I cite the cost savings aspects of AHCPR research because of a recommendation by the Budget Committee to cut AHCPR research by 75%. The committee report also indicates that AHCPR was established to manage health care reform. That assertion is just plain wrong. AHCPR is an important agency for its research, but it was not envisioned to be a health care implementation agency. We may save a few Federal dollars by cutting AHCPR's funding, but we will lose far more in potential savings in our health care system.

The budget resolution also proposes deep reduction cuts in Medicaid and Medicare spending. I oppose those harsh cuts because the people of West Virginia will have health care benefits taken away from them as a result. It seems to me that the only way to rationally reduce costs and not hurt people by reducing their access to care or their quality of care, is to know what works and what does not work. That is precisely the point of the research of AHCPR.

The current budget of AHCPR is about $160 million. This modest investment is just now paying off in research and guidelines which have the potential to reduce cost and without a reduction in quality of care. It is my hope that the Appropriations Committee will continue to provide adequate appropriations for AHCPR and I will do my best to support the agency as the Congress makes its decisions on authorizations and funding for the coming fiscal year.

I ask that the article from the Washington Post be printed in the RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

[From the Washington Post, May 15, 1995]

HOUSE PANEL WOULD KILL AGENCY THAT COMPARES MEDICAL TREATMENTS

(By David Brown)

It doesn't take long to go from being a solution to waste to simply waste.

That, at least, is the congressional budget committees' view of the Agency for Health Care Policy and Research. The $162 million agency is the government home for ''medical effectiveness research.''

When it was created by Congress in 1989, the AHCPR was viewed as an essential tool in the effort to control medical costs without damaging medical care. Last week, the Senate Budget Committee proposed cutting its budget by 75 percent, and the House Budget Committee said it should be eliminated altogether.

AHCPR was launched with the great hope—much of it enunciated by politicians—that it would help the country cut health care costs painlessly by comparing competing treatment strategies to see which works, best, and at the least cost.

Over the last five years, the agency has sponsored 20 Patient Outcomes Research Team (PORTs), each headquartered at a different hospital or university, which studied such topics as back pain, schizophrenia, prostate enlargement, knee joint replacement, cataracts, breast cancer and heart attack.

The teams reviewed the published medical literature on the topic, delineated the variations in treatment, attempted to uncover links between specific treatments and patient outcome (often using large data banks kept by Medicare or private insurance companies), and occasionally devised new tools. For example, the prostate PORT created a video to educate patients about what to expect with certain treatments—including no treatment—and formally incorporated the tool into medical decision-making.

Recently, AHCPR has begun funding randomized controlled trials, which are generally the best way to compare one treatment with another. The topics are ones unlikely to appeal to the National Institutes of Health, where new therapies, not old ones (or low-tech ones), are the preferred subjects of clinical research.

AHCPR trials, for instance, are comparing chiropractic treatment to physical therapy in low back pain; testing a mathematical equation that identifies which patients are most likely to benefit from ''clot-busting'' drugs for heart attacks; and comparing homemade vs. commercial rehydration fluids for children with diarrhea.

The agency also has sponsored 15 ''clinical practice guidelines,'' which, based on the best medical evidence, suggest how to treat such common (and unexotic) problems as cancer pain, urinary incontinence and chronic ear infections.

In a recent example of that program's effects, researchers at Intermountain Health Care System in Utah reported they had cut the incidence of bedsores in high-risk (generally paralyzed) patients from 33 percent to 9 percent at LDS Hospital in Salt Lake City after implementing a modified version of AHCPR's guideline on pressure ulcers. Incidence of ulcers—which cost an average of $4,200 to treat—also fell among lower-risk patients, and the hospital estimated the annual savings will be at least $750,000.

To defund a relatively modest effort like that at a time when the questions they need to answer are becoming even more critical doesn't make a lot of sense to me,'' said Jay Crosson, an executive in charge of quality assurance at Permanente Medical Group, the physician organization of the Kaiser Permanente health maintenance organization (HMO). There's a lot more work that needs to be done than even AHCPR can fund.''

In explaining its recommendation of a 75 percent budget cut, the Senate Budget Committee said AHCPR ''was to be the primary administrator of comprehensive health reform''

This, however, is not true. Although data-gathering by AHCPR-funded researchers presumably would have helped assess the equity of a national health care program, the agency had not official role in the defunct Clinton administration plan.●

TRIBUTE TO THE CITY OF LAUREL

● Mr. SARBANES. Mr. President, celebrations to commemorate the 125th anniversary of the establishment of the city of Laurel, MD, are being held throughout this year. The mayor of Laurel, Frank Casula, along with the entire community, have planned several significant events to commemorate this milestone.

First known as the ''Commissioners of Laurel,'' the citizens of Laurel established their home as recognized by the laws of Maryland in 1870. Yet, even before then, the people of Prince Georges County were living off the land now known as Laurel. The first grist mill that was erected in Laurel would be the outset of community development; many industries, storefronts, offices and homes would eventually appear along that particular stretch along the Patuxent River. Creating what is now known as Laurel's Main Street, the mill built by Nicolas Snowden in 1811, had laid the foundation for a thriving community.

By 1888, Laurel was the largest town in Prince Georges County and had become the focal point along the Baltimore and Ohio Railroad between Baltimore and Washington, DC. In 1879, the Laurel Leader, one of the oldest newspapers in the State of Maryland, was founded. The Leader continues to serve not only Laurel and Prince Georges County, but also the bordering counties of Howard, Montgomery, and Anne Arundel.

Laurel was also a pioneering community in education. The first public high school in Prince Georges County is located in Laurel. Laurel Elementary School was also the first public school in the county to have a cafeteria to serve its students.

Laurel is a model of community spirit and cooperation. The activities being sponsored to commemorate this auspicious occasion exemplify the deep devotion of Laurel's residents to their community. The spirit and enthusiasm of Laurel's citizens have been the foundation of its success. These celebrations provide the opportunity to renew the dedication that has supported Laurel throughout its history and helped it to develop from a railroad stop to one of Prince Georges County's most attractive communities.

We in Maryland are fortunate to have an area as community-oriented as Laurel. I join the citizens of Prince Georges County in sharing their pride in Laurel's past and optimism for continued success in the years to come.●

PROSPECTS FOR PEACE IN BOSNIA AND CROATIA

● Mr. LIEBERMAN. Mr. President, I commend the United Nations for its May 25 air strikes against the Bosnian Serbs. It is about time the United Nations took an assertive, instead of a passive, approach to carrying out its mandated responsibilities to defend Bosnian safe areas and the Sarajevo weapons exclusion zone. Even before the formal expiration of the January-April cessation of hostilities in Bosnia, Bosnian Serbs were violating their commitment to refrain from violence. The Bosnian Government has defended itself, and apologists within the U.N. have mistakenly treated as equal the cease-fire transgressions of the Serb aggressors and the Bosnian victims. This has been wrong. Today's decision, finally, to use force, which has long been authorized, against those violating the weapons exclusion zone is a step in the right direction.

But it is only a small step. I was not surprised to learn of the failure of the