such as Seroquel after listening to Dr. DelBello. But when the reporter from the New York Times asked Dr. DelBello how much money she got from Astra Zeneca, she told the paper: ''Trust me. I don't make much.''

Well, I decided to find out how much, and I went directly to the University of Cincinnati who, by the way, has been extremely cooperative, helpful, and responsive. Soon I figured out just how much ''not that much'' money is. Dr. DelBello's study, which helped put Seroquel on the map, was published in 2002. That next year, she got more money than she has ever received from the pharmaceutical companies—at least that is what the documents that I have say.

In 2003, Astra Zeneca alone paid her a little over $100,000 for lectures, consulting fees, travel expenses, and service on advisory boards. In 2004, Astra Zeneca paid her over $80,000 for the same services.

Now I am not saying this money was a payoff or suggesting there is something inherently bad with accepting drug company money, but let me tell you what Dr. Steven E. Hyman, provost, Harvard University and former Director of the National Institute of Mental Health, said.

He said these payments could encourage psychiatrists to use drugs in ways that endanger patients' physical health. Specifically, he said of doctors:

> We don't connect the wires in our own lives about how money is affecting our profession and putting our patients at risk.

I think this is a rather interesting assessment by Dr. Hyman.

But let me continue. Just last March, several leading physicians released a study on pharmaceutical company payments to physicians. They published this study in the Journal of the American Medical Association, one of the most prestigious journals in medicine. I would like to quote what they concluded about the need to provide public disclosure of these payments to doctors:

Full disclosure would better allow the public to appreciate the relationship between industry and the health profession.

And so, for the sake of transparency and accountability, shouldn't the American public know who their doctor is taking money from? After all, anybody can go on the Internet and see who is funding the campaigns for federally elected officials. Because doctors are expected to look out for the health and well-being of their patients, shouldn't we hold doctors to similar standards?

In fact, some of this is already occurring. Minnesota requires drug companies to report any payments they give to doctors in that State. I think that is a good thing. Apparently, so do the citizens of Minnesota.

I think what we really need is a national program that will require all drug companies to report when they make payments to doctors. I don't think it would be all that hard for those companies to do. After all, companies have to make sure they know where every penny is going. So it should not be that hard to report some of it to the Federal Government and to the American people. Besides, they are already doing it in Minnesota.

In closing, I plan to continue my inquiry into drug company payments to doctors. In addition, I look forward to working with my colleagues in the Senate, as well as members of the pharmaceutical industry, to establish a national reporting system.

I yield the floor.

The PRESIDING OFFICER (Mr. SALAZAR). The Senator from Maryland is recognized.

Mr. CARDIN. Mr. President, I ask unanimous consent to be recognized for 7 minutes, and if the Chair would notify me when I have used 6 minutes.

The PRESIDING OFFICER. The Chair will do so. Without objection, it is so ordered.

Mr. CARDIN. Mr. President, I take this opportunity to speak in favor of the Children's Health Insurance Program and its reauthorization, which is the legislation that is before us. We hear the numbers that 6 million children benefit from the program today—over 6 million—and this will provide for an additional 3 million children.

I want my colleagues to know that each one of these people are people, they are families, and they are affected by what we do here today. I take this time to acquaint my colleagues to Deamonte Driver. He was a 12-year-old who didn't live far from here—6 miles from here—in Prince Georges County, MD. He had a tooth problem. His mother tried to get him help. He had no insurance, and he fell through the cracks. He had a brother, Dashawn Driver, who had six decaying teeth. They tried to get help for him. The mother thought the older brother was in worse shape than Deamonte. He started having headaches and was rushed to the emergency room. They found out his problem—he could not get to a dentist—was an abscessed tooth.

Before this, a social worker made 20 phone calls in an effort to try to get dental care for the Driver family, without success. They could not find a dentist willing to treat someone without insurance or in the Medicaid system. Deamonte ended up needing emergency surgery, which cost $250,000, and he ended up losing his life because the system did not provide care for a 12-year-old.

Mr. President, we can certainly do better than that. Dr. Koop, a former Surgeon General of the United States, said, ''There is no health care without oral health.'' Medical research has shown the linkage between plaque and heart disease. We know now that gum disease can be a signal of diabetes or a liver ailment or a hormone imbalance. We have to do better than we are doing today.

Dental disease is the most common childhood ailment in the United States to date. One out of five children between the ages of 2 to 4 will have some form of decaying teeth. By the time they reach 15, three out of five will have tooth decay.

There is an imbalance as far as the racial effects. Racial minorities are much more likely to sustain untreated tooth decay. Forty percent of African-American children have untreated tooth decay.

I thank my colleague, Senator BINGAMAN, for his leadership on these issues and for introducing legislation and moving forward to try to provide better oral health care for children. I thank Senator SNOWE for her leadership. I thank Senator BAUCUS and Senator GRASSLEY for including initiatives in the legislation that is before us that will help the States meet this challenge—the $200 million included in the bill. That will have a major impact to try to help American families.

We have an important opportunity before us in the legislation that we are considering to help our children, not only to continue the benefits for 6.6 million children but so that we can add another 3 million out of the 9 million who currently have no health insurance.

We have to do more, but this is our opportunity today, and we have to take advantage of it. Our health care system is in crisis.

Earlier this week, I introduced the Universal Health Coverage Act, which would require everybody in this country to have health insurance. I think it is essential that we address the major problems in our country of so many people being without health insurance. We should start with the children, and we can do that with the legislation that is before us.

Why is that important? Well, we know that children who are enrolled in the Children's Health Insurance Program or have insurance are much more likely to get primary health care. They won't use the emergency rooms as much. If you don't have insurance, you have no choice but to go to the emergency room. We have improved health care outcomes if the child has health insurance. We know they are much more likely to have immunization and primary health care.

I want to comment that—again, talking about families and individuals—the Finance Committee held a hearing on the Children's Health Insurance Program. The Bedford family from my city of Baltimore came down here and testified.

Mrs. Bedford said:

> We no longer have to decide whether a child is really sick enough to warrant a doctor's visit.

The Bedford family enrolled in the Children's Health Insurance Program in Maryland. The program is working. Without this legislation, we will have to reimpose freezes on enrollments and people will lose coverage. It happened