best medicine that insurance could buy: a heart bypass operation, extensive hospitalization, plus literally thousands of hours of one-on-one nursing care after the stroke left him partially paralyzed. I remember when the stroke hit: the doctors predicted he'd live maybe nine more months. That was in 1986. He passed away last year.

It would be near impossible to add up my grandfather's medical bills, but I'm sure they totaled hundreds of thousands of dollars. He benefited from a wide range of pharmaceutical products, the most advanced medical technology in the world, and care from highly trained specialists. Above all, he benefited from a health care financing system willing to subsidize such extravagance at every level—from the training of the surgeons to the research that invented blood-thinners to the salary of the worker who lifted him in and out of his wheelchair every day.

I thought about that last week when I read an article on rising health insurance premiums. It was merely the latest confirmation of a trend many economists have long predicted: that, after years of stability, the real price of health care in America is about to start climbing again. According to a study published last fall in the journal Health Affairs, the nation's total health care bill will likely go up by 3.4 percent annually over the next four years—compared with a rate of just 1.5 percent in the period from 1993 to 1996. By 2007, the study predicted, health care will soak up 16 percent of the gross domestic product. That would be quite a lot of money, particularly when you consider that we already sink more than 13 percent of GDP into health care—more than any other nation and well more than we spent in 1970, when health care was just seven percent of GDP.

The predictions are probably right. Today, about 85 percent of Americans who hold private insurance are enrolled in health maintenance organizations or other forms of managed care, which hold down costs by emphasizing preventive medicine; controlling access to tests treatments, and specialists; and simply bidding down the services of doctors and hospitals. Most of the people in these plans shifted over from costly fee-for-service insurance only in the past few years, and that transformation is the primary reason health care spending has remained stable during that time. But the cost containment from HMOs seems to have been a onetime phenomenon. Now expenditures on health care are going back up, if at a somewhat reduced clip, in part because people are starting to demand some of the things HMOs have been denying them, in part because the population is living longer, and in part because researchers continue to come up with expensive new technological innovations that patients want, from Viagra to the protease inhibitors that keep HIV in check.

Once the bill for all of this spending comes due, in the form of higher insurance premiums and more government spending, you can bet that a chorus of experts and high-minded officials will start insisting that we're spending too much. Some will do what former Colorado Governor Richard Lamm did back in 1992: they'll come right out and say we need to stop coddling the elderly with the kind of ''long-shot medicine'' that sustained my grandfather and made him more comfortable in his final years. Others will strike more cautious tones, preaching the need to be more efficient in our outlays, but the end result will be much the same: less generous care particularly at the margins. In a sense, we're already hearing early versions of this argument in the ongoing debate over Social Security and Medicare—two programs in which the current level of expenditures is widely believed to be unsustainable over the long run.

But this may be a case where the average citizen, who intuitively wants to keep spending that money, knows more than the average expert, who insists it's not possible. After all, we spend far more on computers than we did 20 years ago, but nobody makes a fuss about that. The reason is that computers have made economy stronger and our lives discernibly easier. Well, the same logic ought to apply to health care. Among all of the things a nation's wealth could buy, surely the health of its citizens is near the top. And, while some critics might carp about inefficiency in the system, that inefficiency keeps a good chunk of our country employed—while enabling the population as a whole to work longer and harder.

To be sure, many critics question whether our robust health care spending really translates into robust health. They argue that, even though European nations spend less on health care, the differences in health care ''outcomes'' and life expectancy are minimal. But it is notoriously difficult to measure the impact of health care spending. For one thing, those comparatively frugal counties benefit from the pharmaceuticals and treatments largely subsidized by big spending in the United States. What's more, the benefit of more health care spending may be simply to provide a few more weeks here and there, or to make life just a little more comfortable for some of the nation's sickest people. This is not the kind of thing that makes a big difference statistically, but it is the kind of thing a society might rightly deem important. After all, this is what usually happens in societies as they progress economically: the percentage of labor time spent on producing bare necessities—food, shelter, and clothing—shrinks, freeing up greater resources for making life more pleasant.

This isn't to say we parcel out all of our health care dollars wisely. Among other things, we currently subsidize emergency care for the uninsured, which is at once very expensive and not terribly efficient at keeping people healthy, while denying them the basic care most other nations offer as a privilege of citizenship. But the solution to this problem is not to worry excessively about how big the bill has gotten; if anything, we should be making the case for spending even more money and them making sure it's meted out on a more egalitarian basis. (Sound crazy? No less a sober mind than MIT economist Paul Krugman once made a similar argument, speculating that spending as much as 30 percent of GDP on health care might not be unreasonable.)

Yes, there is one catch. If you want to spend that much money on health care, you have to find the money to spend. But that's not a problem—or, at least, it shouldn't be. We have enjoyed enormous gains in productivity over the past few years, which means as a nation we are creating more wealth—wealth that can easily be directed to health care rather than to, say, sport utility vehicles, either in the form of higher insurance premiums or (heaven forbid!) higher taxes. ''The alternatives uses of our resources are not necessarily more noble,'' Mickey Kaus once wrote in this space. He's right. There are a lot of things we could have bought my grandfather in his final months. But none was as valuable as the time itself.

HONORING LIEUTENANT COLONEL DEBRA M. LEWIS

HON. ROBERT A. BORSKI

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 12, 2000

Mr. BORSKI. Mr. Speaker, today I pay tribute to Lt. Col. Debra M. Lewis, the departing Commander and District Engineer of the Philadelphia District of the U.S. Army Corps of Engineers. Colonel Lewis fills many roles in her life. She is a mother to Emily, wife, daughter, sister, equestrian, mentor to many, friend to even more, and last, but not least, a U.S. Army Lieutenant Colonel. She brings great strength, vitality and dedication to all the facets of her life, but it is her allegiance to her country that prompts me to honor her today.

As Commander of the Philadelphia District of the Army Corps of Engineers, she oversees the Delaware River Basin, approximately 13,000 miles spread across the five states of Pennsylvania, Delaware, New Jersey, New York and Maryland. More than 550 civilian and military personnel dedicate their efforts to carry out Corps projects at the request of local and state agencies, as authorized by Congress. Flood control, navigation, military installation support and environmental restoration are key missions of the Philadelphia District, which is a lead partner in the plan to preserve and protect the region and its water resources.

I have also enjoyed working with Colonel Lewis on many occasions. Her professionalism, expertise, and dedication to the Army Corps of Engineers have been an integral part of the success of the Delaware River Main Channel Deepening Project. I have also enjoyed working with Colonel Lewis on my vision for Philadelphia—the redevelopment and the revitalization of the Delaware River Waterfront. Her support has enabled this new project to move forward.

Colonel Lewis came to the Philadelphia District two years ago uniquely qualified to serve as its first female commander. A woman of many firsts, Debra Lewis is a member of the first class to graduate women from West Point. She was also the U.S. Military Academy's first female captain of its highly successful intercollegiate equestrian team, and also the 1980 Academy Equestrian of the Year. Her initiative and perseverance have seen her through many challenging circumstances.

In addition to her other pursuits, Colonel Lewis enjoys collecting quotations. Her personal motto: Attitude is everything. But I would offer one from Harvey Firestone, who once said, ''You get the best out of others when you give the best of yourself.'' It is my opinion that Lieutenant Colonel Debra M. Lewis is the embodiment of that sentiment.

Mr. Speaker, Lieutenant Colonel Debra M. Lewis should be commended for her 18 years of military service in the United States Army and is congratulated for a job well done for her performance as Commander and District Engineer of the Philadelphia District, United States Army Corps of Engineers. I offer her my very best wishes for continued success.