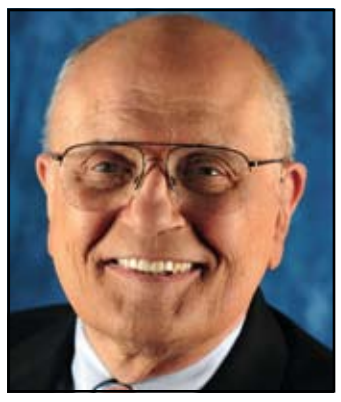
HEALTHCARE

In the 111th Congress









A Special Report Prepared by The Washington Times Advocacy Department

Healthcare Reform Can't Wait

By Majority Leader Steny Hoyer (D-MD)

Since 2000, the health care premiums of American families have more than doubled, while wages have stood still. Last year alone, employees' out-of-pocket healthcare costs jumped by more than 10%. None of us can wait for reform—not the working families being squeezed more and more by healthcare costs each year, and not the 45 million Americans with no coverage at all.

In recent months, Democrats have often been told that the economic crisis means that we can't afford to be bold, that confronting the recession will take all of the resources we have. But here's what isn't being said often enough or loud enough: Reforming the American healthcare system will have a profound, positive impact on the American economy.

Today, America spends $2.5 trillion a year on health care, 17.6% of our GDP. Without a change, that number is slated to rise to $4.4 trillion in less than a decade. And as the recent CBO projections have shown us, our country is facing unprecedented levels of near- and long-term debt and deficits. It is impossible to pay down our debt, reduce our spending, and get a handle on our economy without tackling healthcare costs.

Those costs are crippling American businesses. Our companies spend more than twice as much on health care as their foreign counterparts, putting them at a severe disadvantage against competitors around the globe. The CEO of Starbucks once testified before Congress that their firm spent more on health care than on coffee; the Big Three automakers tell us that an extra $1,500 is tacked onto the price of every car they sell, just to cover health care costs. Small businesses are also under intense pressure—their health insurance costs have increased by 129% since 2000. Healthcare reform means a level playing field for our employers and more jobs for American workers.

Businesses aren't the only ones feeling the squeeze. With 61% of Americans getting coverage through their employers, lost jobs mean lost healthcare. Every time the unemployment rate ticks up one percent, it means that 2.4 million more people lose their employer-sponsored insurance. And in this recession, 14,000 Americans are losing their coverage every day.

Even those of us lucky enough to have steady jobs and good benefits are paying more, for less, every year. Beneficiary costs are going up, employers are scaling back coverage, and, in some cases, current insurance law means that workers are just one disease away from disaster. Lifetime caps, annual caps, and exclusions for pre-existing conditions mean that even Americans with insurance can find themselves unprotected in a time of sickness.

America is home to the best practitioners in the world, the greatest technology in the world, the most advanced research and development in the world—but it is also saddled with a system in desperate need of reform.

Over the coming weeks and months, Congress will debate just what that reform will look like. Recent history has shown us that this argument can be partisan, rancorous, and full of distortions. That is why it is so important for Congress to be clear with the American people about its intentions.

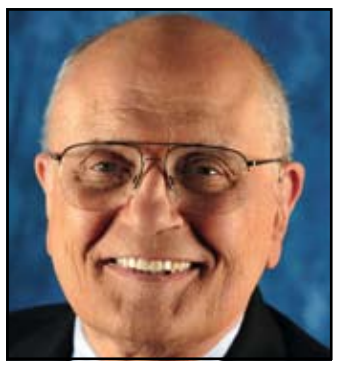
Democrats want to build upon the current system of employer-sponsored care, so that people who like what they have now can keep their current policies. We also want to preserve an element so key to American life: choice. We want a system that guarantees patients their choice of insurance coverage and their choice of doctors.

But we also recognize that, for the almost one in five of us without insurance, the current system isn't working at all. Without insurance, all the healthcare choice in the world is meaningless. So Democrats also support policies that will strengthen private and public coverage and make affordable healthcare available to all.

Finally, without serious work on our part, the cost of healthcare will continue to strain family budgets—and the combined costs of healthcare and our entitlement programs will swallow our national budget in a sea of red ink. We need to lower healthcare costs with a focus on prevention, up-to-date information technology, and national research on the best, most cost-effective treatments. We also have to rein in the growing costs of Medicare and Medicaid—a task that will require, from both parties, political will and a readiness to make hard choices.

President Obama has indeed laid out an ambitious agenda for our nation. But these times call for decisive action. Attentive to our constituents' needs, and mindful of the urgency of these hard times, we Democrats are united in our commitment to health reform that will embrace these clear goals: decreasing costs, increasing coverage, improving quality, and preserving choice. And we look forward to working with Republicans and independents to make reform a reality.

The Cost of Inaction on Health Care is Too High – Especially Now!



By Rep. John Dingell (D-MI)

In the United States, many are so consumed by fear from the first tidal wave hitting us – our economic crisis – that some are taking their eyes off the second wave coming our way. The health care crisis in our nation is about to get much worse. As struggling companies lay off workers and cut back on benefits, we as nation are ill-prepared for the burdens that we will soon have to take on. We already can not handle the over 45 million uninsured and 25 million underinsured Americans as they place an enormous weight on both our hospitals and our economy. In fact, if you look beyond the headlines about our troubled banks and their bad investments, you will see health care costs are a major force in driving people out of their homes and into bankruptcy. Last year health care spending increased more than twice the rate of inflation. The United States now spends more than $2.2 trillion on health care costs each year, approximately 16 percent of the total economy. The skyrocketing costs also have taken a huge toll on American businesses and families. We pay way too much for care that is not as good as in other industrialized countries, even though we have the finest medical professionals in the world.

I have fought for more than 50 years for comprehensive health care reform. I have always been certain about the moral argument that health care is a right, not a privilege. But, I also remember hearing my father, who represented Southeast Michigan in Congress before me, talking with United Auto Workers President Walter Reuther about how health care could break the backs of businesses in the 1930s. Make no mistake, it is both the humanitarian and economic reasons that are driving us act and act quickly.

Whether you think like Mother Teresa or Adam Smith, you can see that our health care system is failing us. My case here ~~is~~ will simply focus on the economic conditions we face. Our economic calamity before us now is so intertwined with the high costs of health care that we cannot fix one without fixing the other.

This floundering economy requires us to take bold steps to reform our health care system. The stars have aligned for comprehensive reform like I have never seen before. Democrats, Republicans, industry, stakeholders, and the American people agree that we must reform our health care system now. When we tried to overhaul the health care system in 1993, we were met with grand resistance and a multimillion dollar misinformation advertising campaign. This time the same groups who fought so hard against reform are joining the discussion. Earlier this month Karen Ignagni, president and CEO of America's Health Insurance Plans (AHIP) wrote in the Washington Times, "Focusing on health care is good politics. More important, it is a strategic domestic priority for a nation coming to grips with an unprecedented financial crisis." The insurance industry was a major player in killing President Clinton's plan.

The Business Roundtable, another group that helped undo President Clinton's health care reform efforts, released a study recently showing that the cost of health care undercuts our global competitiveness. Our five leading economic competitors, Canada, Japan, Germany, the United Kingdom and France, spend 63 cents for every dollar we spend on health care. Our up and coming competitors, Brazil, India and China, spend 15 cents on every dollar we spend. Unfortunately, our greater financial investment in health care has not yielded better quality care for Americans.

I have witnessed this first hand in my home state of Michigan. Last year, more cars were made in Ontario, Canada than in Michigan, largely because of the health care costs associated with manufacturing American cars. American automakers now spend more money on health car per car than they do on steel. The more our companies spend on health care, the less they can invest in new products, new ideas, and new jobs. How can we expect our companies to compete?

Similarly, as health care eats up more of families' budgets, they are forced to make unthinkable decisions. Do I forgo my medicine to provide dinner for my family? Should I cancel this doctor's appointment so I can make my mortgage payment? These questions are far too common for far too many families. In 1987 the share of median family income spent on health insurance was 7.3 percent. In 2006, it jumped to 16.8 percent. Today, the average cost of an employer-based family insurance policy is $12,680, almost equal to what a full-time, minimum wage worker earns in on year. The high cost of health care causes a bankruptcy every 30 seconds. By the end of the year, it will cause 1.5 million Americans to lose their homes. Health care premiums have grown four times faster than wages over the last eight years, and in each of these years, a million more Americans have lost their health insurance. Families can no longer sustain the high costs of health care.

Both Democrats and Republicans understand that failing to act is not a viable option. If left unchecked, our current system will cause irreparable harm to the nation's economic health. Health spending is expected to double by 2020, to $5.2 trillion, meaning it would consume 21 percent of the gross domestic product. We must halt this trend. Furthermore, without reform, the expected full cost of family employer-sponsored health insurance will increase to more than $24,000 in 2016 and the average deductible will reach nearly $2,700. This means in only seven years, almost half of all American households will spend more than one-third of their income on health insurance.

Make no mistake, comprehensive health care reform will cost money and all parties, including the government, providers, insurers, employers, and patients, must contribute in order for our reform efforts to be successful. President Obama has provided a great example by offering a down payment of more than $630 billion. As we draft legislation, we will aim to make sure that it is fiscally responsible. Yet, the costs of inaction are far greater than up front investments in a health care system that covers everyone at a reasonable price, better rewards providers for quality of service instead of quantity of service, and one that provides greater incentives for prevention. These reforms will save our country, our businesses and our families billions of dollars down the road. OMB director, Peter Orszag put it best when he said, "the path of fiscal responsibility must run directly through health care." I couldn't agree more.

In President Obama, we have a leader who understands the urgent need of action and the importance of bringing all stakeholders to the table. While most of us agree that we have to tackle health care reform now, I understand that we are bound to come to disagreements once we get deeper into the specifics of the plan. Of all of the options being discussed in our health care reform efforts, the creation of a public health insurance option has been met with the most skepticism and opposition. I support such an option because I believe it will provide the healthy competition needed in the marketplace to reign in soaring health care costs. The opportune word here is healthy. I invite all interested parties to come to the table to help us draft a plan that does not give the public plan an unfair advantage over private insurance options. I am committed to listening to opposing voices and working with all parties throughout the process. Everyone else must do the same, so that we do not let our own versions of the perfect become the enemy of the good.

Health Care: No Free Lunch

By Sen. Mike Enzi (R-WY)

The humorist and writer P.J. O'Rourke once noted, "If you think health care is expensive now, wait until you see what it costs when it's free."

Everyone can probably agree that every American should have access to affordable, high quality health insurance. Unfortunately, many people seem to think that enacting health care reform will mean that the government will suddenly provide every need, and it will be free. That was certainly the message I got from several of my constituents on my most recent trips back to Wyoming.

Even more disturbing than misunderstandings outside of Washington about free health care are the reports of the hospitals, physicians, drug manufacturers, health plans, and others who don't think that Congress should pay for health care reform. They see a price tag of over a trillion dollars and say, charge it. This thoughtless disregard for the long-term economic health of our nation, and for the future of our children and grandchildren, is reckless and irresponsible.

These health care stakeholders all seem determined to ignore the fundamental problem that plagues the U.S. health care system. The truly difficult challenge that Congress must address is how to get control of America's exploding health care costs. Simply throwing more money at the problem is not a solution.

Rapidly increasing health care costs threaten every American's health care coverage, as well as our nation's potential for long term economic growth. Health insurance premiums have more than doubled in the past 13 years, forcing more and more small and mid-sized employers to drop coverage for their employees.

At the same time, skyrocketing Medicare and Medicaid costs are consuming an ever growing percentage of the federal budget. The costs of these two government programs have played a major role in driving our deficit to a staggering $1.7 trillion dollars this year.

The growth in U.S. health care costs cannot be sustained. If we attempt to expand coverage without addressing the issue of health care costs, we will inevitably explode the federal deficit, kill the potential for future job growth and do irreparable harm to our economy.

Some have argued that we need to fix health care in order to address our current economic crisis. This argument misses the point. If we enact the wrong health care fix, we will create a new crisis far worse than anything we have seen. Enacting reforms without reducing costs represents an unsustainable promise of coverage that the American people will long regret.

We cannot pass these costs along to future generations of Americans. Congress must find a way to pay for health care reform and fully offset the costs of any proposal. Rather than ignoring the costs of health care and allowing our national debt and deficit to continue to go up by the trillions, we need to take a hard look at how we can cut costs while improving quality.

We can do this by getting better value out of every dollar we spend on health care. How do we get better value? Not by spending more money, but by spending money more wisely. Not by undermining free market competition, but by encouraging insurance companies to compete and offer the best plans at the most affordable prices.

I want to work with my Democratic Senate colleagues to develop a competitive market for health care, where consumers can compare prices and quality information, and put intense pressure on health plans to deliver better value.

Patients and purchasers should have access to data on outcomes, so they can identify physicians and providers who provide the highest quality care. We need to realign Medicare payments to reward high quality providers and create incentives for better managing the high cost patients who drive most of Medicare's spending.

The issue of reducing health care costs is a difficult challenge, in part because it is so easy to play on people's fears, uncertainties and difficulties understanding this complicated issue. In spite of this climate, I believe that there is real potential to enact bipartisan reforms that will help to make health care more affordable for all Americans. These reforms are not easy. It will take a bipartisan commitment to enact them. My Republican colleagues and I stand ready to work with the President and Senate Democrats if they are serious about tackling these tough issues.

The first real test of whether the new Administration and Senate leaders are serious about developing bipartisan solutions will be how the upcoming budget addresses healthcare. Reconciliation cuts off most avenues for real debate in the Senate and is intended primarily as a tool to reduce the deficit. If Senate Majority Leader Reid and the Budget Committee attempt to use the budget reconciliation process to jam health care reform through the Senate, they will be sending a clear signal that they are not interested in a truly bipartisan effort. I urge President Obama to stand by his promise to work on health care in a bipartisan way by pledging that he will not support passing reform through reconciliation.

I believe that our country currently faces a unique challenge, but I also believe we have a unique opportunity to make high quality health care more affordable and accessible to all Americans. Republicans are ready to serve as partners in an effort to enact real reforms, and we hope that Senate Democrats will not squander this opportunity.

Cut Health Care Costs through Competition, Not Government-run Programs"

By Rep. Wally Herger (R-CA)

We're facing a health care system in serious crisis. Skyrocketing costs and uneven quality have too often pushed people toward inadequate health coverage or out of the system entirely. Above all, addressing costs must be our first priority in addressing health care reform.

Although health care is an incredibly complex issue that requires open debate covering a multitude of areas, we can find common ground. However, fundamental health care reform must begin with a choice: Are you looking for a government-run program that holds down costs by restricting access to care, or a free-market, transparent program that holds down costs by harnessing the power of competition to drive improvements in quality and efficiency? I believe the free market will offer viable long-term solutions that the government cannot provide.

We need transparency within the system to allow Americans access to information about what a particular course of treatment will cost, or which providers offer the best quality care. In addition to increasing transparency, I firmly believe that providing consistent preventive care, limiting frivolous lawsuits, and harnessing information technology are essential aspects of making health care more affordable in this country.

By bringing down costs we will be better equipped to solve the problem of the millions of Americans without health insurance. But while we make efforts to help the uninsured afford coverage, we must take great care to ensure that people who already have insurance are able to keep the health care coverage that's right for them.

Competition has been the springboard for American greatness since the very beginning of our nation. Competition inherently raises the game of everyone involved, resulting in better products, better service, lower costs, and greater innovation in every industry. There is no industry more in need of vigorous, fair competition than the health care industry.

Proponents of government-run health care have taken to floating the myth that private health insurance can co-exist and compete with an expansive, taxpayer funded program. This simply is not true. It is virtually impossible to guarantee fair competition because government can change the rules of the game at any time. Also, like working Americans, private companies can't subsidize themselves through bloated deficit spending as the federal government usually finds a way to do. Competition between the government and private companies isn't real competition.

During his campaign, President Obama repeatedly insisted that, "if you like the health coverage you have, you can keep it." However, an independent study of his plan tells a very different story. The Lewin Group found that creating a new open-ended government-run plan would result in 120 million Americans losing their current coverage and being forced into the government plan.

The bad news doesn't stop there. The bigger this government-run plan gets, the more likely it will try to control costs by taking medical decisions out of the hands of doctors and patients and putting them in the hands of bureaucrats. Other nations have turned to government-run programs to help rein in costs. Sadly, these programs have only reined in the quality of health care.

In Canada, people are forced to wait months for operations that are needed immediately. Recently, Canada's Supreme Court ruled that Canadians have a right to seek private health care alternatives, noting that "access to a waiting list is not access to care." In the United Kingdom, a government agency with the Orwellian acronym NICE decides which life-saving medicines will be available and which are too expensive. British seniors with macular degeneration must go completely blind in one eye before they can get coverage to save the other eye.

Do you think this couldn't happen in the United States? Think again. A tiny provision buried in the $1.2 trillion spending bill passed by Congress earlier this year sets up a new federal agency to fund "comparative effectiveness research" to evaluate the effectiveness of various medical treatments. While this research is important and should be pursued, it needs to be conducted transparently and it should not be used to deny coverage for medically necessary treatments. Yet Congress failed to provide these key safeguards. In fact, an early version of the bill flatly stated that medical treatments found to be "more expensive" would "no longer be prescribed."

Thus far, advocates of government-run health care in Congress have chosen to move their agenda in incremental measures. It started with a vast expansion of the State Children's Health Insurance Program (SCHIP) to include people who simply shouldn't qualify for the program, including many adults. That isn't close to meeting the program's initial intent of insuring poor children.

The next step was to eliminate the Medicare 'Trigger', a law requiring Congress to consider measures to alleviate Medicare's funding shortfall. With the unfunded liabilities of Medicare skyrocketing, we have a responsibility to strengthen the program's finances. And sadly, government health care programs are already rife with abuse and fraud. In fact, the Chief Counsel at HHS' Office of Inspector General recently said that, "…building a Medicare fraud scam is far safer than dealing in crack or dealing in stolen cars, and it's far more lucrative."

Government hardly has the best track record when it comes to providing efficient, quality service in any field. If you want to see the realistic future of health care in America under a government-run program, all you have to do is take a trip down to your local Department of Motor Vehicles and wait in line.

Instead, we need reform that will ensure medical decisions are made by patients and their doctors and that all Americans have access to the affordable, high-quality care they deserve.

Comparative Effectiveness – Another Way to Say "Rationed Care"

By Rep. Todd Tiahrt (R-KS)

Perhaps even more worrisome than the cost of President Obama's stimulus package was the establishment of comparative effectiveness research as a priority of the new Administration. In a provision that did not get much public attention, the Administration created a panel to coordinate comparative effectiveness research and directed $1.1 billion to fund that research. Comparative effectiveness research is not only the first step toward rationed healthcare but is also a threat to exciting progress being made in personalized medicine.

The provision directs the Department of Health and Human Services to "conduct, support, or synthesize research that compares the clinical outcomes, effectiveness, and appropriateness of items, services, and procedures that are used to prevent, diagnose, or treat diseases, disorders, and other health conditions." The Administration is now directed to seek "optimum coordination of comparative effectiveness and related health services research conducted or supported by relevant Federal departments and agencies, with the goal of reducing duplicative efforts and encouraging coordinated and complementary use of resources."

While this may sound innocuous, what it means is that the federal government will fund research to decide which one medicine or medical treatment works best for most people or is least expensive – and then only pay for that recommended option. In other words, comparative effectiveness is just another way to say rationed healthcare.

Those who will be most affected by this policy are patients with the most to lose. Mental health patients have finally won the battle for parity in healthcare coverage, only to find that the government wants to limit their treatment plans. Similarly, Juvenile Diabetes patients who are finding great success with new devices and see promise in gene therapy could also experience medical setbacks. Seniors are at risk of losing care, particularly access to newer medicines, if the federal government's comparative effectiveness research does not show a clear advantage for them.

Our physiologies are unique, and so are the ways we react to medicines and treatments. The metabolism of many medications may significantly vary between individuals because of genetic differences that are just now being explored. Take any five people on the street and they will probably each react differently to the several cholesterol drugs available today. Prior to the past two decades, we only had one or two options – if that – for the treatment of a disease, which unfortunately left many people to suffer. But thanks to research and American ingenuity, medical treatments have developed rapidly. New pharmaceuticals and new medical devices are constantly introduced in the market that have offered healing and relief from pain for millions of people.

With so many people still suffering from diseases and painful medical conditions, why would we want to stifle hope for new treatments? That's exactly the kind of effect comparative ffectiveness would have on researchers and investors who pay for advanced research initiatives. Comparative effectiveness removes incentives for expensive research and slows medical progress.

This runs counter to what is happening in the world of medicine. We are witnessing the dawning of a new era of personalized medicine. The medical community is beginning not only to develop therapies tailored for an individual's physiology targeted to cure a disease, but will also one day be able to help patients preempt chronic disease. Personalized medicine allows doctors to understand how an individual metabolizes pharmaceuticals and can better determine which drug and what dosage a patient should receive.

In early February, the FDA announced the creation of a new position to focus on ushering in new personalized medicine methods. So, on the one hand the federal government recognizes the direction the medical community is moving with personalized medicine research, and on the other hand it wants to stymie progress through a comparative effectiveness policy that will lead to rationed care. Focusing research on comparing the clinical effectiveness of drugs or treatments is fine when the research is used to inform doctors and patients as to the best treatment available. However, it is not acceptable when the government uses the results of these studies to deny treatment based on cost or convenience without regard to what a patient's physician believes is the best course of treatment.

If you think this policy only impacts those relying on the federal government for healthcare coverage think again. The federal government is the largest customer in the healthcare industry. Once it no longer pays for certain medicines or treatments, it will become financially unsound and in cases impossible for manufacturers to recoup their costs. Simple economics will dictate necessary limits in the development of new products.

Supporters of comparative effectiveness research have argued that it is cost effective and will allow more Americans to receive medical treatment. But that ignores humanitarian concerns about denying patients access to certain medicines that will work best. It also fails to address the cost effectiveness of patients who will be ill longer because they cannot receive the treatment that best suits their physiology.

There are plenty of areas within our healthcare system that, if reformed, would provide better medical services to more people. Pursuing an agenda like comparative effectiveness that generates disincentives for new medical developments is a terrible mistake.

We have seen a backlash against the formulary practices of HMO's, Tricare and other healthcare management systems because of their limits on treatment options. A federal government formulary based on comparative effectiveness would be even more disastrous and would affect the progress of medical technology across all populations.

Comparative effectiveness is a policy that deserves much more attention and public debate. Nothing good can come from rationing medical care or preventing scientific progress. It is not the way to further medical breakthroughs, and it poses dangerous long-term consequences for all Americans.

Access To Quality, Affordable Health Care For All Americans

By Rep. Kay Granger (R-TX)

The overwhelming reason our health care system isn't working is that too many Americans don't have access to quality care. Today, only those fortunate enough to be able to pay for care out-of-pocket have access to innovative, life-saving care.

Health care is expensive, and costs keep rising – year after year. Americans spend $2.4 trillion a year on health care. A recent report by the Business Roundtable found that in 2006, Americans spent $1,928 per capita on health care, at least two-and-a-half times more per person than any other advanced country. When faced with a major medical emergency, many American families find themselves unable to pay the astronomical bills.

More than three out of four Americans questioned in a recent CNN/Opinion Research Corp. survey are dissatisfied with the cost of health care in the United States. We must address rising health care costs in any health reform effort.

In the recently enacted stimulus bill, President Obama and Congressional Democrats included $1.1 billion in funding for "comparative effectiveness" research; supporters claim it will lower health care costs by urging health care providers to use the least-expensive treatments.

Comparative effectiveness research evaluates the merits of various medical treatments with the hopes of arriving at the best and least costly treatment for a condition. It is important to remember the difference between clinical effectiveness – which treatments work best irrespective of cost – and cost effectiveness, where the most effective treatments could be deemed inappropriate because their costs outweigh the perceived benefits.

Historically, comparative effectiveness has resulted in higher health costs. For example, when looking at what treatments are best for cardiac patients who enter an emergency room, numerous studies found that primary angioplasty, an expensive procedure, was the most effective treatment. That finding drove up health costs for cardiac care and treatment.

The other problem with comparative effectiveness research is that historically rigorous original research by the National Institutes of Health (NIH) has had little impact on the practice of medicine. Two NIH studies stand out as examples – Catie and Allhat. Seventy million dollars was spent on the Catie study, and $130 million was spent on the Allhat study. Despite the millions invested in these two research studies, they had almost no impact on clinical care.

The new "Federal Coordinating Council for Comparative Effectiveness Research" won't do much to help contain and lower health care costs. What it will do is serve as political cover for the Centers for Medicare and Medicaid Services (CMS) to make coverage decisions. Once a decision is made not to provide Medicare coverage for a service or treatment, private insurance companies typically follow suit.

Comparative effectiveness research will be used to ration care and thwart innovation and medical progress. It is a first step toward taking medical decisions out of the hands of doctors and patients and allowing government bureaucrats to decide what drugs, screening tests, and medical procedures will be covered by Medicare. It is a step toward a government-run health care system.

In countries with government-run health care systems, comparative effectiveness is often used as an excuse to deny patients life-saving medical care on the grounds of cost-effectiveness. The health care board of the United Kingdom has repeatedly denied breakthrough drugs to citizens suffering with breast cancer, Alzheimer's disease, and even multiple sclerosis on the grounds of comparative effectiveness.

The United Kingdom's National Institute for Clinical Excellence (NICE) is having an impact on health outcomes – and it is not a positive impact. Between 1990 and 2002, deaths from breast cancer declined 2.3 percent annually. Today, nearly 98 percent of women diagnosed with early stage breast cancer in the United States survive at least five years. In the United Kingdom, the five-year survival rate for breast cancer caught early is just 78 percent. The same is true of colorectal cancer. The five-year survival rate for colorectal cancer in the United States is 60 percent compared with 44 percent in the United Kingdom.

We need to find ways to lower health care costs in this country without rationing care. At the same time we need to increase the number of Americans with health insurance. In my home state of Texas, one in four individuals is uninsured, and more than half of those without insurance say it's because they can't afford it.

The solution to lowering the number of uninsured Americans is not a government run "single-payer" or "public health insurance option" that takes away individual choices, doctor control, and threatens the employer-sponsored health insurance market. No one should have to lose his or her current health insurance coverage or change doctors because Congressional Democrats and President Obama push through health reform too quickly.

As House and Senate Committees begin holding hearings on health reform and bills are being drafted, we need to be careful not to enact provisions like comparative effectiveness that may result in higher health care costs. For example, the non-partisan Congressional Budget Office (CBO) released an analysis of President Obama's fiscal year 2010 budget last week. CBO found that the health care reform proposals in the President's budget will cost $21 billion more than previously estimated by the Administration. The expected cost of the President's health care plan could reach $1.5 trillion while only about $600 billion is set aside for health reform in the "reserve fund." The President and Congressional Democrats will have to come up with a way to pay for the escalating costs of their health reform proposals – whether it be through more cuts to Medicare Advantage, tax increases, cuts to other existing health programs, or the fiscally irresponsible choice of increasing the federal deficit.

It is difficult to see how the President's proposals will bring down the cost of health care. We need to find fiscally responsible ways to expand access to affordable health care, and in doing so we need to be sure we are giving individuals and doctors control over making decisions about health care – not the government.

Health Care Refrom: What Will Work – And What Won't

By Rep. Michael C. Burgess, M.D. (R-TX)

At the White House Health Care Summit, I was encouraged to hear President Obama say that he wants to "learn from what works." Medicine is evidence-based; health care policy should be based on the same principles. I pledged to do no harm during my 25 years as a practicing physician, but I know from my experience as a Representative that Congress can create chaos, despite good intentions. Before we modify the current system, we must be responsible and learn not only from what works, but also from what does not work, and why.

The health care reform discussion has focused primarily on Americans who lack insurance, and with good reason – the numbers are astonishing, and growing. Members of Congress need to move beyond searching for a silver-bullet policy to cover the uninsured. The problems we face are complex, extending much further than simple lack of insurance. Our policy decisions should reflect this.

Consider the health care experiment in Massachusetts. Despite an increase in coverage through individual mandates, the supply of primary care physicians does not meet demand. Across the nation, the medical workforce is steadily shrinking; fewer students are completing medical school, and more doctors are retiring early. The decreasing numbers of health care professionals is being met with an increased demand for care. Of course, the difficulty in accommodating patients multiplies in a system that accepts illegal immigrants, but no one seems to want to touch that issue with a ten foot pole.

The government programs that claim to provide coverage to the neediest are encumbered by insolvency. Most medical practices and hospitals accepting Medicaid and Medicare find it difficult to survive financially. It would be irresponsible to make these programs, in their current dysfunctional state, the model for reform. We are punishing patients by denying them the care they need, which is counterproductive to the whole reform effort.

Former Vermont Governor Howard Dean endorsed President Obama's health care reform plan, supporting the creation of a government-administered health insurance plan to compete with private coverage. In addition to calling it "perfect," Dean added that "it's ridiculous to say [health] care would be inferior" under the government-administered plan.

As Vermont's Governor, Dean aggressively pursued expansions of state-run health insurance, and asserted that the program "was very cheap to do." Patients found that the true price to pay is the lack of access to care and services, consequences that Dean failed to mention.

In Vermont, the practice of Dr. Judith Steinberg, Howard Dean's wife, was hit hard by low reimbursement rates and insurance regulations her husband signed into law. Dr. Steinberg had to stop accepting patients on the state's Medicaid program.

To further illustrate my points, let me tell you about a pediatrician from rural Alabama who told her compelling story to the Energy and Commerce Subcommittee on Health last year. She and I both began practicing medicine in 1981, but her experiences in her rural Alabama community were sharply different from mine. The population of patients she served was 70 percent Medicaid and to offset her losses from low reimbursement rates, she borrowed from her retirement savings to keep her doors open. Without a sufficient number of private plan patients to cross subsidize the public plan patients, practice is difficult to sustain. I wonder if this is the perfection Governor Dean speaks of.

Government-administered health care misleads uninsured Americans into believing that they'll finally have access to care. However, denying patients with government health insurance is often a necessary business decision for doctors to make given the low reimbursement rates. Physicians nationwide are already staring down a 20% cut in Medicare reimbursement this year. Coverage becomes irrelevant if the patient cannot find a doctor willing to accept the program.

Jonathan Oberlander, in the August 2008 edition of the New England Journal of Medicine, said of Obama's proposal, "the new national health plan could control costs, but its effectiveness in slowing spending would depend on its enrollment and the political willingness to restrain provider payments." My translation: the only key to continued spending is to cut providers to the point where they could not afford to see patients. Good for patients? Certainly not. But it's a tried and true way for government to promise coverage when they have no intention of guaranteeing access.

Americans already benefitting from private coverage feel safe under the assumption that they'll be allowed to retain their current plans. After all, Obama promised during his campaign, "if you like the insurance you have, you can keep it." Most individuals don't really have their own health insurance – they get it from their employers. If the coverage provided in the government-administered plan is cheaper than what employers are paying now, logic suggests that employers will go for the thriftier option and drop the private plans.

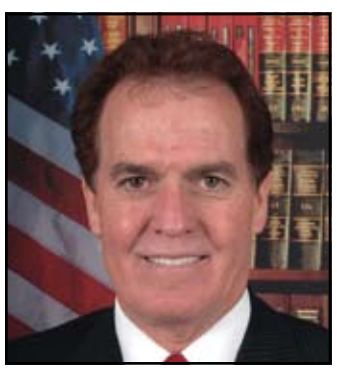
Estimates from independent actuaries at the Lewin Group suggest that as many as 75% of all Americans currently with employer-sponsored health insurance – nearly 120 million individuals – would find themselves switched over from their private plans to the government plan.

As for cost, President Obama stated that $600 billion will account for merely a "down payment" on a government-sponsored overhaul of health care. The full price tag is still unknown.

I've joined with other Republicans in the House in a working group to find solutions to these problems. We need alternatives that will expand access to affordable, quality health care. We know that we need to keep doctors and patients, not the bureaucracy, at the center of health care.

I hope to work with Democrats in the coming months to find valid, working solutions. If Republicans and Democrats really want to fix our health care system, we can't pick and choose what problems to remedy. Let's fight against a silver-bullet answer and work in favor of thoughtful, comprehensive reform.

Washington Bureaucrats Don't Have All The Answers



By Rep. Phil Gingrey (R-GA)

Somewhere in America today, our health care system will fail someone – a patient suffering from a chronic illness like cancer, a young family with a new child, or anyone else who slips through the cracks. In Washington, it doesn't take a doctor to figure out that our health care system is broken because it just doesn't work for too many Americans. Republicans and Democrats both recognize that we need to fix our health care system and that real reform will certainly require bipartisan solutions.

Unfortunately, from Wall Street to Main Street, the current Administration and the Democratic Majorities in Congress seem to have only one cure for everything that ails our nation – more government. From billion dollar bailouts to trillion dollar stimulus bills, Democrats are running empty on ideas that don't involve government intervention and taxpayer exposure. Now, the Majority has set it sights on health care reform with the same mentality that the CBO projects will give us almost $10 trillion dollars in additional debt over the next ten years. I think most Americans realize or will realize that we simply can't afford government-run health care and that we can't afford to turn the patient-doctor relationship into a patient-government relationship

For instance, many Congressional Democrats have argued for the creation of a government-run insurance plan that would compete against traditional family plans already in the marketplace. In theory, this government plan would be a low-cost alternative for those in need. However, independent actuaries at the Lewin Group have found that such "competition" would cause as many as 119 million Americans—three out of every four individuals with employer-sponsored health insurance – to lose their current health benefits as employers drop coverage, forcing their workers into the government-run health plan. The end result would likely be the virtual elimination of private health insurance and the creation of a one-size-fits-all government system that would use "comparative effectiveness" studies to limit the types of treatments patients can receive.

While a government plan might ensure every American an insurance card, an insurance card is no guarantee of access to quality health care. In fact, to see what government-run health care looks like, we need look no further than the Medicaid program. While surveys show that most individuals are happy with their current health insurance, a study by the liberal Commonwealth Fund found that low-income families would prefer to enroll in private insurance rather than Medicaid by a more than two-to-one margin. One mother and Medicaid participant from Michigan said it best: "You feel so helpless thinking, something's wrong with this child and I can't even get her into a doctor….When we had real insurance, we would call and come in (to see a doctor) at the drop of a hat." Americans don't care about the card in their wallet; they just want to be able to see their family physician who they know and trust.

To be certain, Congress does have a lot of work to do – not only by making sure states have the flexibility to modernize their Medicaid programs, but also by laying the foundations for more comprehensive reform. There are free market solutions within our grasp that will ensure greater choice for consumers and also preserve the fundamental patient-doctor relationship. Congress can and should focus on reducing the costs and inefficiencies that plague our health care system putting quality care out of the reach of so many. We can expand access to quality coverage and improve health care for patients by encouraging doctors to adopt health information technology and by enacting medical liability reform to keep "jackpot" justice for a few from increasing health care costs for everyone. The regulatory barriers that keep many small businesses from being able to afford coverage for their workers must be torn down. Additionally, Congress can provide assistance for low-income individuals and create a market-based "exchange" where traditional family health plans compete against each other to ensure the best quality of care for the best price.

Finally, health care is more than just treatment – it's prevention. We need market-orientated incentives for healthy behaviors so that consumers can live healthier, longer lives and avoid costly medical treatment for preventable diseases. At the end of the day, we need a health care system that is defined by terms like prevention, access, quality, and patients – not by bureaucrats and government intervention.

Robbing Peter to Pay Peter?

By Rep. Michele Bachmann (R-MN)

Last fall, we were inundated with catchphrases that were powerful enough to influence our political landscape. Nowhere was this more obvious than in the debate about health care. The words "affordable health care" pack a powerful punch, but what they mean and how to get there vary widely throughout Washington and the nation.

In order to fund President Obama's visions of "affordable health care," he proposed raising taxes on all Americans. In the President's fiscal year 2010 budget proposal, he included a $634 billion reserve fund for health care reform, and he notes that this only a "down payment." He expects to pay for at least half of it with tax hikes. The other half would be paid for by cuts to Medicare and Medicaid programs. If it seems a little as if President Obama is proposing to pick one of your pockets to fill the other, you are right. He will be squeezing middle class taxpayers with other higher taxes—like the $4,000 energy tax the average family will pay under his budget to "help" them afford health care. And, he will be cutting Medicare and Medicaid to "help" people get more affordable care. It's a dangerous shell game that can end in one-way full government care from cradle to grave, with taxpayers footing a rather hefty bill.

Last week, the Obama Administration also signaled support for taxing some employee health care benefits—this is in addition to the tax hikes in his budget. When his opponent in the Presidential election made similar proposals, Obama criticized it as the "largest middle-class tax increase in history." Again, we are picking the pockets of middle-class taxpayers instead of helping them make the most of their resources to spend on the health care of their choosing.

President Obama also proposed increasing health care costs on the veterans who sacrificed so much to serve and protect our nation. Under the President's proposal, the VA would have been allowed to charge private insurance companies for treating veterans with service or war-related injuries. The VA now pays those bills, only billing insurance providers for medical treatment that is unrelated to military service. As veterans groups rightly protested, the Obama proposal would have discouraged employers from hiring disabled veterans by raising the premiums insurance companies charge.

After many of us here in Congress urged the President to abandon these plans and maintain our government's commitment to caring for America's veterans, I am pleased to announce that it sounds like the President is backing off this proposal. However, it does raise two important questions: Is the President's primary interest in providing affordable health care, or simply overhauling the current system for the sake of nationalization? And, is he just grasping at straws to pay for his grandiose plans?

Everyday, I hear from constituents tied up in the red-tape suffocating government health programs. The government is infamous for their inefficiency. So why would we entrust the government with something as critical and essential as our health?

Rather than introduce another expensive, inefficient government-run program to overhaul one of our most important resources, I advocate improving affordability at the same time we expand consumer choices. I introduced the Health Care Freedom of Choice Act, which would provide full tax deductibility of individual health care expenses, including medical care, dental care, long-term care, and health insurance premiums. Under current law, medical care purchased through an employer's insurance plan is tax-free, but the same premiums and expenses are not fully deductible if paid by an individual in the private market. People who are self-employed or work for small businesses clearly get the short end of the stick.

Even businesses that provide health insurance offer employees the "choice" of only one plan. This has resulted in the creation of a few health care conglomerates in lieu of thousands of competitive providers of medical services and health insurance. This skewed tax structure forces many working and retired Americans to limit their options. Consumers can choose from 64 varieties of air fresheners, why should they be limited to the possibly single option provided by their employer?

Furthermore, the urgency and necessity to provide tax-free individual health insurance premiums will only increase if tax-free employer-provided benefits disappear with the Administration's potential "largest middle-class tax increase in history."

Consumers should have the freedom to purchase the health insurance of their choice, to choose their own doctors, and to make their own medical decisions. Through the Health Care Freedom of Choice Act, we can increase quality and choice without raising taxes. Real health reform and real affordability come from empowering health care consumers. Give them the resources and the choices, and our nation will be able to put true meaning behind the phrase "affordable health care."

The Obama Administration's Flawed Plan for Vets Health

By Rep. Mary Fallin (R-OK)

President Obama's bizarre flirtation with billing private insurers for health care extended to wounded military veterans has created an understandable firestorm among veterans groups. David K. Rehbein, president of the American Legion, referred to "the moral and government-avowed obligations that would be compromised" by the Obama proposal.

What most Americans don't realize is how deep that "moral and government-avowed obligation" runs through our history. It predates nationhood itself.

In 1636, officials of Plymouth Colony, faced with Indian hostilities, voted to assure care for any member of the colonial militia disabled in the fighting. The Continental Congress established a system of pensions and land grants for soldiers who fought in the Revolution. In 1789, the first Congress passed legislation assuring care for veterans.

The first forerunner of the Veterans Administration hospital system was opened in Philadelphia in 1813 to care for veterans of the Revolution and the War of 1812.

It wasn't until the Civil War that large numbers of wounded and disabled veterans flooded the system. In his second inaugural, President Lincoln urged Americans to "care for him who shall have borne the burden, and his widow, and his orphan." We did. The last surviving Civil War veteran was still collecting a small pension when he died in 1956.

When America went to war again in 1898 and 1917, Congress and the states joined in making provisions for wounded veterans. In 1930, the system was federalized with the creation of the Veterans Administration, and in 1988 the VA was elevated to cabinet rank.

Today there are 171 VA hospitals, some 350 clinics and hundreds of nursing homes and other care facilities dedicated to caring for and sustaining veterans of all of our wars. This is clearly a sustained national commitment that dates back almost 375 years. No other government program has such a deep and continuing history.

Today the VA provides care to millions of military veterans. The system imposes modest co-pays, comparable to private insurance, on veterans who seek care for non-service related illnesses. Those who suffer from service-connected disabilities, former prisoners of war and all veterans awarded the Purple Heart for combat wounds are exempt from those payments.

Unfortunately, for many years the VA system was known for crowded conditions and sometimes substandard care. That has changed. A 2003 study in the New England Journal of Medicine compared VA hospital care to that received by Medicare enrollees. On 11 key measurements, VA patients were found to be receiving care that was "significantly better."

Can the health care we provide veterans be even better? Certainly. There is still red tape in the system, a bureaucratic reality inherent in all government programs, and a warning against the further federalization of health care.

But the VA remains a symbol of a national commitment that goes back almost four centuries. Why, then, is the President considering tinkering with what works?

The flaws in his proposal to bill private insurers for VA-delivered services are evident.

Many disabled veterans require extensive – and expensive – medical procedures and sustained supportive care. Most private insurance policies include lifetime maximum outlays, which could be rapidly consumed by such care. A veteran whose family also depends on that health policy could easily reach the lifetime maximum, leaving his wife and children uncovered.

Veterans might also be subject to co-pays if the Obama plan makes their private insurance the source of first billing.

Worst of all, this proposal could actually worsen the problems of unemployment and the uninsured. A disabled veteran seeking private sector employment might be turned away by employers concerned that the extra costs billed to a private insurer would increase coverage costs for his entire workforce.

Those are all practical considerations, but the underlying one remains moral. We are a nation that has always honored our veterans and sought to sustain those who have shed their blood in our defense.

President Obama's proposal violated that pledge in a fundamental way.

Better Health Care in America – It Is Possible

By Rep. John Fleming (R-LA)

The United States delivers among the best health care in the world, but the financing of it is a "basket case." Insurance coverage is a mosaic of many different standards and systems, is very bureaucratic and difficult to navigate, millions of working Americans cannot get affordable coverage, and costs go up endlessly despite the attempt by government and private insurance to freeze reimbursement rates for providers below sustainable levels. Economists, lawmakers and many others have attempted to tackle this problem on a macroeconomic level with dismal results. The pathway out of this vexing problem lays in the medical exam room, itself a microeconomy, where decisions between the doctor and patient have the largest impact on quality and cost but is largely ignored by experts and policy makers.

I have practiced family medicine in Minden, Louisiana, for the past 27 years, and for the past 22 years I have started and continue to own and manage several non-medical businesses. During this time I have been able to witness the many perverse incentives built into the health care system in the name of quality and cost that actually have the opposite effect----something we rarely see in private business. The most glaring paradox is the way government and insurance companies arbitrarily and without negotiation, regulate pricing for all health care providers.

Health care is the only segment of our economy that is under strict price controls and the results of such controls, as economists will explain, will always be opposite to that intended----higher costs. If the President and Congress move to expand Medicare and Medicaid to become the dominate or only health care administrative systems, we will also begin to see shortages and rationing. There will no longer be a private system to absorb the current and enlarging, but impossible to avoid, government waste.

So, in returning to the exam room, we learn that doctors and patients have tremendous latitude in making decisions about each situation that can have an impact on cost varying from less than $100 to many thousands for the same type and level of medical problem with no correlation to quality. Doctors have been forced to be creative with types and volumes of services, which echoes much higher cost into the system in terms of hospital care, tests, etc, though only a small minority of these system costs financially benefit the doctor. Patients have also played a large role in driving costs by making decisions and influencing doctors to accommodate them in their goals which may not necessarily be consistent with better health, lower costs or efficiency of care.

As the problems are multi-layered and systemic, so must the solutions be comprehensive, common-sense and based on proven economic models. We can't afford to experiment with our health care, one of the largest segments of our economy. Fortunately, there are now tremendous opportunities to fix the system, but it will not be easy to convince bureaucrats in Washington to do the right thing.

The fundamentals of this solution to a broken system must contain the following elements.

First, despite the need for federal and state governments to pay many of the health care insurance bills, the government itself should get out of the administration of programs. The reason for this is the inability by government to manage incentives and behaviors of providers and patients that run up cost. Government simply can't micro-manage people. Government looks for waste, fraud and abuse which is expensive to find, hard to prosecute and is only the "tip of the iceberg." Private organizations are far more effective as they can simply re-educate or terminate a provider who is not following the proper guidelines of health care efficiency and quality.

Second, the government and insurance companies should stop price controls on health care providers and allow them to organize into large groups who can then compete with each other on the basis of quality, price and customer service. Economists will tell you that competition is the only successful way to lower cost and increase quality, not government regulation. On the other hand, government is the perfect entity to ensure an even playing field and to protect consumers.

Third, we need to provide basic, private insurance coverage for every American in this country subsidized by government for the poor and elderly as we now do with Medicaid and Medicare. Working families with higher incomes can continue to pay more and more of their share of premium costs as their incomes rise. Providers already have a legal requirement to provide care to anybody regardless of ability to pay. Unfortunately we end up providing the care in the emergency room when the disease is out of control, resulting in the poorest outcomes and the highest cost to the system. Creating affordable insurance coverage for all will dissolve the need for this expensive and unfair cost-shifting.

Fourth, we should allow the public to be informed consumers with simple and transparent systems so they can make wise choices.

Fifth, we should reform antiquated insurance laws and give incentives to the young and healthy to opt into private insurance so that we have large risk pools so that the term, "pre-existing illness," drops from the American lexicon.

Sixth, we need to move forward on incentives for providers to move into the digital age with electronic health records that will greatly enhance communication with patients and providers to achieve better care.

Seventh, we should make family physicians the "lynchpin" of our health care system. Supported by mid-levels, they can have a tremendous effect on lowering cost while improving care.

Finally, we need to provide strong incentives for patients to function as consumers and behave in every way possible to prevent disease rather than entering the system at the worst possible time----when cost is highest and outcomes are poorest.

We now exist at a historical "fork in the road" in American health care. Will we move toward a single-payer, one size fits all government run health care system that will undoubtedly lead to exploding budgets, poor customer service and rationed care? Or, will we apply the economic fundamental strengths that have made this country so successful in other areas and enjoy better health for all and lower costs in the future? I strongly urge the latter.

True health care reform is possible, but it will require less bureaucracy and more input from those directly affected by the policies being created. That is the most critical element to creating affordable, available and accessible health care for every American.

Health Care: My Personal Issues

By Gregg Harper (R-MS)

WASHINGTON, DC – Over the past several years, the federal government has consistently addressed America's health concerns. I commend Congress for continuing its pursuit in improving access to quality, affordable health insurance. While I understand the constant struggles in acquiring and retaining health insurance, one struggle is closer to my family than others and I have taken an active role in examining this issue.

I want to tell you about my 19-year-old son, Livingston. Early in his life, my wife Sidney, and I noticed he was slow to walk, talk, and reach other developmental milestones. He would sometimes flap his hands, rock back and forth, or chew on objects. We were told not to be concerned; that he was 'developmentally delayed' and that he would grow out of it.

Finally, at about 19-months of age, our doctor told us that something was wrong; that he didn't know what it was but that we'd start looking. The next two years of Livingston's life were filled with occupational therapy, speech therapy, testing, more visits to the doctor, and other hospitals. Sidney dealt with these issues daily.

Livingston was misdiagnosed with mild cerebral palsy and was said to be 'a near miss' on autism. Almost two years later, thanks to our next-door neighbor, who was the head of Special Education for our county school system, Livingston was tested and found to have Fragile X Syndrome. Since that time, we've taken him to hospitals in Denver and Sacramento to learn as much as we can. Today, we know that Fragile X Syndrome is the most common cause of inherited intellectual disability, resulting in a wide range of mental and physical impairment.

For our family, Fragile X has become a lifelong labor of love and daily blessings. With diploma in hand, Livingston graduated from Pearl High School last May. In fact, Livingston is now enrolled at a local community college, taking two classes and working at a local restaurant. Though his future is uncertain, with help and the prayers of many friends, our hope is that his life will be rich and rewarding. Ours already is. We thank God for Livingston everyday.

As the only member of Congress who has a child with Fragile X, I understand the challenges that face thousands of families who experience this condition. Sidney and I are committed to making sure there is increased awareness and funding to help those families who are blessed with a child with Fragile X.

Congressman Phil Hare (D-Ill.) has championed this issue on Capitol Hill for the past several years, and I want to thank him for his support of Fragile X families across the country. This year, Congressman Hare, Congressman William "Bill" Delahunt (D-Mass.), and I will be working together on this issue. As co-chairmen of the Fragile X Caucus, we will work closely with the National Fragile X Foundation and other Members of Congress in support of additional federal funding for the treatment and ultimately a cure of Fragile X-associated disorders. My goal is to contribute substantially towards increasing public awareness of Fragile X disorders and letting Fragile X families across the country know that they are not alone in this journey.

One of the more difficult times for our family was the eight years Livingston was not covered on our health insurance. The financial sacrifices Sidney and I made during this time period were challenging and we understand that many families currently face this economic burden.

While quality, affordable health insurance is on the minds of all Americans, I have several concerns with many proposals before Congress. During President Obama's campaign, he promised his health plan would reduce American families' health care costs by $2,500 per year. Yet judging from his first budget, President Obama finds a peculiar way to reduce costs – by increasing government spending.

President Obama's budget proposal includes nearly $1 trillion in new health care spending, a $634 billion reserve fund as a "down payment" for expanded coverage funded mostly through tax increases, and nearly $330 billion in increased reimbursements to physicians and other government programs. The fund would be paid for in part through $318 billion in tax increases on filers who itemize, "competitive bidding" for Medicare Advantage plans, and tighter government price controls on pharmaceutical makers.

Republicans do not believe more spending will control the costs. At a time when government actuaries project that health spending will jump from 16.6% to 17.6% of GDP this year alone, the President's plan proposes an additional $1 trillion in expenses on top of the spending included in the already enacted stimulus bill. Additionally, more government spending means more government control. Administration officials confirmed they will seek legislative authority to impose a least costly alternative reimbursement policy for Medicare – a policy of rationing access to care consistent with a draft House Committee report saying that more expensive treatments will no longer be prescribed as the result of research into the effectiveness of various treatments.

I support efforts to reduce health care costs for small businesses and promote entrepreneurship such as H.R. 1470, the Equity for Our Nation's Self-Employed Act. This bill would allow self-employed individuals to deduct the cost of their health insurance premiums as a business expense from their taxes so they can reinvest and grow their businesses.

I am also seeking continuity in coverage for children through state risk pools. Far too often, children who suffer from chronic illnesses are denied coverage due to their pre-existing conditions if their parents lose health insurance.

Republicans are willing to find constructive solutions with our Democratic colleagues. However, the current budget proposal has far too much spending in the short term and could result in government-rationed care as the only way to reduce health care costs in the long term. We can do better.

NIH Funding: A Sustained Investment in a Healthy Future

By Darrell G. Kirch, M.D.
President and CEO
Association of American Medical Colleges

As we think about the substantial challenges facing our health care system today, we sometimes forget about the progress we have made. Over the last 30 years, deaths from heart disease have declined by 50 percent, and deaths from stroke by more than 60 percent. And while four of five children with leukemia once died, today four out of five survive. This progress would not have been possible without the medical research conducted at the nation's medical schools and teaching hospitals through the support and funding of the National Institutes of Health (NIH)

The NIH is the primary federal agency responsible for conducting and supporting medical research. In just the last decade, NIH-funded advances have led to new, targeted therapies to treat cancer, a test to predict breast cancer recurrence, identification of genetic markers for mental illness and many other diseases, improved asthma treatments, and the near-elimination of mother-to-child HIV transmission. In addition, important new treatments for leukemia, clot-busting drugs to treat stroke, and stents for heart disease were all based on NIH-funded research.

As we look to the future, we must remember that the investment we make in medical research is critical to our nation's economic health, as well as our physical health. The research conducted today not only represents our best hope for new cures and treatments, it also will make us a healthier and more productive society.

The past few weeks have given the medical research community renewed hope. After five years of NIH funding that failed to keep pace with biomedical inflation, the economic recovery package included $10.4 billion over two years for the NIH. The 2009 appropriations bill also included an increase of nearly $1 billion.

While we are encouraged by – and grateful for – this substantial infusion of funds, there is still a long way to go. In FY 2008, only one in five research proposals submitted to NIH could be funded, and there was a backlog of more than 10,000 scientifically approved grants waiting for support. These are the projects that will produce a deeper understanding of the molecular basis of disease and disability, as well as new and more effective treatments, and possibly even cures, for cancer, diabetes, Alzheimer's disease, and autism, among others.

History has shown us that "boom and bust" cycles of support for research funding have resulted in lost opportunities for science and delayed hope for patients and their families. The recent increase in support for NIH cannot be an isolated event. Rather, it must be a first step toward a renewed national commitment to sustained, real growth in NIH funding over the long term.

It is also important to keep in mind that medical research has immediate benefits. NIH research supports our economic health today by creating skilled jobs and new products that generate economic growth. According to a Families USA study, NIH funding is responsible for over 350,000 jobs with an average salary of $52,000, well above the national average. This study also showed that every dollar of NIH funding generated more than two dollars in state economic output in 2007.

One of the other major strengths of the nation's medical research enterprise is that much of the work takes place in medical schools and teaching hospitals where the next generation of physicians is educated and trained and cutting-edge medical care is delivered. It is through these individuals and institutions that medical research will transform health care as we know it.

But reaping the full enefits of scientific discoveries takes decades. By restricting funding now, we will undermine medical progress for generations to come.

As we plan for 2010 and beyond, and consider our "post stimulus" budgetary needs, significant, annual increases in medical research funding are critical.

Our national spending priorities must offer a solid return on the investment of our tax dollars as our nation works toward economic recovery. Sustained, real growth in the NIH budget will benefit our nation's fiscal as well as physical health and is one of the most effective investments we can make in our future. And for the millions of Americans who still--or will--suffer from cancer, heart disease, Alzheimer's, depression, diabetes, asthma, and other serious illnesses, medical research is their best hope for a healthy future.

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Health Reform: An Opportunity For Change

By Dr. Ken Thorpe
Executive Director
Partnership to Fight Chronic Disease

Health reform is back on the agenda in Washington, with the American public asking for change and the White House making it a top priority.

This comes not a moment too soon, as the high cost of health care has become unsustainable for our companies and our families. Americans are now paying for this cost in lost workplace productivity and market competitiveness, lower quality of life and – most importantly – in lost lives that could be saved.

As health care reform is debated in Congress and in regional forums sponsored by the White House, one thing is clear – we must address the trend of increasingly costly health care. For those who have waited more than a decade for another opportunity to address these issues, there is good news. We have a convergence of factors indicating reform may be possible, including the fact that groups who just a few years ago would not meet with one another, let alone work together, are joining together to support reform. And yet, a question remains: do we have the will to make health reform a reality?

Positive developments like the new Administration's focus on health reform and the framework introduced in Senator Baucus's "Call to Action" white paper indicate the answer just might be "yes."

As a White House advisor in the early 1990s, I was part of the Clinton health reform effort. What I learned from that experience, and my work on efforts at the state level, is that to regain control over crushing costs, the single most important policy change will be addressing the growing chronic disease crisis.

How can we stem rising health care costs by reducing the incidence of chronic disease? To answer this question we must go where the money is.

Of our annual health care spending, 75 cents of every dollar goes towards treating patients with chronic illnesses. These conditions represent an even higher burden in public health insurance programs: In Medicaid, this figure is 83 cents of every dollar; in Medicare, it's an astounding 96 cents.

But the economic impact of chronic disease is not isolated to treatment expenditures. Lost productivity due to chronic illnesses is affecting our global competitiveness and draining the strength of our workforce. The annual cost of lost productivity due to the seven most common chronic illnesses alone is estimated at $1 trillion. By 2023, these indirect costs could grow to over $3 trillion.

One reason for these high costs is the dramatic rise of illnesses such as diabetes, and hypertension. These illnesses, which in many cases could have been prevented by changes in behavior or could be better managed through early detection and appropriate access to treatment, are reaching into younger and younger generations of Americans, affecting children at such high rates that for the first time ever, they may have a shorter lifespan than their parents.

The rise in obesity is also at the root of much of this increase. Roughly 30 percent of the growth in health care spending seen over the past twenty years is linked to a doubling in obesity rates. A recent study from the University of Oxford found that being obese can shorten our lifespan and, in the case of morbidly obese patients, have the same effect as lifelong smoking, taking about 10 years off their expected lifespan.

All of this leads to another question that must be addressed: how do we improve affordability while providing health care coverage to more Americans?

Because of the rapid rise in chronic disease, the cost of health care coverage has risen. Why? The answer is simple: as our disease burden has risen, and we have required more health care services more regularly, the amount of money it costs to insure them has increased.

For insured Americans, that means all of us are shouldering these costs through our health insurance premiums, even if we ourselves are not chronically ill. And yet, for all this spending, most of us are not feeling healthier.

So, what, then, is the point of our health coverage if it's not helping us get and stay healthy?

This is a good question, and one that suggests a need to re-design our health insurance packages to make sure we are incentivizing activity that prevents illness and treats disease before it becomes acute and aggressive.

Right now, the incentive schemes and reimbursement mechanisms for health insurance are backwards for patients and providers alike. Patients are often fully reimbursed for treatment of acute illness – for things like an amputation of a foot from poorly treated diabetes – but they are forced to pay out of pocket to see a doctor to prevent such problems. Providers, meanwhile, are told that they will be reimbursed for providing a treatment, but not for simple counseling about how to prevent a condition from developing or worsening.

We need to make it easy and rational from a cost and time perspective for Americans to prevent disease. While this may all sound simple enough, no politician has yet mastered how to incorporate strategies to fight chronic disease into health reform at the national level.

When the Clinton Administration tried to pass reform, the debate was mostly about how to provide and pay for coverage for those without insurance. Today, the debate has expanded to include the question of how we lower the cost of health care for all so we can better afford to pay for covering the uninsured. This is good news, as addressing the many challenges of affordability will chart the path toward successful coverage—and the path to successful health care reform goes straight through more effective chronic disease prevention and treatment.

PARTNERSHIP TO FIGHT CHRONIC DISEASE

Veterans Health: Why More Outreach Is Needed

By John Rowan
National President
Vietnam Veterans of America

Serving in the military poses potential long-term – as well as immediate – risks to the health of a soldier, sailor, marine, airmen and -women. The immediate health issues – bullet or shrapnel wounds, traumatic amputations, obvious injury to the brain – are treated properly, for the most part, first by military medical personnel, then by clinicians at healthcare facilities of the Department of Veterans Affairs, the VA. Some of the long-term health conditions – Post-traumatic Stress Disorder (PTSD) or Traumatic Brain Injury (TBI) that may manifest years later, as well as a host of health conditions that are presumed by the VA to have derived from one's military service – are often not connected by the veterans to their time in uniform – and often not until it's too late.

Because there is very little outreach to the men and women who served our nation honorably and well, and because too many veterans succumb to diseases that can be traced back to their time in service, Vietnam Veterans of America (VVA) has created, in partnership with dozens of interested healthcare and advocacy organizations, the Veterans Health Council (VHC).

The mission of the Council is to improve the health of veterans by creating an ongoing forum via its website, www.veteranshealth.org, for veterans and their families as well as for clinicians. The Council was formally introduced and its web site launched at a press conference at the National Press Club in Washington, D.C. on February 25, 2009.

The goals of the Council are fourfold. We want to inform veterans and their families about health issues related to their military service as well as the health care and other benefits available to them. We want to educate healthcare communities about the multiple health issues associated with military service. With advocacy organizations, we want to develop educational materials for medical colleges, nursing schools, teaching hospitals, and related entities, as well as to "target" veterans in the booklets and brochures published by these organizations along with other means of electronic dissemination. And we want to advocate on behalf of healthcare initiatives for veterans and their families.

This effort is necessary because up to 80 percent of veterans do not use the VA for their healthcare needs. And the sad reality is that many veterans are simply unaware that they may have health problems related to their military service: diseases, conditions, and maladies which entitle them both to medical care and compensation from the VA. Also, most private-sector physicians and other clinicians are unaware of the potential connection between health problems and military service.

The VHC web site, which we expect to "grow" exponentially, provides information initially on health conditions associated with military service along with links to other healthcare sites related to specific diseases associated with three periods of war: Vietnam, the Persian Gulf, and the Global War on Terror. We urge veterans and their loved ones to visit www.veteranshealth.org to learn about the illnesses related to a particular period of service. Furthermore, if a veteran dies from a service-connected illness, the spouse may be entitled to Dependency Indemnity Compensation (DIC), as are eligible dependents.

Most importantly, the web site offers general information on how to file a claim for disability compensation. If a veteran has a service-connected medical condition, or if a surviving dependent believes that the veteran died from such an illness, the web site provides a link to a locator service for accredited veterans service representatives who can assist them in filing a claim for VA benefits.

Over the next few years, we hope to improve and expand our outreach efforts, through the web site as well as other means of communication. Because far too many veterans, and healthcare professionals, do not know about the connection between military service and health conditions which may affect veterans years after they've returned to the civilian world – and this is knowledge that they really need to have.

VIETNAM VETERANS OF AMERICA

About This Supplement

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Chronic Disease: The Next Crisis

The growing crisis of chronic disease could bankrupt our health care system — unless we act now.

"The costs associated with preventable, chronic illnesses are crippling the U.S. health care system and weakening our economy."

— Ken Thorpe
Executive Director
Partnership to Fight Chronic Disease

The dramatic growth of chronic disease is both a challenge and an opportunity.

If we ignore the problem, the cost of treating chronic conditions like diabetes, cancer, Alzheimer's and cardiovascular disease could overwhelm American health care.

But improving preventive care and better disease management are cost-effective solutions that can help reduce spending as part of comprehensive health care reform.

It's just common sense. Keeping people healthy — along with new treatments and cures — will cost less in the long run. Savings that will enable us to provide affordable health care for every American.

For more information on promising practices to promote health and wellness please visit fightchronicdisease.org — and join us in the fight against chronic disease.

PARTNERSHIP TO FIGHT CHRONIC DISEASE
fightchronicdisease.org