resolved by, I forgot that was a rule. It's not the way it works, and that's not the way it should work.

We've got issues before this Congress that are issues that divide this Nation. We are about putting back this Nation together, not dividing it. That is what our President has told us. We, in this body, are about putting this body back together in a healthy way. The noble statements made by the Speaker are only noble if they're carried out. But if they're only words—we hear lots of words around this place. There is more than just words involved in everything we do. There is action. Let's resolve these issues. That is all I ask. That is all the Members of Congress ask. And I think that is all that the American people ask. Let's resolve these issues.

I guess the ultimate resolution will be at the polling place, but that is not really the solution we should have. There should be more pride in this institution than having to settle it at the ballot box. That is kind of like settle it out in the street in Gunsmoke. That is not the law we want to have in this country. Let's settle these issues.

I thank the Speaker for his patience, and I yield back the balance of my time.

HEALTH CARE AROUND THE GLOBE

The SPEAKER pro tempore (Mr. MINNICK). Under the Speaker's announced policy of January 6, 2009, the gentleman from Illinois (Mr. KIRK) is recognized for 60 minutes.

Mr. KIRK. Mr. Speaker, when I returned home from Afghanistan, I have been spending the last several months on the health care issue and the need for reform in this country.

Before being elected to Congress long ago, I used to work for the American Hospital Association as a young researcher in their hospital research and educational trust. Now, with the service in the Congress and this background, I have been working for several weeks now intensively building a bipartisan and centrist agenda for health care reform. Our base for this is the Tuesday Group, 32 centrist GOP moderates, which I co-Chair along with Congressman CHARLES DENT. Tomorrow, we will outline a detailed health care reform agenda with 70 representatives of patients, doctors, hospitals, employer and insurer groups.

Our President has set three top goals for health care reform: to lower costs, to increase choice, and to expand access. But what model should the Congress use in providing the reform that our country needs?

I want to talk tonight to provide some details on key issues that we are facing to review comparisons of health care systems in the United States and among our key allies and then to discuss detailed centrist, bipartisan solutions that we could put forward—especially in Senate health care legislation—that could make its way to the President's desk.

First, on the details. Our system is built largely on private health care for people under age 65, and we have seen a tremendous explosion in defensive medicine. Defensive medicine is driving costs up in our country probably faster than other countries because, as you can see from this chart, the cost of defending across a lawsuit has been rising steadily in recent years, and this is unique to the United States. This chart alone shows that especially for obstetricians, gynecologists, and neurosurgeons, the need is clear for lawsuit reform to restrain the growth in medical costs, especially in health insurance.

This chart shows a comparison in the critical issue, which I believe that our top focus is not in health care costs but in health care outcomes. The question should be whether you live or die in the system first, then how much does it cost.

When we look at, for example, patient-reported health care outcomes in pap smears and mammograms, we see stark differences in coverage for Americans and in other countries. Here you see pap smears in the last 3 years, women aged 25–64, 89 percent coverage for the United States; but among our British allies, only 77 percent, and probably the key model that many in Congress are looking at, Canada, falls well below the United States.

Also in mammograms, key for long-term health status among women in the United States, 86 percent coverage for women aged 50–64, and much lower across the board in more status, government-controlled health care systems.

We also looked at a key fact in health care, which is health care delayed is health care denied. The problem with waiting times is present in the United States, but it's much more acute in other countries. When we look at patients who waited more than 4 weeks to see a specialist doctor, we see in the United States it's about 23 percent, 1 percent better, actually better, in the German Republic. But in the principal cases of Canada and the United Kingdom, which offer so many examples to many in this Congress for the kind of health legislation they would like to put forward, waiting times are double what they are in the United States. That means that the health care that they provide would be much poorer than for our country, especially during a long wait.

This chart shows even a more serious situation. It shows the percent of patients that had to wait more than 4 months for health care. In the United States, just 8, even slightly better in Germany, but when you look at Canada, and especially the United Kingdom, now reporting 41 percent of patients who have waited more than 4 months for health care.

Health care outcomes are distinctly different for the United States and other countries, especially with breast cancer incidents. This chart shows mortality per 100,000 females of breast cancer, and it shows that the United States actually has the best numbers compared to Canada and the United Kingdom at 28 for the U.S., 29 for Canada, and 34 for the United Kingdom.

When we look at high-tech medical procedures in Britain, Canada, and the United States, the critical procedures necessary to actually survive key bits of morbidity are not available in Britain and Canada as compared to our country. In dialysis, and I speak especially as the co-Chair of the Kidney Caucus here in Congress, we can see access in Britain is far lower than in the United States. For coronary bypass, the United States is clearly much better. And in coronary angioplasty, we are significantly, by almost a factor of 6, better than other countries.

One of the key differences between the United States and other countries is people ask, Why do we spend so much money? Why do we have, in some areas, lower health outcomes? And part of it might be the health practices of Americans themselves.

This shows obesity across countries, and we know that, in general, Americans will be heavier than people from other countries.

□ 2200

And that leads to higher health care costs. The question is whether building a large State control which will restrict access to health care is the way to go, or whether a program, I think, that would have strong bipartisan support to encourage a reduction in obesity would be the more appropriate stand.

When we look at how to address health care needs, that is primary through health insurance. Health insurance currently in the United States is governed by the States. Some States have a fairly modest threshold for offering health insurance and therefore their health insurance costs would be expected to be fairly low. Other States would have extremely high mandates for health insurance, making it more expensive. As you can see here, the pattern differs, and it sets up a way for Federal officials to compare outcomes of health systems in our countries.

Probably the biggest difference that we see is in the difference of health care costs between New Jersey and California. In New Jersey, we see that health care costs are totaling $6,048 per patient, whereas in California they're down to $1,885. That roughly $5,000 difference is a tremendous barrier to access for medium- and low-income persons in New Jersey that is not present in California.

It should be the policy of the United States to remove barriers so that we can offer low-cost insurance like what is offered to the people of California and not have a highly regulated, high-barrier system, like New Jersey, prevail for the United States.

When we look at the uninsured, a number of people look just at the overall number, totaling $37 million in 2002,

totaling $49 million just afterwards. Obviously, with the recession that's going on, the number of uninsured has been rising. But we ought to look a little bit deeper as to who the uninsured are.

As this data shows from the National Survey on America's Families, we see that out of the 49 million uninsured, 22 percent were uninsured for just less than 5 months. Another 25 percent were uninsured for 6 months to 11 months. Roughly half were the long-term uninsured—over 12 months—that I think is very appropriate for Federal policy to look at.

As you can see, this problem might be somewhat smaller than originally estimated. Also, when you look at the uninsured, you have to ask the question: Can people access or do people have a problem accessing health insurance because they can't afford it? Or, for some, is it because they simply have decided not to pay for it?

When we look at the uninsured by household income, we find that 19 percent are over $75,000 in income, who really should have paid for health insurance on their own with that kind of income. That is above average for the United States. Eighteen percent, $50,000 to $74,000. Then, for the modest- and low-income, we see roughly 60 percent. Especially for the plus-$75,000 income, we ought to ask: Should the State, should the taxpayer be paying for their health insurance, or should we instead look for them to make some of their own decisions?

When we look at the very low-income uninsured, obviously we have a number of programs already addressing the needs of low-income Americans. This chart shows that a considerable number of low-income Americans are already eligible for public coverage. But as we have seen, for example, in the State of Massachusetts, for some of the very hardest to insure, with unsteady addresses, sometimes registering in the emergency room under different names, an insurance model may not be the best way to care for this group of people, our fellow citizens. A better way may be the public hospital approach that can take anyone at anytime, for a community in the 1 percent to 2 percent range that is very difficult in keeping solid addresses, solid identities, or keeping appointments.

When we look at the uninsured and how much the Federal Government already pays, by one estimate in 2004, the Kaiser Commission on Medicaid and the Uninsured estimated that we already commit about $35 billion on coverage for lower-income Americans. And the question that we may ask, which may not be fully explored in this Congress, is: Is that sum of money substantially above the gross domestic product of many of the members of the United Nations? Is that sum of money being wisely used already, or is there a system which would provide a more flexible and effective coverage for low-income Americans, which would in fact return a considerable amount of authority and power to them in making their own health care insurance decisions?

Now, in briefly reviewing the key details and issues before us, I want to also compare health care in the United States to that in other countries, especially the two principal models that many here in the Congress are looking to, Canada and the United Kingdom, for what they can tell us about how health care could be changed for the better or the worse in the United States.

In my view, our country should work towards providing a universal access to health care. While a nationalized government HMO could prompt tax increases, inflation, and a decline in quality, I think this Congress can enact policies to dramatically expand health care access for Americans.

When we reform health care, in my view, we should follow key principles, first and foremost, that reform should enhance the relationship that you have with your doctor. Insurance companies already interfere too much with our care. But a government HMO might do far worse.

Second, reforms should reward the development of better treatments and cures. Americans strongly support treating diseases like diabetes, heart disease, or cancer, but they are passionate about a cure.

Finally, reforms should be sustainable, because especially the sickest and most elderly of our citizens will depend for their very lives on these reforms.

The worst thing that we can do is to enact a health care program that the Federal Government cannot afford to keep. In considering United States health care reforms, many Americans look to Canada and Britain as our model. But Canadians have a very different view.

While over 60 percent of Americans are actually satisfied with their health care plan, only 55 percent of Canadians report the same satisfaction. Over 90 percent of Americans facing breast cancer are treated in less than 3 weeks, but only 70 percent of Canadians get such treatment. Meanwhile, thousands of Canadians come to U.S. hospitals instead.

The average Brit waits even longer—62 days. And Britain now has fewer oncologists treating cancer than any other Western European country. It may be no wonder that Britain ranks 17 out of 17 industrialized countries for surviving lung cancer.

Similar statistics tell a tale of lower quality care for coronary heart disease, where 94 percent of Americans are treated, versus 88 percent of Canadians; or emphysema, where 73 percent of Americans are treated versus just 53 percent of Canadians.

The most dramatic differences come in the field of cancer, where Britain's most respected medical journal, The Lancet, published the details of a very broad review of cancer and its survival rates in Europe and America. In short, here is what the Lancet reported:

The cancer survival rate for American men in September of 2007 was 66 percent. For European men, just 47 percent. The cancer survival rate for American women was 63 percent. For European women, just 56. Of the 16 cancers studied, only Sweden showed survival rates that were close to the American rates, but still well below our level.

We know that diabetes is one of the principal causes of senior health care problems. In the United States, 93 percent of Americans are treated within 6 months, while in Canada, less than half—43 percent—see a doctor in the same time. In Britain, it is even worse. Only 15 percent of British diabetics are seen within 6 months.

□ 2210

Over 80 percent of American women receive a mammogram, while only 73 percent of Canadians receive one.

Hip replacements offer a very stark contrast between the countries. In the United States over 90 percent of seniors are treated with a hip replacement within 6 months. In Canada, less than half of patients are treated in the same time, but many Canadians wait for a hip for over a year. Britain is not the place to break a hip because only 15 percent of patients are treated within 6 months, and many die during the wait.

Many advances of 21st century medicine come from MRI scans. Most Americans wait less than a week for an MRI. Most Canadians wait for over a year. In the United States, doctors use 27 MRI scans per million people. In Canada and Britain, it's less than a fifth of that at just five MRI scans per million.

The care for children also varies. Newborns most at risk need the close care of a neonatal specialist. In the United States there are over six neonatologists per 10,000 live births. In Canada they have fewer than four, and Britain has fewer than three. In our country we have over three neonatal intensive care beds per 10,000 births, just two and a half in Canada and less than one in Britain. It may be no wonder that babies in Britain have a 17 percent higher chance of dying compared to 13 percent a decade ago. Overall, the life expectancy of a British woman below the poverty line is falling.

The starkest difference in care between the countries comes when you are the sickest. In Britain, government hospitals maintain just nine intensive care beds per 100,000 people. In America we have three times that number at 31 per 100,000. In sum, Britain has less than two doctors per 1,000 people, ranking it next to Mexico and Turkey.

Even dentists are in short supply. The average American dentist sees 12 patients a day while the average British dentist must see over 30.

Stories of poor care under a government-only system are common in Britain. Last February, the Daily Mail reported Ms. Dorothy Simpson, age 61,

had an irregular heartbeat. Officials at the National Health Service denied her care because she was ''too old'' at age 61. The Guardian reported in June that one in eight British NHS hospital patients wait more than a year for treatment.

We know that governments regularly run out of money, and this can have a real impact if they are in charge of you or your family's health care. Ontario canceled funding for childhood immunizations, routine eye exams and physical therapy services when they ran out of money. Government unions also regularly go on strike. In British Columbia they had to cancel 5,300 surgeries during a health care worker strike. The Fraser Institute, an independent Canadian research organization, reported that the average wait for surgery is now up from 14 to 18 weeks. Queen Elizabeth Hospital in Halifax reports that its X-ray machine—by the way, no MRI available—was installed during the Nixon administration. To compare, Northwest Community Hospital in Arlington Heights, Illinois, flunks its own publicly reported quality standard if a patient does not receive a PCI test within 90 minutes of surgery.

In Washington there are many proposals to have the government take control of health care. Some bills in Congress even call for pushing all uninsured people, including illegal aliens, into Medicare. We should look very carefully at such proposals.

Remember, Medicare covers 40 million Americans at a taxpayer cost of $400 billion annually. Adding another 40 million patients to Medicare's costs would likely cost taxpayers an additional $400 billion annually. Knowing the government will run a $2 trillion deficit this year during the worst recession in living memory, can we enact an enormous tax increase, or do we just have to borrow the money from China?

Seniors and low-income Americans will absolutely depend on the Congress's promises, and I believe the worst thing that we can do is make commitments that are too expensive and then pull the rug out from those who can least afford to cope. Instead, we should back bipartisan reforms that the government can afford to keep.

There are a number of steps Congress should take to expand access to care and bring down the cost of medicine. First, we should expand the number of Americans who have access to employer-provided health care. One of the best ways to do this is to allow small businesses to band together to form larger pools of insurable employees to share risks and administrative costs. We should also allow franchises to offer national health care plans so that their members, working at Starbucks or AlphaGraphics or Subway, can create one large national insurable pool of their generally younger and currently uninsured employees.

Second, Congress should expand access to care for millions of self-employed Americans who do not have insurance. A refundable tax credit for individuals and families equal to the same tax credit large employers get would help millions buy insurance. Individuals could be eligible for a credit of up to $5,000 annually, and lower income families would be eligible for a credit worth up to $8,000.

Third, as jobs become more portable, so should health insurance. We should protect Americans who lose their jobs, and their families, who are excluded from coverage by pre-existing conditions. Congress should also remove the current 18-month time limit on COBRA continuing health insurance coverage. This would give families the option of always, if they wanted to, at their own expense, sticking with the health insurance plan they like and currently have. This expanded coverage should also act as a bridge for retirees who may not yet be eligible at age 65 for Medicare.

Fourth, we must pass commonsense measures to bring down health care costs. The Veterans Administration already uses fully electronic medical records to care for 20 million patients while saving lives and cutting wasteful spending.

We also need lawsuit reform. State supreme courts controlled by the plaintiff's bar, like in my home State of Illinois, are expected to strike down local lawsuit reforms that cap noneconomic damages in medical liability cases. We need Federal lawsuit reforms to lower insurance rates across the country, keeping doctors in the practice of medicine.

Finally, the Federal Government should mandate and enforce the right to see in-house infections caused by hospitals. Nearly 2 million Americans contract hospital infections every year, costing Medicare about $5 billion annually. We should create incentives for hospitals to reduce their infection rates and to publish their results.

In sum, there's a great deal that the President and Congress could do without making the mistake of Xeroxing the 40 years of mistakes made in Canada and Britain.

So having described some of the issues that we face, let's look in detail at one of the key numbers driving the debate here in Washington—the uninsured. According to last year's Census, there are 45.7 million uninsured in America. But according to CRS, 9.5 million of those are illegal aliens, 6 million are children now covered by the SCHIP program that I voted for that was signed into law by President Obama in January, about 10.8 million have above-average incomes in the United States, and about 9.1 million are only temporarily uninsured. That means that if we focus on the problem of U.S. citizens who are of lower income, who have not been insured for longer than a year, it is 10.3 million folks, hardly a number that justifies a government takeover of health care, but one that a bipartisan centrist agenda could address to make sure that those family members have the health insurance they need.

Yesterday I took a survey of voters in Illinois. We received 3,400 responses, and the question we asked was this, ''Should Congress raise taxes to fund a new government health care plan?''

□ 2220

The answers came back: 2,730, or 80.3 percent, said ''no''; and only 454, or 13.4 percent, said ''yes''; 214, or 6.3 percent, said they didn't know. Clearly, in the face of the deepest recession in modern memory, we should not raise taxes in a significant way throwing millions of families out of work for a government program that we cannot afford to keep.

Therein comes the third part of my discussion tonight. Given these problems, given the comparisons to other countries, and given the fiscal constraints on the Federal Government, is there room for a bipartisan reform agenda in Congress? The answer is emphatically ''yes.'' And we will outline that tomorrow in front of 70 different groups.

In the view of the Tuesday Group reform agenda, our comprehensive reform agenda will accomplish eight major goals. Number one, we will guarantee the doctor-patient relationship. Number two, we will put forward reforms that will lower the cost of health insurance. Number three, we will increase the number of Americans who have insurance. Number four, we will allow Americans to keep insurance they like. Number five, we will improve quality and accountability. Number six, we will increase personal responsibility. Number seven, we will lower the demand for federal borrowing. And, finally, number eight, we will do it in a bipartisan and sustainable way so that momentum for this program will not just be built up during the Obama administration, but future presidencies, including Republican presidents.

In this agenda, our primary objective is to guarantee your relationship with your doctor. That is why tomorrow we will be putting forward the Medical Rights Act. The Medical Rights Act will guarantee the rights of patients to carry out the decisions of their doctor without delay or denial of care by the government. This legislation will uphold the right of individuals to receive medical services as prescribed by their doctor and will not allow the government to restrict or deny care if the care is privately provided. We allow, of course, the government to run its own health care programs for the military, for TRICARE, for the VA, for the Indian Health Service and others. But if the health care is paid for by you, you should control it. And there should be no attempt to control your health care by the Federal Government.

The reason why we think this is necessary is because in other countries it is illegal for patients to pay for the care out of their own pocket. The most infamous restriction comes against Canadian citizens that face this barrier.

For them, they at least have one out, because the drive is not too far to the United States. But if we have the government take over health care in America, where will we be able to drive? And how will we find care if it is denied by a government program? That is why we need the Medical Rights Act. And in my judgment, it fulfills the promise of the President that you will always have choice and control of your health care. It is a bill that he should support.

Secondly, our goal is to lower the cost of health insurance. What we would like to do is allow alliances to form, for example, among the Libertyville Chamber of Commerce members or among national franchise members to build larger and larger insurance pools from self-employed or small employers to spread risks, lower cost and share administrative expenses.

We would also like to equalize the tax benefits that the self-employed receive so that small and self-employed individuals have the same tax break that large employers have when they provide health insurance to their employees.

To lower the cost of health insurance, you also need lawsuit reform. And the proliferation of frivolous malpractice lawsuits, as demonstrated on late-night TV for all the ads that you see, would be a huge reform that would help us drive down the practice of defensive medicine and therefore the cost of health insurance.

Doctors who practice in certain high-risk fields such as emergency medicine, general surgery, thoracic surgery and obstetrics and gynecology especially need this reform to stay in the practice of medicine. By one estimate, the cost of defensive medicine in the United States is over $100 billion a year. Our reforms will call for blame to be allocated responsibly among key parties, to stabilize the compensation for insured patients and to encourage the States to adopt innovative strategies, especially alternative dispute resolution incentives for doctors and hospitals, and new health care courts specializing in resolving medical injury disputes.

We will also be calling for State innovation programs to reward States that reform insurance markets to provide a more flexible insurance product to meet the needs of patients. Instead of dictating and controlling health insurance from a new Washington national office, the Congress should follow the direction of the National Governors Association that said that States must have the flexibility to respond to justifiable variation in local conditions and costs. Obviously, health care in Alaska is very different from health care in Florida. And we should allow States to manage that flexibility in the most appropriate way. Programs that we focused on and looked at most intensely are Idaho's high-risk reinsurance program and the Massachusetts State insurance program. And these flexible programs should not be overridden by Congress.

We also want to provide more control and flexibility, but most importantly, dignity to low-income patients. With 25 percent of people already eligible for public coverage, not even enrolling in the public plans currently offered, we should find ways to have patients be able to join lower-cost private plans that with a combination of subsidies and tax credits, lawsuit reform, health information technology and deductions would not only make their insurance more affordable but would suddenly give lower-income Americans the same control over their health care that middle- and upper-income Americans have.

Another key point of our agenda reform is to increase the number of Americans who have access to health insurance. There is a key point of common sense here that lowering the cost of health insurance will expand access. As I outlined earlier, on average, health insurance in California costs about $5,000 less than health insurance in New Jersey. By permitting health alliances and pooling national resources, deploying health information technology and equalizing tax breaks for self-employed Americans, we will dramatically lower the cost of insurance and therefore expand access.

We should also take some time to expand rural health care. In the Congress, the National Health Service Corps and the area health care centers should be reauthorized and expanded to make sure that we can address this critical rural need, especially in primary care.

One of the items not talked about very much in the House or the Senate is the potential for damage that we could cause to the health insurance that Americans currently have. Legislation in the House and Senate called the Healthy Americans Act would end the tax break for employer-provided health insurance in the United States. That sounds like a technical phrase, but you should remember that employer-provided health plans cover 160 million Americans. And most of those plans are supported through the ERISA legislation and tax break that employers receive. Legislation like the Healthy Americans Act not only kills the Federal Employer Health Benefit Plan that covers every Member of this Capital, staffer, Senator, Congressman and all Federal employees, but it then goes on to wipe out the Federal tax break under ERISA for the other 155 million Americans that depend on this health insurance.

□ 2230

In fact, just yesterday, the Director of the Office of Management and Budget said we may need to look at cutting back the tax benefit that supports employer-provided health care. In my view, this is an idea whose time has never come.

One of the key rules in health care is to do no harm, and for this Congress to attack employer-provided health care is an attack on the health care of every Federal employee and 155 million civilian employees who depend on employer-provided health care.

Instead, our bipartisan agenda strengthens employer health care and continues the benefits under ERISA that cover 160 million Americans. We should not only allow Americans to keep the health insurance they like, we should also improve quality and accountability. One of the best ways to do that is to accelerate the deployment of health information technology.

The Congress should accelerate the setting of standards and using payment incentives under Medicare, Medicaid, TRICARE, which covers military retirees, and the VA and Indian Health Service to encourage the more rapid deployment of health information technology to reduce medical errors, to limit the waste of defensive medicine, and to improve health outcomes. Many of these advances, especially with electronic medical records, have already been made at the Veterans Administration, leading to an 80 percent reduction in health errors.

Key health information technologies also include e-prescribing, chronic disease registries, and clinical decision systems that will dramatically lower cost, improve outcomes, and eliminate errors.

This Congress also needs to work on eliminating fraud, waste, and abuse in the current government health care systems. The Congressional Budget Office estimates that more than $10 billion in improper Medicare payments were made in 2008 alone. There is strong bipartisan support for a number of policies outlined in both the Ways and Means and Finance Committees to improve transparency, to prosecute fraud, and to require provider accountability.

When we look to the future, I think we should emphasize research and not rationing. It was a bipartisan effort led by President Clinton and Speaker Gingrich that doubled the resources to the National Institutes of Health. In my view, we should accelerate that momentum on basic research.

The Congress also approved funding for comparative effective research. Now, this research has the potential to help patients and doctors to make informed decisions. But many in the Congress would like to use the $1 billion recently approved for comparative effectiveness research to actually begin a system of restrictions and rationing in the United States. In my view, this takes us into the problems that I described earlier in my talk and would ruin some of the key advances that distinguish American health care among those of our allies.

We should also foster public-private partnerships to avoid an innovation gap that is currently existing between where public research, especially funded by the NIH, ends and where real

health care delivery mechanisms can begin.

Congress can use this opportunity to foster a new bridge for biotech companies, universities, patient advocacy organizations, pharmaceutical companies, and research institutions to accelerate the deployment of new research in the practice of medicine, an area where the United States has excelled, a country that has already received more Nobel Prizes in medicine than any other country on Earth.

Finally, on the research side, we should look at compassionate access. With little to lose, many terminally ill patients can only hope for the very quick FDA approval of cutting-edge treatments and drugs for hope in their own case. Compassionate access can provide real hope to patients that need it most, can save their lives, and can accelerate treatments for nearly everyone, but especially the seriously ill.

When we look at the key objectives of this bipartisan agenda, we also have to return to a basic principle, I believe, central to the American character, which is increasing personal responsibility. It's time, like the chart that I outlined here, to look at bad health habits, principally obesity, drinking, and smoking, and to encourage or reward Americans who do not exhibit these habits. Normally, we see 75 percent of the Nation's health care spending is dedicated to chronic diseases related to these three areas, all entirely preventable if we encourage the right habits.

Also, we ought to expand the use of health savings accounts, because we know that Americans who directly control health spending from their own tax-deferred health savings account, much like an IRA, will take a much greater role in the health care decisions they make. Their patient compliance will likely be higher, and the choices they make will be more appropriate for end-of-life care. These health savings accounts are critical, not just to empowering patients, but also to eventually either becoming part of a patient retirement savings or an estate for their children.

Finally, when we look at all of these reforms, we have to pay key attention to the bottom line. Health care reform in the United States has to lower the demand for Federal borrowing, now at what the President already describes as a completely unsustainable rate. Because many sick and elderly Americans will depend on the reforms that we make, the reforms instituted by this Congress must be fiscally responsible and sustainable over time.

The Congressional Budget Office reports that we will borrow $1.18 trillion just in fiscal year 2009 in a completely unsustainable way, and that new revenues for a health care bill that could be put forward by this House are simply not there.

In its place, this Congress could look at an enormous tax increase or at faltering climate change legislation that already looks like it will not provide the revenues initially hoped for in its early drafts. In the face of this lack of funding, either on the borrowing side or the unwillingness of Americans to go through a new tax increase and faltering prospects for a climate change bill, it's essential that we return to the kind of reforms that I just outlined here tonight as a way to lower the cost of health insurance, expand access, and improve health care outcomes.

I spent quite a bit of time here tonight talking about the situation in detail because, in my view, this is going to be the biggest subject this Congress deals with this summer. When we look at the worst angels of our nature, we might be able to expect a fairly fierce and partisan debate here in the House. That is predictable but unfortunate.

My hope lies in the moderates of the Senate who can come forward and make sure that we have a bipartisan, modest, and sustainable set of health care reforms that will improve health care for every American in this country in a sustainable way across Presidential administrations and across parties, and not end up making the same mistakes as our allies in Canada and Britain.

Well, those are the details. We will be providing further details in the Tuesday Group meeting tomorrow, and we look forward to joining with many Members on the Democratic side in building what can be one of the greatest opportunities for this Congress to affect the daily lives of the Americans that we represent.

And I yield back the balance of my time.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. ELLISON (at the request of Mr. HOYER) for today on account of official business in district.

Mr. KANJORSKI (at the request of Mr. HOYER) for today on account of official business.

Mr. STUPAK (at the request of Mr. HOYER) for today.

Mr. WAMP (at the request of Mr. BOEHNER) for today on account of his 24th wedding anniversary.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. HARE) to revise and extend their remarks and include extraneous material:)

Ms. WOOLSEY, for 5 minutes, today.

Mr. HARE, for 5 minutes, today.

Mr. DEFAZIO, for 5 minutes, today.

Ms. KAPTUR, for 5 minutes, today.

(The following Members (at the request of Mr. BROUN of Georgia) to revise and extend their remarks and include extraneous material:)

Mr. POE of Texas, for 5 minutes, May 22.

Mr. JONES, for 5 minutes, May 22.

Mr. PAUL, for 5 minutes, May 19, 20 and 21.

Mr. MCHENRY, for 5 minutes, May 19, 20, 21 and 22.

Mr. MORAN of Kansas, for 5 minutes, today, May 19, 20 and 21.

Mr. BROUN of Georgia, for 5 minutes, today.

ADJOURNMENT

Mr. KIRK. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 10 o'clock and 39 minutes p.m.), under its previous order, the House adjourned until tomorrow, Tuesday, May 19, 2009, at 10:30 a.m., for morning-hour debate.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 2 of Rule XXIV, executive communications were taken from the Speaker's table and referred as follows:

1876. A letter from the Secretary, Department of Health and Human Services, transmitting the Department's reports entitled, ''The National Healthcare Quality Report 2008 (NHQR)'' and ''The National Healthcare Disparities Report 2008 (NHDR)'', pursuant to Public Law 106-129; to the Committee on Energy and Commerce.

1877. A letter from the Acting Assoc. Bur. Chief, Federal Communications Commission, transmitting the Commission's final rule — In the Matter of Amendment of Part 90 of the Commission's Rules [WP Docket No.: 07-100] received April 30, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

1878. A letter from the Acting Assistant Secretary For Export Administration, Department of Commerce, transmitting the Department's final rule — Additions and Revisions to the List of Approved End-Users and Respective Eligible Items for the People's Republic of China (PRC) Under Authorization Validated End-User (VEU) [Docket No.: 090415662-9687-01] (RIN: 0694-AE61) received April 30, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Foreign Affairs.

1879. A letter from the Chairman, Federal Accounting Standards Advisory Board, transmitting the Board's report entitled, ''Estimating the Historical Cost of General Property, Plant, and Equipment: Amending Statements of Federal Financial Accounting Standards 6 and 23'', pursuant to Section 307 of the Chief Financial Officers Act of 1990; to the Committee on Oversight and Government Reform.

1880. A letter from the Director of Regulations Management, Department of Veterans Affairs, transmitting the Department's final rule — Per Diem for Nursing Home Care of Veterans in State Homes (RIN: 2900-AM97) received April 27, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Veterans' Affairs.

1881. A letter from the Director of Regulation Management, Department of Veterans Affairs, transmitting the Department's final rule — Headstones and Markers (RIN: 2900-AN29) received April 30, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Veterans' Affairs.