY in your leadership on this subject and your years in Congress.

I want to say first of all, Mr. Speaker, that health care in the United States is among the best in the world, but the financing of it is a basket case. We have 47 million uninsured Americans and they are not who you think they are. They are not the poor; they have Medicaid. They are not the elderly; they have Medicare. They are not workers for large corporations or the government, such as us tonight. They are owners of small businesses and their employees. They have tremendous difficulty acquiring affordable insurance. And I see this every day.

I, myself, am a small business owner apart from being a family physician with still an active practice. And what is, in fact, going on in this situation is this: the risk pool for a small business is very small, and all it takes is one heart transplant or certainly renal dialysis and it can blow the whole plan up; everybody in the company can find themselves without insurance.

Well, I think that we, on the GOP side, we Republicans, and certainly we Republican physicians, agree with the other side and also with our President that we do need comprehensive health care. We need access to health care and coverage for all Americans.

And in fact, when you think about it with the entitled laws in the 1980s, every American today is entitled to health care regardless of his ability to pay. And if you don't believe me, go to an emergency room demanding care, and you will receive that care without anyone asking about your ability to pay. And that is certainly an honorable and laudable value that we have.

The problem is that that same individual probably has an illness such as diabetes or hypertension, which, if they had received care early in the disease or maybe in a stage of prevention, would not only not be in the emergency room, but the outcome would be much better and the cost would be much lower.

So, you see, when someone goes to the emergency room or staggers into an emergency room perhaps on their death bed and we providers have to pull them out, somebody gets a bill for that. And that bill is going to be many times higher than what it would have been otherwise. This, of course, creates bankruptcies. Many families end up filing bankruptcy after going through a major thing like this. So who absorbs that cost? The cost is absorbed by those who pay insurance premiums and taxpayers.

So it is not free medicine. So since we're already providing the resources, why not front-load that into preventative and early diagnostic care?

I am a strong believer in health care reform, and I will just tick through several of them that I think need to be implemented with all dispatch.

First, we need to have portability. Dr. MURPHY mentioned that before. We do need to go to electronic health records in a way that is going to make practices more efficient. We need to do away with archaic insurance laws which cause these small risk pools. We need to create large risk pools and make ''pre-existing illness'' a term that is no longer in the American lexicon.

We need to make sure that everyone gets basic private health care insurance, and I think that family physicians should be the linchpin in health care because it has been proven time and time again that family physicians, the primary care providers, create a much more efficient form of health care, but they also work very closely

with their colleagues to ensure that they get uploaded or downloaded or whatever is necessary in order to get the best.

But let me comment on one more thing before I yield. And that is that we're right now in a crossroads of decision making. We all agree that we need comprehensive health care reform. The question is will it be a single-payer governmental system such as what we have today with Medicare or Medicaid, or will it be a private health care system?

Now if we expand Medicare to include everyone, as some have suggested in this body, what is going to absorb that overflow and cost?

You see today, Medicare is somewhat successful in that the fraud, abuse, and the waste is being absorbed by the taxpayer and also those who pay private subscription rates. When we go to an entire system that is a single payer Medicare system, there will be nobody to pick up the tab at that point. So what are we left with?

Well, number one, we know that when you have a government-type system, a micromanaged system from the top, you end up with spot shortages, which we already have today; and I am sure that Dr. GINGREY will discuss that further. But also you have a situation beyond the spot shortages that is how do you control costs? And government can control costs only one way, and that is rationing. That means that somebody is told ''no'' when there is in fact something that can be done.

On the other hand, you take a private system, even if it's funded by government entities, either partially or in whole, if it's administered privately, it is far more efficient. And I will just give you a quick example.

Today, we talk about fraud and abuse and waste. And how can we find this fraud and abuse and what do we do about it? Well, we have to go after it legally to prosecute it. It is very expensive. You only find the tip of the iceberg. In a private plan, everyone works to build efficiency in the system, and if someone is just a little bit off the graph, you reeducate, you help them, or if they don't respond. You terminate them. You don't have to worry about finding someone who is manufacturing health claims or any of that kind of nonsense. It just doesn't happen.

So the bottom line is we need to get physicians, all providers, on board with working towards a much more efficient system, and we need to get the patients involved as well.

For many years, as my colleagues here, I know, have experienced, you couldn't talk patients into accepting generic drugs. Today with the tiered payment systems, the incentives are in favor of generic drugs, and now you can't beg patients not to take generic medications because they are much cheaper.

So there is a lot of work that we need to do, Mr. Speaker, and these are just some of the suggestions.

But finally, I would just like to say that we need to do a lot more to improve the availability, particularly of primary care providers, and we're going to have to do that by increasing the reimbursement rates because what we're really getting is a paradoxical effect. The more we clamp down reimbursement rates for family physicians and others, the more they have to do other things to make up the difference, which echoes costs throughout the system.

So thank you.

Mr. GINGREY of Georgia. I thank the gentleman from Louisiana, the good doctor.

And, you know, again, stressing this theme of going forward, the shortage of manpower, it has a lot to do with physician satisfaction in their chosen profession. And I think that is basically what we want to make sure, Mr. Speaker, that everybody, all of our colleagues understand on both sides of the aisle, that as Dr. FLEMING was saying, if you have access to an affordable health insurance policy, as we all hope and pray for those 47 million, if it's a system that is run by the government and we crowd out the private market completely—and that is one of my big fears and I think that of my colleagues—then these young men and women that normally would—our best and brightest who would normally want to go to medical school and maybe become a family practitioner and provide this care, they are not going to do it. They are going to choose another profession. They are going to maybe become lawyers, but not doctors. And I think that is a big concern.

And I don't think anybody knows more about this than the next person that I will yield to, Dr. PHIL ROE, a fellow OB–GYN physician, who has provided women's care and delivered lots of babies in the Tri-City area of Tennessee—Kingsport, Bristol, Johnson City—and he knows of what he speaks. And I think he's going to talk to us a little bit about what probably everybody in this Chamber is aware of, and that is something called TIN care in Tennessee, and I am happy to yield to my colleague, a freshman representative doing a wonderful job, Dr. PHIL ROE.

Mr. ROE of Tennessee. A couple of things to historically go back over, and I might mention that if the public out there that is watching this tonight thinks that the government's management of AIG is good, then they are going to be thrilled to death with the government management of health care, I can tell you that.

I am going to go through a couple of historical things.

You and I went through the managed care in all of the 1990s and all of the promises that were going to occur, the cost savings and so forth, that didn't show up; and one of the things that concerned me about health care going forward is accessibility, not just in physicians but in other health care providers.

For instance, our nursing staff. By 2016—that is 7 years from now—we're going to need one million more registered nurses in this country. And in the next 8–10 years, more physicians will be retiring and dying than we're producing in this country.

And let me go back a few years to read this to us just briefly. It is a 1994 report to both Congress and the Secretary of Health and Human Services, the National Council on Graduate Medical Education noted, ''In a managed care dominated health care system, the Bureau of Health Professions Commissions projects a year 2000 shortage of 35,000 generalist physicians and a surplus of 115,000 specialist physicians'' and recommended that the ''nation 'produce 25 percent fewer physicians annually.' '' That was just 13 years ago.

''In 1995, the PEW Commission recommended medical schools 'by 2005 reduce the size of entering medical school class in the U.S. by 20–25 percent,' arguing further that this reduction should come from the closure of existing medical schools.''

Have you ever heard of anything as ridiculous as that? And think of what a catastrophe that would have been had we followed this.

The Institute of Medicine committee ''recommended 'no new schools of allopathic or osteopathic medicine be opened, that class sizes in existing schools not be increased, and that public funds not be made available to open new schools or expand class sizes.' ''

Now, to give you an example just to reiterate what you said, if physicians don't retire—and there are over a quarter of a million physicians over the age of 55; that is a third of the practicing doctors in America—do retire in the next 10 years, which they most certainly will, this number—and the reason that is so important for the folks listening is is the access to care. What happens will be that patients won't have access to their physicians, and I have seen that.

I have practiced and trained in Memphis, inner-city Memphis and a rural area where I am now, and you all know inner-cities and the rural areas are the two most underserved areas in America now.

□ 2230

Patients in those areas are now not only having a difficult time paying for care, just finding someone to give them the care. So this particular recommendation that was made, if it had been followed, would have been an utter disaster for the American health care system.

We need to encourage more and more young people. The community where I live has a Quillen College of Medicine, has 26 students. It hasn't increased the class size in 20 years. Why? They don't have funding to do it, and we have a tremendous shortage of primary care physicians.

At the end of my practice last year when I was still in the operating room, one of the most difficult things I had to do was find a primary care provider for a post-surgical patient. It is difficult to do now, and it is going to get much, much, much worse.

I will mention a couple of things about our TennCare system, and it was a system that was started with noble objectives, to provide care for all Tennesseans. It was rapidly put together, and I heard you say at the beginning of this, we don't need to do this fast; we need do this right. It's to important.

The health care that we provide affects every citizen in this country. Every one of us is going to have to abide by this system, and who should be in control of that system are the patients and the physicians. That's who should be making these health care decisions.

Now, in a survey that was done in the current budget crisis in the State, the State was about $1 billion short before the stimulus package came along. And what the stimulus package does is simply put off these hard decisions for about 2 years in our State. But that survey showed that nearly half the physicians in the State of Tennessee would end their participation or consider ending their participation in one or both of the MCOs in the State—that's the medical care organizations—if those cuts were enacted to ease the State budget crisis, and another 31 percent said they would reduce the number of TennCare patients they're seeing. That's 80 percent either would stop or reduce the number that they're currently seeing.

I spoke to one of our large hospital administrators this past weekend, and right now, we have TennCare covering 60 percent of hospital costs. Medicare covers about 90 percent of hospital costs. The uninsured obviously cover none of the costs, and the private payers have to make up that difference to keep the hospital open.

You hear that your medical benefits are tax deductible and so forth. Well, I would argue they're not. If you go ahead, that's a hidden tax right there that a person who has private health insurance has to pay when they pay it. Now I know this year because in the past year, I bought my own policy. I've a health savings account, and to buy this health savings account, I was fortunate to be able to do that. It is about $1,000 a month, but I had to earn about $18,000 to pay that after taxes. So, for a person with a health savings account or a small business or whatever, they're on your own, you're in real trouble in this country now.

And I think the health care plan in this country should have about four principles. One is a basic health plan for all Americans, and we can define that a lot of ways, but I think one of the ways you could define it is the least expensive government plan.

And number two, illness should not bankrupt you. If you get sick, if you develop multiple myeloma or a malignancy or something or at no cause of your own, you should not be bankrupted by that illness.

And number three, it should be portable. You should be able to move. If your lose your job, as many people have done during this current recession, you should be able to carry your health benefits along and not have COBRA payments that people with expensive, who let's say Bill Gates would have a hard time paying.

So I look forward to continuing this discussion in the future.

Mr. GINGREY of Georgia. Well, I thank the gentleman from Tennessee and the words of the wisdom that he brought us to.

Before I yield to my colleague from Georgia, I want to just make a few comments, Mr. Speaker, about some of the statistics in regard to physician workforce shortage. Any my State, my home State of Georgia, it's ranked 40th in the Nation with respect to active physicians per 100,000 people. In Georgia, there are 204 per 100,000. National average is 250.

Georgia also has the dubious ranking of 44th in the Nation with respect to active primary care physicians. You just heard that from Dr. FLEMING, and you will hear it in just a minute from Dr. PAUL BROUN, a family practitioner in Georgia.

Seventy-three primary care physicians per 100,000 in Georgia; the national average, 88.1. Eighty-nine percent of job seekers graduating from Georgia medical residency programs received and accepted job offers in 2004 but only 54 percent of them stayed in my great State of Georgia.

So just kind of bringing home some of the statistics from where we live and represent.

At this time, I'm proud to yield to Dr. PAUL BROUN, the gentleman who represents my hometown of Augusta, Georgia, and Athens, Georgia, the home of the University of Georgia, the great bulldog nation and many, many wonderful counties in between.

I yield to the gentleman from Georgia, Dr. PAUL BROUN.

Mr. BROUN of Georgia. Thank you, Dr. GINGREY. I appreciate you bringing these very important points to the floor tonight.

I want to talk about the issue that you just brought up about the lack of primary care physicians in our home State of Georgia, but before I do that, I wanted to remark about something Dr. MURPHY brought up tonight, and that's the cost of regulatory burden on the health care system, particularly as it deals with lab and X-ray and those types of things.

I want to give an example. Back a number of years ago, I was practicing medicine in rural south Georgia, and Congress passed a bill called the Clinical Laboratory Improvement Act. It was signed into law. It's called CLIA. I had a small lab in my office, totally quality controlled, wanted to make sure that the tests that I did there were accurate so that I could give the best quality care to my patients that I possibly was trained to do.

And CLIA shut down that lab. Well, why? Well, the reason that CLIA shut down the lab was that the people here in Congress decided that it was a conflict of interest for doctors to own labs and that they may be an overutilization. But the thing is, what this has done is it's markedly driven up the cost of health care for all of us, the cost of insurance, and it made insurance less affordable.

Now, to show you how that works is that in my lab, if a patient came to see me with a red, sore throat, maybe had little white patches on their throat, running a fever, coughing, aching all over, runny nose, this could be a strep throat, need a penicillin shot or some antibiotics. It could be a viral infection. They look exactly the same. I would do a test in my office called the complete blood count, or CBC. It took 5 minutes to do the test. I charged $12 for the test. I made 50 cents on it, if any at all.

Well, CLIA shut down my lab. I couldn't do those tests any longer. If patients came in with those same symptoms, I had to decide whether just to go ahead and give them antibiotics and expose them to the overutilization of antibiotics that, not only the exposure to them which could create superinfections, also increases the cost, because the overutilization of antibiotics markedly drives up the costs for all of us. Or I would do the test, and to do so, I would have to send them over to the hospital to get that done. It would take 2 to 3 hours to do a test I could do in 5 minutes, and it cost $75 whereas the test in my office cost $12.

You can see what that one test, the cost across the whole health care system has been for that one test for patients that come in with sore threats which is a very common illness that primary care physicians, like I, see.

So the regulatory burden on the system markedly increases the cost and makes it less affordable. So if we could get the regulatory burden off of the health care system, it would literally lower the cost of insurance and would make it more affordable.

We actually hear of about 47 million people in this country not having health care. Well, everybody has health care. As Dr. FLEMING was talking about, entitlement laws made it so that people could go to the emergency room and get health care. So everybody has access to health care. Everybody can get health care. The question is where do they get it, at what cost, and who pays for it.

Well, if we go to a socialized medicine system—and the code word for socialized medicine in this body here is comprehensive health care reform—if we go to socialized health care, it's going to make it less affordable and be harder for people to get health care, provided to them.

But in Georgia, we have a tremendous lack of primary care doctors. In fact, in more than one-third of the counties—we have 159 counties in the State of Georgia. Fifty-eight of those counties, over a third, are officially designated as primary health professional shortage areas. This means on average that there is less than one doctor per 3,500 people in those counties. About 1.5 million people in the State of Georgia alone are affected by the shortage of doctors.

We need in Georgia 259 more doctors to serve those underserved areas, just to fill that official estimate of shortage, and ideally, in fact, the experts say that there should be one doctor per 2,000 people. To attain that goal, we would need another 421 doctors, primary care providers, to face that shortage.

Now, the Medical College of Georgia, my school that I graduated from, is just expanding and developing new campuses. There's one that's going to start accepting their new class in Athens, and they're going to have other communities around the State of Georgia to try to train physicians. But we've got to give doctors the freedom to practice medicine, not put constraints on them, not to shackle them. We've got to get the regulatory burden off of their practices so they can practice medicine without all this government intrusion so they can give the care that they're trained to give.

And going down this road of socialized medicine that this administration and that the liberal leadership here in Congress is pushing us towards is going to hurt the health care system. It's going to create a larger doctor shortage, and it's going to mean that people have less access to care, particularly good, quality care.

So we need to have a patient-focused health care reform and not a government-focused health care reform, which is what we and the Doctors Caucus, what the Republican party is bringing forth as the solution to the health care crisis, which is actually a health care financing crisis, not a health care crisis in itself.

So I thank the gentleman for bringing this up tonight. I thank the gentleman for yielding, and I look forward to working with our colleagues so that we can actually find some commonsense, market-based solutions that we propose and, hopefully, the American people will demand it from their Member of Congress so that we can continue to give good, quality health care here in America.

I thank the gentleman for yielding.

Mr. GINGREY of Georgia. I thank my colleague, Dr. BROUN, for joining with us in this hour, talking about the issue of strengthening the doctor-patient relationship and not destroying it.

And as Dr. BROUN pointed out in some of his statistics, those shortages that he was talking about in the State of Georgia—and this is applicable to 49 other States as well—we're talking about under the current system. But once we cover the 47 million uninsured, and these numbers just get that much more difficult, and actually the shortage increases by 4 percent, and these statistics are frightening.

And before I introduce the next speaker, my colleague from Texas, my fellow OB/GYN colleague, I wanted my colleagues to see this next slide. And part of the reason of this physician shortage—and as I say, it will only get worse in the future—is declining reimbursement ranked as the number one impediment to the delivery of patient care.

Sixty-five percent of physicians surveyed said that Medicaid pays less than the cost of providing that care, and 35 percent of the physicians surveyed said Medicare pays less than cost of providing that care. Nobody in this House of Representatives has worked harder than my classmate, the good OB/GYN doctor from Plano, Dallas-Fort Worth. He has worked so hard to try to provide a reimbursement based on a reasonable formula and not this current sustainable growth rate.

Nobody can really understand how that's ever figured, but doctors know that every year it's figured in a cut in their reimbursement, and that indeed, Mr. Speaker, is not sustainable.

And with that, I yield to my colleague from Texas, Dr. BURGESS.

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Mr. BURGESS. I want to thank my friend for yielding. I should mention, of course, you know we passed out of our committee, the Committee on Energy and Commerce, just 2 weeks ago, H.R. 914, which would have, for the first time, increased the number of primary care residencies available. It was a self-replenishing loan program. Oftentimes, the biggest barrier to entry for a hospital that doesn't currently offer a residency program, the biggest barrier for entry is the cost for getting into that residency program. This will provide an ongoing self-replenishing series of loans.

We have been held up a little bit by the Office of Management and Budget. It is one of the weird things that happens to you here in Washington. Last year's Congressional Budget Office said this bill was not a problem financially. Last year's Congressional Budget Office is this year's Office of Management and Budget. And this year's Office of Management and Budget says, Wait a minute. If you make more primary care doctors, they're going to see more folks and they're going to send in more bills. It's going to cost more money. So we can't have that.

We've kind of reached a little bit of an impasse there. I hope to get past that. It just underscores sometimes the futility of working in this environment in which we find ourselves.

Now, just a few weeks ago I was fortunate enough to be asked down to the White House to participate in the health care summit, and President Obama, to his credit, as he was wrapping things up said, Look, I just want to figure out what works.

Well, I'm here to help him. I'm so glad to hear him say that. He says, The cake was not already baked. We would work through this in our congressional committees. He'll provide guideposts and guidelines. At the end of the day, it's going to be a congressional decision.

I applaud him if that's the case. I still have some reservations deep down inside that this bill has already been written in the Speaker's office. But I will take the President at his word because, after all, we are charged in the practice of medicine for following evidence-based practice. We are told to practice evidence-based medicine. We as policymakers should also practice evidence-based policy as well.

The reform discussion has centered primarily on the number of Americans who lack insurance. That's understandable. It's a good reason. The number is astonishingly high—and growing.

But, honestly, we do have to look beyond just the single knee-jerk, silver bullet response to, We want to fix the number of uninsured. Because that may not solve our problem.

We have a grand national experiment going on in the State of Massachusetts right now. A great increase in coverage because of an individual mandate. But we have a problem. We don't quite have the number of primary care physicians required to render the care to all those folks who now have that coverage.

So, across the Nation issues with the medical workforce are going to continue to loom large and, like my colleague from Tennessee, I can remember sitting in those medical meetings 15 years ago and hearing the stories about how we were over providered. I didn't even know that was a verb, quite honestly. We were over providered in health care in this country, and we needed to scale back the number of doctors we were producing.

Now, 15 years later, that sounds like nonsense. When you consider the length of time that it takes to make one of us, those of us who are on the House floor late tonight. I don't know. Certainly, 12 years after college and my professional education, it is not at all an uncommon story. It takes a long time to make one of us.

So changes in that pipeline really can have a dramatic effect down the road. It's so important for us to get the policy right.

Another point on our Energy and Commerce Subcommittee on Health. Last fall, we heard from a woman who's a pediatrician in rural Alabama. It sticks in my mind because she went into practice the same year that I did—1981. She has worked her heart out there taking care of poor kids in rural Alabama.

Her practice currently has reached a point where it's 70 to 80 percent Medicaid. And she can't keep her doors open. She's having to borrow from her

retirement plan in order to pay the overhead for her office to keep the clinic doors open.

Well, I learned that lesson a long time ago with managed care back in the 1990s. If you're losing a little bit on every patient, it gets harder to make it up in volume. The harder you work, the more behind you get.

That was exactly the situation that she had found herself in. It's because we require such a significant amount of cross-subsidization. The private sector has to cross-subsidize the public sector—Medicare or Medicaid—or doctors cannot afford to keep their doors open. Precisely the information you have up on your slide.

Government-administered health care misleads Americans into thinking that they have coverage. But the reality is they're denied care at the out end because there simply is not the doctors offices there to provide it.

Well, you have been very generous with your time. I'm going to yield back so we can hear from some of our other great colleagues who are on the floor with us tonight. I thank you for bringing this hour together.

Mr. GINGREY of Georgia. I thank my colleague on the Energy and Commerce Committee, Dr. BURGESS.

I want to yield to another of my physician colleagues from Georgia, Dr. TOM PRICE, an orthopedic surgeon who represents the district adjacent to mine, the Sixth District of Georgia.

Dr. PRICE is going to tell us a little bit about these 47 million uninsured, many of whom are employed and simply cannot afford what is offered by their employer, their portion of the premium, and many of them of course work for very small employers that can't afford to offer coverage at all.

At this point, I am proud to yield to my colleague, the chairman of the Republican Study Committee, Dr. TOM PRICE.

Mr. PRICE of Georgia. I thank my friend from Georgia, Dr. GINGREY, for yielding and for his leadership in this area and for organizing this hour this evening.

Mr. Speaker, you have heard a lot of conversation tonight about health care and about access and affordability and quality and primary care physicians. I think it's important to talk about the thing that all of those affect, and that is patients. Patients are what this is all about.

I'm pleased to join my physician colleagues on the Republican side of the aisle tonight to talk about patients and the effect of health care and national health care policy on patients.

If I think about the eight physicians who are here on the floor tonight, we probably have seen a half million patients in our professional life and get a sense about what it means to take care of people and make certain that they get well, depending on the malady that befalls them.

We all have our different principles about health care. Mine are five—the usual three: Access and affordability and quality. Then I add innovation and responsiveness. I think it's imperative we have a system that has the greatest amount of access, the greatest amount of affordability, the highest quality, and the most responsive and most innovative system.

I would suggest, as I know my friend would agree from Georgia, and my other physician colleagues here, that governmental intervention and increasing involvement doesn't improve any of those things. It doesn't improve access, it doesn't improve affordability, it certainly doesn't improve quality, doesn't improve innovation or responsiveness.

So what's the solution? What's the solution for the patients across this Nation who are maybe watching this evening, Mr. Speaker, and saying: What are you going to do?

Well, the solution, I believe, as I know my colleagues do, is to make certain that patients have ownership of the system. The only way to get the system to move in the direction that patients want it to move is to have a patient-centered system so that patients own and control their own health insurance policy.

Everybody's got to have health insurance. You can get to that system in a way that most of us support, which is through the Tax Code. Making certain that it makes financial sense for all patients to have health insurance. But, once they do, how do you make the system move in the direction it ought to move, and that is the direction that patients want it to move. It's to allow for patients to own and control their health insurance policy, regardless of who's paying the cost.

That's important because that changes the relationship between the insurance company and the patient. Right now, when the patient calls the insurance company and says, You're not doing what I need to have done, or my doctor recommends, the insurance company, by and large, says, Call somebody who cares. Because you aren't controlling the system.

When patients own and control the system, then the system moves in the direction that patients want it to move.

We are working diligently to come up with a product that will allow the American people to look to Washington and say, Hey, those guys are doing what we think ought to be done in our health care system.

I'm so pleased to be able to join you tonight and talk about positive solutions for our health care system that puts patients in control.

I yield back.

Mr. GINGREY of Georgia. Dr. PRICE, thank you so much.

Mr. Speaker, I realize that we are running very close to that witching hour. Maybe I saved the best until last. He probably thinks that I'm shorting him on time because his LSU Tigers whipped up pretty badly on my Georgia Tech Yellow Jackets in the Bowl game. That's is not the case at all.

I'm proud to yield to the internist and gastroenterologist from Baton Rouge, Dr. Patrick.

Mr. CASSIDY. You're so bitter about that loss, you call me Patrick instead of CASSIDY.

I actually teach residents. I'm still on faculty with LSU Med School. It's not accidental that we end up having too few specialists.

For example, just to put the issue into focus, only about 2 percent of medical school grads in 2007 planned to go into a primary care career. That's 2 percent.

Now, it's not accidental why this is. As it turns out, the Federal Government gives more money to train specialists. It gives less to train a generalist and more to train a specialist.

When you're out, reimbursement is less for visits, but more for procedures. So the primary care physician that we don't have enough of gets paid less for the amount of effort he or she puts into their job.

So I say this to say that it's Federal policies that have gotten us here, and there are wise Federal policies that can get us out. But I want to just give a little bit of humility to the people who want to remake our system, assuming that a top-down approach will benefit.

I echo what Dr. PRICE said—it's better to have that patient in charge of the system. When it's top down, we end up with systems which end up skewing us towards more specialists and fewer generalists. I think if we take history as a guide, we will say that we will be much better if the patient have the power as opposed to CMS or another Federal bureaucracy having the power.

With that, I yield back.

Mr. GINGREY of Georgia. Mr. Speaker, I thank Dr. Patrick. And I thank all of my colleagues. You can see the level of interest of the GOP Doctors Caucus. But we want to work with the physicians, the medical providers, the nurses on the other side of the aisle, and work in a bipartisan way.

In this area of a second opinion, we will continue to bring other issues forward as we continue in the 111th Congress.

Mr. Speaker, with that I yield back.

OMISSION FROM THE CONGRESSIONAL RECORD OF THURSDAY, MARCH 19, 2009 AT PAGE H3701

BILLS PRESENTED TO THE PRESIDENT

Lorraine C. Miller, Clerk of the House reports that on March 18, 2009 she presented to the President of the United States, for his approval, the following bill.

H.R. 1127. To extend certain immigration programs.

Lorraine C. Miller, Clerk of the House reports that on March 19, 2009 she presented to the President of the