''It was pretty shocking to us,'' Ezzati said. And contrary to what might be expected, he said the observed declines in life expectancy did not seem to correlate with race or income. Ezzati emphasized this wasn't just a trend affecting poor minorities.

''This appears to be something beyond race and income,'' he said. Most of the worst-off counties were lower-income in comparison with other counties, Ezzati said, but the decline in life expectancies did not simply correlate with income. ''For example, the data for low-income whites in northern Minnesota looked quite different than low-income whites in Appalachia,'' Ezzati said. ''The geographical differences here are capturing something significant.''

The researchers found that the diseases most closely associated with the observed declines in life spans appeared to be related to smoking, obesity and high blood pressure. Women probably have suffered more significant declines, Murray said, because of increased rates of smoking and obesity, compared with men.

''But that's still just speculation,'' he said. ''We really don't know all the reasons for this.''

Both Ezzati and Murray said it would be wrong to simply conclude these declines in life expectancy in certain regions are attributable to poor lifestyle choices—smoking, poor diet or lack of exercise.

''If this was just a matter of bad individual choices, you would expect to see these declines in life expectancy evenly distributed around the country,'' Ezzati said.

''I don't think it's as simple as lifestyle,'' Murray said. Having high blood pressure or diabetes isn't really a matter of choice or lifestyle decisions, he said.

In the 1960s, when traffic deaths were increasing, Murray said the nation launched a safe-driving campaign that failed to reduce deaths or accidents. When policymakers instead began treating that as an engineering and regulatory problem—requiring cars to have seat belts, later air bags and improving the safety of the roads themselves—''that's when the deaths started to go down,'' Murray said.

Likewise, he and Ezzati said they hoped their findings will spur policymakers to both improve chronic disease surveillance and explore methods aimed at curbing this disturbing, deadly trend.

IN WASHINGTON

Over the past four decades, life expectancy in the U.S. has increased overall for men from 67 to 74 years and from 74 to 80 years for women. But in certain locations, starting in the early 1980s, researchers say life expectancy began to stall or decline—especially for women. In Washington State, four counties (Lewis, Cowlitz, Benton and Grays Harbor) are among those places where life expectancy has not declined, but also has not improved much since the early 1980s.

THE HEALTH CARE SYSTEM I WANT IS IN FRANCE

(By Mary Cline)

PARIS, April 15, 2008.—Shortly after we moved to Paris, my son, Luke, cut his lip in a fall at school. I rushed him to the emergency room of a suburban Paris hospital, where a nurse asked my name and address and a doctor quickly stitched up his cut. When I tried to pay, the cashier asked me to call the following week because the ''computer is slow.'' A bill eventually arrived in the mail for the equivalent of $60.

The same week I took Luke to have his stitches removed at a clinic where a doctor spent nearly an hour with him first softening a scab on the cut. This time, the clerk was apologetic as she handed me the bill, explaining she was sure my American health insurance would reimburse some of the cost. The total bill: $7.50.

As presidential candidates hammer out proposals to deal with the increasing millions of uninsured Americans, I know which health plan I'll choose: the French one.

The World Health Organization has named the French health care system the best in the world. (The U.S. ranked 37th). It's physician-rich, boasting one doctor for approximately every 430 people, compared with a doctor for every 1,230 residents in the U.S. (and French docs tend to charge significantly less). The average life expectancy is two years longer than the U.S. And while the system is one of the most expensive in the world, costing $3,500 per person, it's far less than the $6,100 spent per capita in the U.S.

I've had a unique opportunity to see both systems up close and personal: I had breast cancer in California nine years ago and a recurrence in Paris this year. I received excellent care in both places, though looking back now my California oncologist's office was a bit of a meat market—always packed with patients, from the seemingly not-so-sick to some a step from the grave—a time-consuming disadvantage of living in a much larger country with a lower doctor-to-patient ratio.

My French doctors and nurses have been sensitive, skillful, caring—and not so harried. But the biggest difference has been money.

My top-level health insurance paid for most of my U.S. care, but it was often a struggle to shake loose the money. I was frequently stuck in the middle of disputes between the company and my hospital and doctors over ''agreed to fees.''

Continually dunned by the hospital for fees and facing multiple complaining phone calls to my insurance company, I sometimes simply caved in and wrote checks to cover bills that I knew were the insurance company's responsibility—part of a wearing-down strategy I was convinced was deliberate.

Here in France I have a green carte vitale—literally a ''life card'' or social security card that provides entree to the system. It's funded by worker contributions and other taxes. My husband (and our family) is covered through his work with a French subsidiary of a U.S. company, and so is everyone else; coverage is universal. The French are responsible for co-pays, but some 80% of them have supplemental private insurance to cover the co-pay. People least able to pay and those with chronic or serious illnesses often have the best coverage. Because I'm being treated for cancer, I'm cent pour cent—100%—covered.

The effect of a system where hospitals and doctors don't worry about getting stiffed by a patient or an insurance company seems to be a far more relaxed, generous system. When my surgeon discussed breast surgery here, he suggested that I stay in the hospital five days. ''Of course I can do it the American way, kind of an outpatient situation,'' he told me, apparently not wanting to sound unsophisticated. ''But I don't like pain.''

Maternity stays for a normal delivery are a minimum of five days, not the 48 hours mandated by U.S. federal legislation in 1998 after many insurance companies insisted stays be even shorter.

I've always had health insurance in the U.S. And yet the few times I'd had to walk into an American emergency room I've always felt a thief who seems to be expected to sign over all worldly goods before any medical care can begin, regardless of the state of agony someone might be in. French doctors address problems immediately and aren't constrained by approvals from some medical decision maker in a distant insurance office.

Years ago, my husband had to wait several hours in a Manhattan emergency room as administrators tracked down someone in our out-of-state insurance company who would approve (and therefore agree to cover the bill for) antibiotic treatment for a horrifying infection in his face that doctors were concerned could have been flesh-eating strep.

There's no question you'll be treated in France. Everyone is. The nation pays the bills and the hospitals don't get stiffed. It's an all-encompassing cradle-to-grave system. My fear now is that I won't be able to even get insurance when and if I return to the states, much less be able to afford it.

''The French health care system has a lot of lessons for the U.S.,'' said Northern Arizona University Professor Paul V. Dutton, who has studied both extensively for his book ''Differential Diagnoses: A Comparative History of Health Care Problems and Solutions in the U.S. and France.''

''There seems to be a feeling that Britain's socialized health system is the only one we can look at because it's English, it's the mother country. But in fact, the French share many of the same values that American consumers seek, like choice of physician and freedom from insurance company authorization of medical decisions. The French system is already far more similar to the American ideal,'' Dutton said.

Except it works.

COLOMBIAN DRUG CARTELS USING SUBMARINES TO BRING COCAINE INTO THE UNITED STATES

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Texas (Mr. POE) is recognized for 5 minutes.

Mr. POE. Mr. Speaker, I want to bring to the House's attention a new innovative idea to import drugs into the United States. The drug cartels in South America, specifically in Colombia, continue to figure out ways to import cocaine at a profit into our country. Now they are doing it by sea, and they are using submarines that they make in the jungles where they make the cocaine that they bring into the United States.

I have here, Mr. Speaker, a photograph of a submarine. This photograph was taken by the United States Coast Guard as they were on patrol off the coast of Colombia with the United States Navy. This submarine is made out of fiberglass. It is about 100 feet long and it carries approximately $300 million worth of cocaine. It has a crew of five.

It is made in such a way that when intercepted by the United States Navy or the United States Coast Guard, they are able to pull certain levers and valves on this submarine and it is junked in the Gulf of Mexico or off the coast of Colombia. They scuttle these ships, because what happens is when they scuttle them, the five man crew jumps off the boat into a lifeboat, and then our United States Navy has to rescue them and save them, but they can't prosecute them for importation of drugs into the United States.

These submarines cost the drug cartels about $1 million apiece to manufacture. Intelligence sources tell us

that the drug cartels will bring in approximately 90 more loads of drugs into the United States from Colombia using these submarines the rest of this calendar year.

They are made in such a way that they are highly mobile. They go about 14 knots apiece, and they are able to go all the way from Colombia into the United States without refueling. It is a constant problem for our Navy and our United States Coast Guard to track these individuals and to catch them with the cocaine.

Only one situation where we, I say we, the United States Navy and the Coast Guard, were able to capture one of these vessels before it was scuttled and prosecute the crew was when they tried to sink it off the coast of Colombia after seeing the United States Navy. But what happened was after they scuttled the submarine, a load of cocaine, a bundle of cocaine, if you will, came to the surface. Once it came to the surface it was confiscated by our Navy. The five member crew was captured and they have been taken to Tampa, Florida, and they are on trial for importation of narcotics into the United States.

I bring this to the House's attention, Mr. Speaker, because of the fact that Congress needs to deal with this issue. These submarines carry no flag. They are not registered to any nation or foreign government. The crew members come from all over the world, mostly from Colombia. They claim no citizenship from any nation. And they don't claim, of course, possession of the vessel.

So Congress can deal with this issue by making it a Federal offense to use a submarine within international waters that carries no flag, carries no registration of another nation, and if a person is caught operating one of these vessels, they could be prosecuted as if they had drugs. The drug cartels are smart. They know if they can destroy the evidence they can't be prosecuted. We need to make a law that being in possession of this submarine is enough to prosecute them for crimes on the high seas.

Mr. Speaker, I might add that these vessels are so manufactured that they are not just able to carry cocaine into the United States worth $300 million, or 12 tons, that is how much cocaine, but that same vessel can go into any of our ports in the United States as a submarine carrying weapons, explosives, weapons of mass destruction, and used as some type of suicide submarine, similar to what was used against the USS Cole some years ago in the Middle East.

So the United States Coast Guard and Navy is to be complimented for tracking these vessels and doing everything they can to interdict the individuals that bring that cancer into the United States, and Congress needs to deal with the issue, to have these submarines that are basically at war with the United States bringing in these narcotics, have it be a crime to be in possession as a crew member of one of these vessels. It is things like this where we have to keep constant diligence in fighting the war on drugs.

Just to be clear, Mr. Speaker, intelligence tells us that these submarines are made by the Revolutionary Armed Forces of Colombia, or FARC. That is the military wing of the Colombian communist party. Of course, that is how they finance their revolution and the revolutionary ideas in South America.

And that's just the way it is.

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Oregon (Mr. DEFAZIO) is recognized for 5 minutes.

(Mr. DEFAZIO addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

PRESIDENT'S COMPASSIONATE CONSERVATISM A FAILURE IN AMERICA

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Ohio (Ms. KAPTUR) is recognized for 5 minutes.

Ms. KAPTUR. Mr. Speaker, last week when Pope Benedict XVI visited our Nation's Capital and then the United Nations, he inspired America and the world by invoking the moral imperatives of peace, justice and human rights. In greeting the Pope to America, President Bush dusted off his message of ''compassionate conservatism,'' which has lain dormant for 8 years since the Bush-Cheney campaigns of 2000.

President Bush said as the Pope sat there, ''Here in America, you will find a Nation of compassion. Americans believe that the measure of a free society is how we treat the weakest and most vulnerable among us.'' The President said, ''So each day citizens across America answer the universal call to feed the hungry and comfort the sick and care for the infirm.''

The President might be correct that American citizens try to fulfill these moral obligations of feeding the hungry and comforting the sick, but they are doing it with no help from his administration. Surely his administration has been conservative, but not compassionate.

The United States Government under George W. Bush has turned its back on the hungry. Ask any person who handles a food bank in this Nation. They took one program, the Commodity Supplemental Food Program, and totally eliminated it, a program that feeds our Nation's hungriest. And while food pantries across our Nation are short and donations way down, the President turns a blind eye and utters those false words before the Pope.

The United States Government under George W. Bush has turned its back on the sick and the infirm. It was he who vetoed the children's health program and has since failed to provide health care for so many millions of our Nation's children whose families are working but still have no health insurance.

If the measure of a President is how his administration has treated the weakest and most vulnerable among us, then George W. Bush has failed the test of that leadership.

Here at home we have people converging on food pantries that are not able to cope with the demand. We have young people unable to find summer jobs, find it difficult to get student loans, and even more difficult to get a job to pay them off. We have families that lack health insurance. We have 10 seniors waiting for every one available affordable housing unit. And we have veterans in dilapidated facilities without the proper health care and support they need to rebuild their lives when they return home. This in a land where President Bush says, ''Each of us is willed and each of us is loved.''

Mortgage foreclosures have a death grip on our economy, yet Washington continues to drag its feet on a solution with real bite. An estimated 1.6 million foreclosures occurred in 2007, and as of December, 2.9 million loans were past due, signaling that the worst is in front of us. This means that more than 40 million homeowners are at risk of seeing their property values decline as a result. And by early 2009 as many as 12.5 million homeowners will have no equity in their homes or will owe more than their homes are worth. In fact, America today is experiencing something it never has before, negative net equity in home mortgages. The value of the home is less than what people owe.

Where is the Bush administration? I invite the President to Ohio. Help us get these mortgage servicers to a table so we can do workouts. Where is HUD? Where is the Federal Reserve? Where are all these regulatory agencies? Where are they? Where is the President?

States and localities are struggling because of the Federal Government's absence in this area of workouts, and municipalities' tax bases may drop as much as $356 billion over the next 2 years, further undermining their ability to provide vital services for strapped residents because their tax bases are going down as a result of declining property values.

We have had the largest home equity washout in U.S. history. And what is the Bush response? To transfer $29 billion to bail out Bear Stearns, a Wall Street fast buck operation which is a Federal Reserve favorite and a primary dealer of U.S. Government securities. Yet nothing is done to help the States where these foreclosure crises are going on every day, to help America's families reposition so that they don't lose their major asset.

Yes, the Bush administration is conservative, but it is not compassionate.