

If you look, for example, at the PARCA bill, it is largely a design of all the professionals who now want their share of the pie, and it's their version of how they would redesign it if health care was a pork-barrel project. But what you need to understand is, that is a natural partner of historic evolution once you politicize these decisions.

I'm not up here today to say anybody is right. I'm up here today saying let's look at the whole country. The M.D. is going to be threatened because the truth is we can begin to turn into expert systems. We can begin to have more preventive care. We can begin to have more patient responsibility. We can begin to have more information to the patient.

All of that is going to threaten the medical doctor. But their problem now is going to be science and the Information Age, not the HMO administrator. The HMO administrator must recognize that if you don't have a very high-quality response, if you're not very customer oriented, and if you haven't built a very good response system for your customer so that they have a ventilation point where they can get a second opinion, where they can appeal to a higher authority against the authority that's made them mad, you're guaranteed to get political action; that the only way to avoid political action is to have a self-fine-tuning, a self-responding, and a self-evolving system that is customer-friendly and consumer oriented.

In addition, I would argue that if we are really at the vision level talking about the future of health in America, it's likely to be a different system than anything we've seen, that the ideal model is one that goes back to dramatically strengthening the patient, that the patient ought to have a lot more choices and more responsibilities.

I've always like the International Paper model where they list every doctor in the area and every hospital in the area, and they say, here is how much they cost, and here is their background, and, by the way, we'll pay 100 percent of the median price. Go to anybody you want to. Now, if you want to go to a more expensive doctor, fine, you pay the additional costs. But it begins to dramatically transfer knowledge and power and responsibility.

Dr. Tom Coburn, who serves as a Member of Congress for Oklahoma, came up to me at our retreat in Williamsburg, and he said, I think we ought to reapply free-markets principles to health care; and being a conservative, I promptly said, yes, what do you mean? I know it's right theoretically. I know Adam Smith is right theoretically, but what does it mean in the middle of this 1943 tax code, third-party payment, highly convoluted, big structure, HMO, provider-sponsored network, hospital-based, doctor-based, secondary professions—in this mess, this huge, complex ecosystem of health, what does "free market" mean?

He said, I'll tell you a true story. He said, during the break, I had a couple who were between jobs and they had lost their health coverage, but they had savings. She needed an operation. I gave her five surgeons and three hospitals to call. They negotiated. They got an \$11,000 procedure for \$5,000, but they paid in cash without paper work.

Now, that's a fairly astonishing number. My guess is all of you could find similar stories or already know similar stories. From my standpoint, what I want to do is say, so how do we maximize the rate of change? Because what the human genome projects is telling you and what lasers are telling you and what all the other breakthroughs are telling you is you're going to see a rate of change in health capabilities. And, again, I don't want to talk about health care yet. You're going to see a rate of change in health capabilities that is stunning.

So how do we maximize that rate of change? How do we maximize the citizens' access to knowledge, including their knowledge about their own responsibilities and knowledge about their own characteristics and knowledge about how to stay well rather than get sick? How do we maximize the ability to connect the citizen to the professional at the minimum cost with the maximum choice? How do we create feedback loops, both so that we know it's the right professional, and so if something goes wrong, we can check on it?

And if you could tomorrow morning take your HMO or take your health organization and find a way to have 100-percent deductibility for health, so that a person who paid out of their own pocket had exactly the same deductibility as a big corporation and said to all of your members, "Here is basically a cafeteria plan. Which of these nine things do you like better?" you would lose some of your mass purchasing power, but you would put back on their shoulders their responsibility. So you like the HMO? Fine. Come in and join one. You would rather go and buy it all on your own? Fine. Go buy it all on your own.

And what I'm suggesting is that where we need your help is not only doing better, and a lot of you represent some of the most enlightened and most aggressive and most patient-oriented and also most health-research-oriented people in the country. But I'm also asking you to take a little extra time, go back up to the vision level. Help us solve the big issues. Help us think about what do we mean in the 21st century by health in America. What should a citizen have access to? How do we maximize the rate of change?

And I'll just close with this thought. Health is not a problem. Health is an opportunity. Health will be the largest, foreign-exchange, income earner in the 21st century. If we have the best system of health on the planet, if we have the best research on the planet, if we provide the best care on the planet, as people get wealthier worldwide, they will come to America, either personally, or by electronic means, in order to have access to the finest health in the world.

We will earn far more money out of providing the best health capabilities on the planet than we will earn out of the motion picture industry, jet airplanes or computers, and we ought to see health as that opportunity—the opportunity to provide the best health for our own citizens and to provide the highest-paying jobs on the planet in a growth industry of enormous potential if we maximize the rate of change and innovation and bring to bear the best science we can as rapidly as we can.

And if we then educate our citizens into a knowledge-based model of caring for themselves, we will maximize their health and minimize their costs, and we will do so in a way that I think will be profoundly different than the current debate between more bureaucracy-less bureaucracy, more trial lawyers-fewer trial lawyers, and I think we need this much larger level dialogue in order to define where we want to go over the next 15 or 20 years.

#### DRUG-FREE AMERICA TASK FORCE AWARENESS

**HON. GEORGE R. NETHERCUTT, JR.**

OF WASHINGTON

IN THE HOUSE OF REPRESENTATIVES

*Wednesday, May 20, 1998*

Mr. NETHERCUTT. Mr. Speaker, as a Member of the Drug-Free America Task

Force, I have had the opportunity to meet with numerous organizations and individuals interested in finding ways to reduce drug use. One of the studies that caught my attention was a study by the Center on Addiction and Substance Abuse. It stated that a 12-year-old who smokes marijuana is roughly 80 times more likely to use cocaine than one who does not, adults who as adolescents smoked marijuana are 17 more times likely to use cocaine regularly, and 60 percent of adolescents who use marijuana before age 15 will later use cocaine.

It seems to me, Mr. Speaker, that the key to reduce overall drug use is to find ways to curtail the number of our children who use drugs. As a parent, I realize that the lifestyle decisions my wife and I make will impact our children. Our children are fortunate that they have had a good example set for them, but there are many kids whose parents or other role models send them the wrong message that drugs are acceptable by their own drug use. I believe the government has an obligation to punish more severely those who influence the children of America by using or possessing drugs in their presence.

Mr. Speaker, the Save Our Children Act, which I am introducing today, sends a strong message that drug use or possession of drugs around children will not be tolerated. Under current law, there are enhanced penalties for the distribution of a controlled substance to persons under age 21 by persons over age 18 (21 U.S.C. 859); employment of persons under age 18 for violation of the Controlled Substance Act or unauthorized distribution to a pregnant individual (21 U.S.C. 861) and distribution or manufacturing of a controlled substance in or near schools, colleges or youth-centered recreational facilities (21 U.S.C. 860).

The Save Our Children Act, Mr. Speaker, fills a gap in our Sentencing Guidelines by directing the U.S. Sentencing Commission to enhance the sentences for the commission of a drug offense in the presence of a minor. While the Sentencing Commission is given discretion to amend the Sentencing Guidelines, the Save Our Children Act sets a minimum of two offense levels greater or 1 year whichever is greater for the first offense, and 4 offense levels greater or 2 years for a second offense.

I urge all my colleagues to consider becoming a cosponsor of my legislation.

#### WEST LIBERTY CLASSICAL ACADEMY HONORED BY DEPARTMENT OF EDUCATION

**HON. WILLIAM J. COYNE**

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

*Wednesday, May 20, 1998*

Mr. COYNE. Mr. Speaker, I rise to commend the students, faculty, and administration of West Liberty Classical Academy, whose outstanding performance was recently honored by the Department of Education and the National Association of State Coordinators of Compensatory Education. West Liberty is one of only 109 schools nationwide to be recognized by the Title I Recognition Program. The Title I Recognition Program honors schools that have set and reached high student achievement goals, fostered professional development, and built partnerships with parents and the community.