

patients in that country. Pharmac says its goal is to use its “expertise” to “help . . . decide which new hospital medicines are cost-effective.” And like the government board in Great Britain, if Pharmac does not think a drug’s cost justifies its benefits, it can refuse to make it available to patients or doctors who want it.

One drug that Pharmac did not think was worth the cost was Herceptin, which had proven to be effective in fighting breast cancer. Although Pharmac began covering the drug for advanced breast cancer in 2002, it refused to fund the drug for early stage breast cancer. After a public outcry and a reevaluation of the decision, Pharmac finally relented and decided to allow the drug for early stage breast cancer in 2007, but only for a limited amount of treatments.

These kinds of decisions about which drugs should or should not be covered are based on a method commonly known as “comparative effectiveness.” Comparative effectiveness is not alien to the U.S. health care system. Indeed, the stimulus bill Congress passed earlier this year included significant funding to lay the groundwork for just this kind of research in the United States. In my view, the more research we do on the effectiveness of drugs and treatments the better. Doctors should have as much good information as possible in dealing with their patients.

What Americans strenuously oppose, however, is the government using this information to deny access to treatment or procedures that patients and doctors choose to pursue—just as government agencies such as NICE and Pharmac do in Great Britain and New Zealand. Americans oppose this kind of government-mandated limitation on health care. They simply will not allow it.

That is why my friend, Senator KYL, will propose a bill that will prohibit the government from ever using comparative effectiveness in this way. It is a wise bill, and it should be included as a part of any health reform we consider. Americans want their doctors to have clinical information on which treatments work best and which ones do not. But government bureaucrats should not be able to use that information to determine what treatments Americans can or cannot get. That is a decision we currently leave between a patient and his or her doctor, and that is where it should remain.

Americans want to see changes in the health care system, but they don’t want changes that deny, delay, or ration care. They want reforms that control costs, even as they protect patients. They want us to discourage frivolous medical liability lawsuits that limit access to care in places such as rural Kentucky. They want prevention and wellness programs that cut costs by helping people quit smoking, overcome obesity, and diagnose illnesses early. And they want us to address the needs of small businesses without im-

posing new mandates or taxes that kill jobs.

All of us want reform, but the government-run plan some are proposing in the United States is not the kind of change Americans are looking for. We should learn the lessons from problems we have seen in countries such as Great Britain and New Zealand. We should learn a lesson from the nightmares so many people in these countries and their families have endured as a result of government-run health care and the bureaucratic government boards that almost always come with it.

Madam President, I am about to yield the floor, but before I do that, I see my friend from Arizona is on the floor. I want to express to him my gratitude for his leadership on this very important issue. The most important issue we will be dealing with this year is the question of whether the government should literally take over and run 16 percent of our economy. We have seen the government take over banks, insurance companies, and automobile companies. Now it appears as if there is an effort underway to take over health care as well.

I thank my friend from Arizona for the contribution he has made on this important issue in the past and say we are looking forward to working together on this in the future.

Madam President, I yield the floor.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Under the previous order, there will now be a period for the transaction of morning business until 2 p.m., with Senators permitted to speak for up to 10 minutes each, with the first hour equally divided and controlled between the two leaders or their designees, with the Republicans controlling the first 30 minutes and the majority controlling the second 30 minutes.

The Senator from Arizona.

HEALTH CARE REFORM

Mr. McCAIN. Madam President, I rise to discuss two issues this morning, health care reform and also the pending supplemental spending bill that, according to news reports, does not include the Senate language that explicitly allowed President Obama to keep photos of detainee abuse during the Bush administration confidential.

I thank my friend from Kentucky, the Republican leader, who has shown such impressive leadership on, as he describes, probably the most important domestic issue that certainly will be addressed by this Congress. I look forward to working with my colleagues

over the next few weeks on legislation reforming our current health care system.

Americans are looking to Congress to enact health care legislation that provides all Americans affordable access to health insurance and the ability to choose the health insurance policy that fits each American’s needs. Yesterday, it was reported that 62 percent of Americans support Congress enacting a major overhaul of the U.S. health care system, according to a Diageo/Hotline poll.

I believe health care should be available to all and not limited to where you work or how much money you make. I believe any proposal must use competition to improve the quality, availability, and affordability of health insurance and match people’s needs, lower prices, and promote portability. I believe American families, not Washington bureaucrats or insurance companies, should be in charge of any health care decision. But I don’t believe we need to expand government’s bureaucracy to control one-sixth of our economy to ensure the uninsured get health coverage. Nor do I believe Americans should be asked to pay more in taxes to cover the costs of any comprehensive health care reform legislation.

Last month, the Wall Street Journal stated:

But now Democrats need the money to finance \$1.2 trillion or more for their new health insurance entitlement. . . .

A sampler:

End or limit the tax-exempt status of charitable hospitals. . . .

Make college students in work-study programs subject to the payroll tax. Also targeted are medical residents, perhaps on the principle that they’ll one day be “rich doctors.”

I agree that any real health care reform proposal must address the tax treatment of employer-provided health benefits, but not in such a way that would force Americans to fork over more of their hard-earned money to the Federal Government, particularly during these difficult times.

Today individuals who receive health insurance through their employer are not taxed on their health care benefits, as we know. However, those who purchase coverage on their own do not receive such a tax break. That is unfair and regressive. It hits those who need this tax break the most—the self-employed or working poor whose employer does not offer health insurance coverage.

To offset the taxable treatment of this income, I believe Americans should have funds returned to them to assist with the cost of acquiring health insurance. An approach such as this treats individuals equally, in stark contrast to the system we currently have.

Key to any proposal is a policy that allows people to have accessible, portable, and affordable health insurance coverage. Policies should also address what I hear from Americans everywhere I go—choice. Americans want